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Identifying the Capacity Building Needs of Two Urban Indian Health Clinics

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Description of Need

Sexually transmitted infections (STIs) continue to be a serious health concern for American Indian and Alaska Native (AI/AN) people. In 2009 the rates of chlamydia and gonorrhea among AI/AN were 4.2 to 4.3 times, respectively, compared to the rates of Whites.^{1,2} According to the Center for Disease Control and Prevention (CDC) and Indian Health Service (IHS) joint published surveillance report on the state of sexually transmitted infections in Indian Country, the overall IHS chlamydia rate was 2.0 times higher than the US rate (816.2 and 409.2 cases per 100,000 population respectively), and the rate of gonorrhea versus the US average was 111.6 and 99.1 cases per 100,000 population.³

April is STD Awareness Month

This is the fourth year that the National STD Program has presented a special April issue of *The IHS Provider* to draw attention to STD Awareness Month; the noteworthy efforts of the program and its partners are reflected throughout the articles.

For more information about the IHS National STD Program, visit <http://www.ihs.gov/epi>.

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STI rates vary by IHS Area, with some Areas coming in well under the national average, and others continuing to battle particularly high rates and localized transmission patterns. The Aberdeen Area (comprised of North and South Dakota, Nebraska, Iowa, and part of Minnesota) had the second highest rate of gonorrhea and chlamydia in 2009 among all Areas (surpassed only by the Alaska Area).⁴ This region is also home to some of the largest American Indian reservations and poorest counties in the country.⁵ Within the state of Nebraska, the STI rates are significantly higher in Omaha and Lincoln (the two largest cities). Douglas County (where Omaha is situated) reported 2,731 cases of chlamydia in 2010 (almost three times as many as the second highest county, Lancaster [where Lincoln is situated] with 955 cases).⁶ This statistic is mirrored in the gonorrhea statistics, with Douglas County reporting 779 cases and Lancaster 217 in 2010.⁷ About 18,427 people (or 1.3% of the Nebraska population) identify as American Indian or Alaska Native, and an estimated 7,000 live in the Omaha and Lincoln areas alone.^{8,9,10}

Denver is located within the Albuquerque IHS Area, and is home to the largest urban Native community in the state of Colorado, one of the largest in the region. The Native American population in Denver has been disproportionately impacted by STI. Within the state, the chlamydia case rate in 2010 among American Indians was 255.3 per 100,000 (second highest among reported specific racial/ethnic categories).¹¹ The number of new STD visits for American Indians at the Denver Public Health (DPH) STD Clinic decreased by 60% from 2007 to 2011.¹² While this could be attributed to many reasons, the statistic clearly indicates American Indians are not accessing STD screening and treatment services through the highest traffic STD clinic in the metropolitan area. From those receiving screening services from the DPH STD Clinic, there was a 13.9% positivity rate for chlamydia (third highest among reported racial/ethnic categories) and a 2.9% positivity rate for gonorrhea (second highest).¹³ American Indians receiving services at the clinic also exhibited the lowest percentage accepting expedited partner therapy (50%).¹⁴

These statistics point to a need to 1) further identify the nature of the STI health disparity among American Indians, and 2) explore the need to provide services and technical assistance to strengthen resources available and accessible to American Indians and Alaska Natives to address the disparity.

Project Overview

In 2012, the National Native American AIDS Prevention Center (NNAAPC) was funded for one year by the Division of STD Prevention, CDC in collaboration with the Office of State, Tribal, Local, and Territorial Support, CDC to 1) strengthen the capacity of urban Indian programs to conduct effective and culturally responsive STD/HIV education, counseling, screening, and referral services, and 2) facilitate the communication and collaboration between the targeted

providers, community-based partners, and stakeholders.

Based upon STI prevalence, and through informal consultations with the IHS, NNAAPC decided to focus programmatic efforts in the Aberdeen and Albuquerque Areas. Two clinics within those areas were approached: Nebraska Urban Indian Health Coalition and Denver Indian Health and Family Services. Clinic leadership and staff were contacted and invited to participate. Upon acceptance, MOAs were drafted with each clinic. Each of the clinics agreed to participate in a site visit, complete an assessment, create an individualized action plan, engage in a series of webinars, attend a face-to-face project meeting and training in Denver, attend the National Indian Health Board Public Health Summit, and host on-site capacity building activities (i.e., trainings, coaching). In order to facilitate completion and offset any related costs of individually identified capacity building needs, each clinic was provided a small monetary stipend. All project activities were to be completed within 12 months.

Assessing Needs

NNAAPC created a standardized assessment document, which assessed current clinical operations across seven different domains: clientele, STI testing and screening, STI treatment, marketing/networking, program evaluation, STI prevention and education, and capacity building and training needs. NNAAPC project staff sat down with clinical staff from each partner site to discuss the project and to conduct the comprehensive assessment. The assessment is designed to qualitatively and quantitatively identify areas of strengths and areas of potential improvement. It was at the discretion of clinical staff who would participate in the assessment process; however both clinics created opportunities for multiple parties to preview the assessment tool, and to jointly complete it with NNAAPC staff.

Completed assessments were analyzed by NNAAPC staff. The goal of analysis was to identify areas for potential and desired improvement. NNAAPC staff developed individualized plans for addressing these areas, which were reviewed, edited, and ultimately approved by each of the partner sites.

Identified Needs and Strengths

The following tables present data culled from the two assessments conducted with Nebraska Urban Indian Health Coalition and Denver Indian Health and Family Services staff. These tables contain paraphrased areas of strengths (from the both the organizational and staff perspective) and areas of identified needs for growth and development, and are only a small portion of what was reported to NNAAPC staff in the completed 87-question assessment documents.

The challenges, barriers, and needs presented in Tables 1, 2, and 3 are neither quantified nor prioritized in terms of urgency or debilitation. They are simply a presentation of stated areas for technical and capacity building assistance.

Table 1. Organizational challenges when providing (or seeking to provide) STI testing and screening

| |
|---|
| Lack of lab technicians |
| More training on conducting HIV testing as part of routine medical care |
| Lack of onsite lab to conduct more complex tests |
| Lack of onsite pharmacy |
| Patients must pay for non-CLIA waived STI testing |

Table 2. Significant barriers to the provision of STI services to the community

| |
|---|
| Small size of target population |
| High risk homeless people, people who inject drugs, and people with HIV are hard to reach |
| Men in their 20s and 30s do not regularly seek out medical care or testing |
| Lack of funding |
| Limited and small staff |
| Denial of risk among target populations |
| Poor access to services (e.g., location, transportation problems, geographic challenges) |
| Target population unaware of available services |
| Insufficient coordination and collaboration among service providers |
| Prevailing STI stigma |
| Lack of access to training, technical assistance, and other resources |
| Co-factors of trauma, abuse, and substance abuse |
| Takes time to establish credibility with the community |
| Community misinformation about STIs |
| Do not distribute STI treatment |

Table 3. Identified needs of the program/clinical staffs, and organization

| |
|---|
| Cultural competency for special and high risk populations |
| Monitoring and evaluation |
| Strategic planning |
| STI testing/screening |
| STI treatment |
| STI lab processing |
| Assistance partnering with other agencies and creating networks |
| Counseling and interviewing techniques |
| Information about the impact of the Affordable Care Act on service delivery |
| Updated policies/procedures/standing orders to govern STI testing and treatment |

Table 4. Identified strengths of the program and clinical staffs

| |
|--|
| Acknowledged their role in the Native community as providers of health and wellness |
| Desire to perform expanded and enhanced screening |
| Belief they had the ability to impact rising STI rates |
| Understood the impact of STIs in the community |
| Possessed professional and personal experience with the STI |
| Have necessary referral network |
| Onsite lab to process CIAA waived tests (GC and CT cultures, RPR, HIV rapids, and HCV tests) |
| Multiple staff able to conduct STI testing |
| Risk reduction counseling is offered to high risk patients |

Table 5. Identified strengths of the organization

| |
|--|
| Integrated routine testing for not just HIV, but for people who present with risk co-factors for STIs |
| Relationship to state health department allows access to training, materials, and medical consultation |
| Onsite lab to process GC and CT cultures, RPR, HIV rapids, and HCV tests |
| Community is aware of STI services provided |
| Linked databases and electronic health records help to track STI patients, tests, and data |
| Allow for the distribution of condoms and other prevention materials |
| Can provide services for free or reduced costs depending on enrollment status and available funding |
| Good facilities |

The strengths presented in Tables 4 and 5 are neither quantified nor prioritized. They are simply a presentation of stated areas for of acknowledge capacity and development. These strengths are the foundation for providing assistance to address any identified need.

Discussion and Conclusion

This article is seeking to highlight the results of the assessments conducted with the two urban Indian health clinics. The results presented herein cannot be generalized to all urban Indian health centers, much less all IHS and tribal clinics. It is also important the particular challenges and barriers presented here not be misconstrued as a representation of any significant deficiency on the part of the staff of each of these clinics. Quite the contrary appears to be true. The staffs at both clinics are highly motivated, professionally trained and licensed, knowledgeable about STIs, motivated to make changes at both the clinical and community level, and willing

to work within their respective systems to bring about that level of change. The primary barriers presented (consequently barriers that are difficult to overcome in such a short amount of time) are those related to funding and community norms.

Funding. The level of desire to enact change on the part of the staff is not aligned with the diminished and consistently stressed funding streams under which they operate. These constraints have effectively halted efforts to work outside the clinic walls – to conduct education and prevention efforts, community wide social marketing efforts, distribute condoms, or create community-specific brochures and materials. Both staffs stated clearly they would like to do community-based educational sessions and presentations, but do not have the funding or the staff to make it a reality. Prevention cannot happen solely within the walls of a clinic.

Communal Attitudes. The collective political will and attitudes of the community also pose a significant barrier that short term capacity building assistance cannot effectively

impact. Community norms around not talking about sex or disease are prevalent in both communities, and are barriers to people accessing services, as well as clinical staff taking prevention messages to the community. Norms and the reigning political reality around drug use also prevent staff from conducting syringe service programs — even though the desire is present and the science justifies the effectiveness of such efforts.

Training and Technical Assistance Resources. In order to maintain the capacity that already exists and capitalize upon the desire expressed by clinical staff, there is a need to expand the training and technical resources available to urban Indian clinics. That is not to say high quality resources are not in existence; however, concerted efforts should be made to 1) bring those training resources to the sites (as often time, training and TA efforts are not focused in lower seroprevalent states or cities), and 2) ensure Native clinics are familiar with the resources and have open channels of communication with program coordinators responsible for allocating training and TA resources. Each of the urban clinics relied heavily on their respective state health departments for training. While this is an excellent use of local resources, regional or national programs like the National Network of Prevention Training Centers, the AIDS Education and Training Centers, and the Addictions Technology Transfer Centers have professional designed skills building opportunities that can benefit urban clinics — especially in their expressed needs to address community risk co-factors (such as substance use), reach high risk populations, coordinate and network among service providers, instituting routine HIV testing, and raise the level of staff's cultural competence (with lesbian, gay, bisexual, transgender, and two spirit peoples; substance users; and other racial and ethnic groups). These training programs should tailor content for Native populations through regular communication regarding outstanding training needs and, ideally, offer continuing education credits as a key incentives for clinical staff to attend.

Policies and Procedures. Policies and procedures are a direct reflection of the internal operations of an organization, and a key component to sustainable infrastructures. Policies and procedures need to reflect the most up-to-date clinical information, treatment modalities, screening processes, and federal recommendations. While each of the participating sites had policies and procedures (to include standing orders), they also expressed their desire to update them. This is a short term CBA need that can be addressed fairly quickly, but can have a lasting impact. Policies and procedures can be designed in such a manner as to include not just medical practice, but clinical practice as well (i.e., designate staff responsibilities, outline reporting procedures, strengthen referral services, include evaluation practices, reinforce confidentiality measures, and state appropriate front desk best practices). A policies and procedures template that can be produced and disseminated to urban programs may be beneficial and help to ease the burden

of reconstructing such a document internally.

The intent of this grant program is to examine and address short term capacity building needs. Within a short time frame, such needs have to be prioritized by cost effectiveness, impact, and feasibility of implementation. NNAAPC has attempted to work with the sites to undertake this and create plans that include activities that focus on networking, resource brokering, knowledge and skills development, and cultural competency. However, there are longer-term CBA needs that have been identified by each of the sites, and these cannot be ignored. The fostering of relationships with funders and health departments to identify resources to expand urban Indian health programs to include onsite pharmacies, enhanced laboratory services, and more comprehensive public health programming and that addresses behavioral health and community-based education can only serve to raise the health and wellness of Native American communities. It is not until the level of service provision is raised to align with the need in the community that STI rates begin to fall significantly.

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Our Apologies

We apologize for the delay in the production of this issue. Constraints on funding at the end of the fiscal year made it impossible to complete the preparation of the issue until now.

We will catch up with our usual monthly publishing schedule as soon as possible. We are currently accepting submissions for the August issue.

Native GYT Efforts: A piece of the sexual health puzzle

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The Indian Health Service (IHS) supports various efforts to promote the sexual health of American Indian and Alaskan Native (AI/AN) populations. Communities address HIV and STDs by promoting holistic sexual health and well-being.¹ Currently, the IHS is entering its fourth year of partnership with the GYT campaign to empower Native youth to take care of their sexual health. The **GYT: Get Yourself Tested** campaign (www.GYTNOW.org) was created to reduce the spread of STDs among young people through information; open communication with partners, providers, and parents; and through testing and treatment as needed. Although race and ethnicity alone do not put individuals at higher risk for STDs, AI/AN people are disproportionately affected by high rates of HIV and common STDs, including chlamydia, gonorrhea, and syphilis.

To promote the GYT campaign, the IHS National STD Program is collaborating with the Centers for Disease Control and Prevention (CDC), MTV Networks, the Kaiser Family Foundation, and Planned Parenthood Federation of America. In 2012, many creative on-the-ground and online activities such as family cookouts, talent shows, banner ads on Native-specific websites, online videos, and promotional materials in local clinics were used to spread the GYT message. These efforts and more are being encouraged this year during April in support of STD Awareness Month.

GYT efforts with Native youth have not only been enthusiastic and successful, these efforts are part of broader efforts focused on sexual health promotion at CDC. In recent years, national leaders in public health, including those at CDC, have become more interested in the role that promoting wellness and healthy decision-making can play in preventing

diseases and injuries.² The US faces significant public health challenges related to sexual behavior, including high rates of HIV, STDs, teen pregnancy, and sexual violence. These adverse outcomes result in substantial economic costs annually.³ Many efforts to address sexual and reproductive health issues that focus on specific diseases and other negative outcomes have not provided optimal results. Alternatively, complementing existing efforts with more holistic and wellness-based approaches to sexual health has the potential to enhance traditional prevention efforts.

To raise interest and increase dialogue around sexual health, CDC sponsored a supplemental issue on sexual health in the February 2013 issue of *Public Health Reports*. This issue contains various articles on the evidence base and practical application of sexual health. Articles focus on priority areas including:

- Research (e.g., the impact of individual and social level factors on sexual health);
- Surveillance - (e.g., ways to measure domains of sexual health);
- Programs (e.g., examples of sexual health program implementation); and
- Commentaries -on the need for provider training and national leadership in sexual health.

Findings outlined in the supplement suggest that a more holistic approach has the potential to impact sexual health outcomes in positive ways. This supplemental issue is particularly timely given recent national recognition of the importance of sexual health in documents such as *Healthy People 2020*⁴ and *The National Prevention Strategy*.² The supplemental issue provides new insights into sexual health, which we hope will help increase the knowledge base and facilitate progress in the field of sexual health.

CDC also supports partners working in sexual health. In 2011, Partnership for Prevention received funding through a CDC cooperative agreement to manage a national coalition for sexual health promotion. In 2012, the National Coalition for Sexual Health (NCSH) was established to advance sexual health in the general population and to conduct more targeted work with adolescents and men who have sex with men. Its mission is *to improve sexual health and well-being by encouraging productive and sustained conversations about*



*sexual health and promoting high quality sexual health information and health services.*⁵ Goals of NCSH include empowering individuals to protect their own sexual health and encouraging organizations and health professionals to use positive, evidence-based approaches to promote sexual health and well-being.

In their work thus far, NCSH has held consultations and reviewed research to guide their work in five areas central to sexual health. These include health care, public policy assessment, communication, sexual health education, and sexual violence prevention. NCSH is guided by a steering committee comprised of Morehouse School of Medicine's Center of Excellence in Sexual Health, the American Academy of Nurse Practitioners, the National Campaign to Prevent Teen and Unplanned Pregnancy, the National Viral Hepatitis Roundtable, and Project Inform. Currently, other organizations and individuals with shared interest in sexual health promotion are being invited to join NCSH. Organizations interested in learning more about or joining the National Coalition for Sexual Health can contact Partnership for Prevention (e-mail nesh@prevent.org, or telephone (202) 375-7805).

CDC is also interested in the increasing number of state health departments developing approaches to comprehensively address sexual health. Three state plans have already been released to improve specific program outcomes (e.g., prevention of teen pregnancy, STDs) because previous risk-based strategies to address the problem were not thought to be producing optimal results. Several more plans are currently being developed. Many of these efforts are underway in states with a larger concentration of AI/AN populations, and their implementation may be relevant to Native youth. For example, with the release of their state plan in 2009, Oregon shifted from a predominantly risk-focused approach to teen pregnancy prevention to one centered on youth sexual health promotion.⁶ The 2012 Colorado statewide plan uses a holistic perspective to address sexual health as an important part of young people's lives, in order to complement the prevention of adverse outcomes such as STDs and teen pregnancy.⁷ Minnesota and Massachusetts also have emphasized sexual health promotion within state programs.^{8,9}

CDC has been interested in learning from these state-based efforts, and in May of 2012 provided technical assistance to the National Coalition of STD Directors (NCSH) in surveying state health department programs about their efforts to address adolescent health and prevention of STDs, HIV, teen pregnancy, and sexual violence. Among the respondents, almost half reported current activities related to sexual health. In follow-up to the survey, in February 2013, CDC supported NCSH in convening a meeting on "Advancing Sexual Health through State Sexual Health Plans." The meeting aimed to facilitate collaborative relationships as participants shared and learned about emerging practices in the development of state sexual health plans and their linkage to national level efforts. Attendees at the meeting included representatives from

departments of health and education at the state level, and community partners such as non-government organizations (NGOs) and universities.

Overall, CDC looks forward to further collaboration with IHS and other federal agencies, states, and other partners to improve the sexual health of youth and adults in Indian Country and across the nation. It's time to GYT and advance our sexual health!

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Treating Sexual Contacts of Gonorrhea and Chlamydia Cases: A Critical Component of STD Control Among AI/AN Populations

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In the wake of rising gonorrhea cases amidst high background chlamydia rates among AI/AN populations,^{1,2} multiple Indian Health Service (IHS) Areas have been faced with the need to expand sexually transmitted disease (STD) services to accommodate increased demand and disease burden.³⁻⁶ National recommendations include chlamydia screening of young sexually active women ages 25 and under, and some service Areas have expanded this screening recommendation to include men, broader age groups, and additional infections, depending on local morbidity.⁷⁻¹⁰ Screening for gonorrhea among women tends to follow that of chlamydia as the widely used Nucleic Acid Amplification test (NAAT) for chlamydia is automatically paired with a gonorrhea test. However, within IHS Areas that do not have screening recommendations for asymptomatic men, diagnosis following symptomatic presentation or referral as a partner to a female case remain the predominant gonorrhea and chlamydia identification measures among males.

Patient Delivered Partner Therapy

Contact (partner) tracing and treatment is an evidenced-based component of STD control.¹¹ Both men and women treated for chlamydia and gonorrhea have high rates of re-infection due to re-exposure to untreated partners.¹² In addition to increasing the availability of STD screening to diagnose asymptomatic infection, many service units have adopted protocols for the use of Patient-Delivered-Partner-Therapy (PDPT) also known as Expedited Partner Therapy (EPT),^{7,10,13-15} and some have experienced subsequent declines in gonorrhea and chlamydia following implementation. As the name suggests, PDPT/EPT refers to the practice of providing an additional dose of medication or a prescription for a patient to deliver to their partner for empiric treatment of chlamydia or gonorrhea. PDPT/EPT is an IHS and Centers for Disease Control and Prevention (CDC) recommended tool to expand treatment for chlamydia and gonorrhea.^{12,16-17}

Although any medical provider delivering care to AI/AN populations outside of the IHS must abide by state and other

laws regarding PDPT/EPT, federally-employed practitioners within the IHS are able to provide PDPT/EPT to patients receiving care at IHS facilities, notwithstanding contrary state laws so long as IHS has approved the practice for use within its federally-operated facilities.¹⁸ In addition, IHS practitioners are able to provide PDPT/EPT to sexual partners that are non-IHS beneficiaries (non-tribal members) as an effort to prevent disease spread.¹⁹

Due to increasing concerns about the spread of antimicrobial resistance, CDC recently released updated guidelines for the treatment of gonorrhea.^{20,21} The use of intramuscular ceftriaxone (250mg IM x 1 dose) PLUS azithromycin (1 gram PO x 1 dose) or doxycycline (100mg PO BID x 7 days) are now the only recommended medication regimens. However, the oral use of cefixime (400mg PO x 1 dose) PLUS azithromycin (1 gram PO X 1 dose) or doxycycline (100mg PO BID x 7 days) remains an alternative treatment option. CDC continues to endorse the use of PDPT/EPT using oral cefixime “*for heterosexual partners of patients diagnosed with gonorrhea who are unlikely to access timely evaluation and treatment.*” CDC recommends that patients and partners treated with an alternative regimen for gonorrhea should receive a test of cure one week following treatment.^{21,22}

Protocol guidelines for the implementation of PDPT/EPT, including patient and partner information sheets, have been developed by IHS in collaboration with the CDC for use within IHS facilities and other clinical facilities providing care to AI/AN populations.¹⁷ Protocol excerpts related to the delivery of PDPT/EPT include the following specific guidance:

*For heterosexual patients diagnosed with **gonorrhea** or **chlamydia** whose partners are unable or unwilling to present for testing and treatment, provide treatment to the patient to give to the partner(s) via expedited partner therapy (EPT).*

- *Expedited Partner Therapy (EPT) is the clinical practice of treating the sex partners of patients diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the patient to take to his/her partner without the health care provider first examining the partner. This practice is also called Patient-Delivered Partner Therapy or PDPT.*
- *Patients with **gonorrhea** should be provided with the*

medication or a prescription(s) for cefixime (400mg to be taken orally for one dose) PLUS azithromycin (1 gram to be taken orally for one dose) to deliver to their partner(s).¹

- Patients with **chlamydia** should be provided with the medication or a prescription(s) for azithromycin (1 gram to be taken orally for one dose) to deliver to their partner(s).¹ (Patient-Delivered Partner Therapy or PDPT).
- Provide information sheets to the patient on PDPT to give to their partner.
- Document this activity in the medical record.

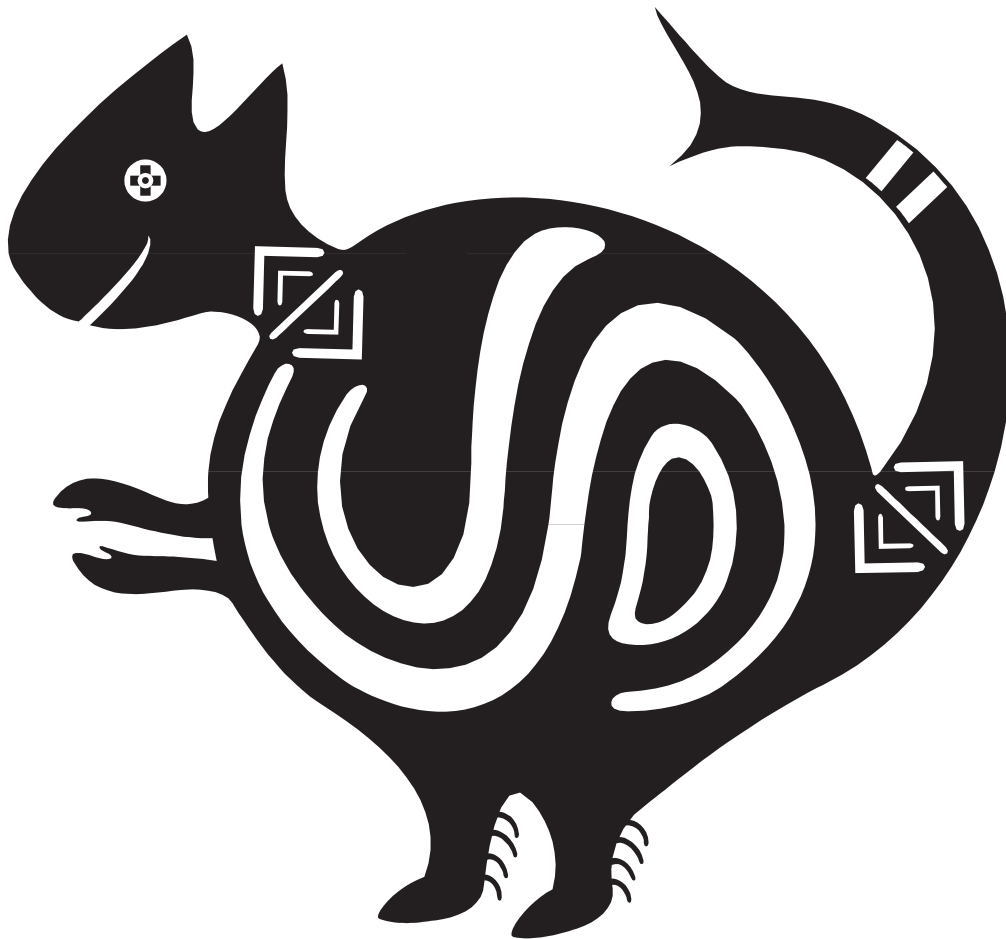
Partner solicitation and referral for clinical testing, diagnosis, and treatment remains the primary recommendation for partner management,¹¹ and some service units have successfully expanded the role of public health nursing to include the field-delivery of medications to untreated cases and contacts of gonorrhea and chlamydia.⁸ However, need and national guidance highlight the role of PDPT/EPT as an evidence-based backup to contact tracing in circumstances where clients are unwilling to divulge partner information. Service units considering expansion of STD services to include the implementation of PDPT/EPT should review IHS protocols adopted for this purpose,¹⁷ as well as contact service units listed in the references sections to obtain information on experience and locally-adapted protocols and practices.^{7,9,10}

Additional resources exist for areas experiencing outbreak-level increases in STDs including CDC epidemiologic assistance.³ Please contact Scott Tulloch for further information at scott.tulloch@ihs.gov.

Resources:

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Iknowmine.org:

Sexual Health Information for Alaska Youth

Connie Jessen, MA, HIV/STD Program Services, Division of Community Health Services, Alaska Native Tribal Health Consortium, Anchorage, Alaska; and Brenna Simmons, PhD, Liver Disease and Hepatitis Program, Alaska Native Tribal Health Consortium, Anchorage

What began in response to more than a hundred conversations with Alaska Native youth is now a one-stop, multimedia, and interactive website with medically accurate health information and useful resources for Alaska Native youth. When *iknowmine.org* first launched in December 2009, Alaska was experiencing a gonorrhea outbreak and endemic rates of chlamydia. Alaska Native people, especially youth, shouldered the largest burden. Now almost three years later, sexually transmitted diseases (STDs) are still an obstacle to the wellbeing of Alaska Native people, yet there has been progress; in 2011, chlamydia cases decreased by 5% for the first time since it became a reportable disease in 1996, and gonorrhea cases decreased by 25%.

Alaska Native youth face many interrelated challenges to achieve overall wellness, and to further reduce the burden that STDs place on youth, the Alaska Native Tribal Health Consortium (ANTHC) HIV/STD Prevention Program embarked on a journey to recreate *iknowmine* as a readily accessible, comprehensive health resource that tackles many of the issues that matter to youth, such as relationships, emotional health, nutrition, safety, drug and alcohol use, and sexual health. The new website launched in October 2012.

On www.iknowmine.org youth can:

- Find answers to questions like, Can I catch a STD if I haven't had sex yet? Are my traditional foods healthy? I'm worried my friend is depressed; how can I help?
- Text4health to 313131 to ask health questions and to

receive health messages

- Connect with [facebook.com/iknowmine](https://www.facebook.com/iknowmine) for latest events, information, and contests
- Follow [@iknowmine](https://twitter.com/iknowmine) on Twitter for current health and Alaska Native news
- Read - iknowmine.tumblr.com posts to learn about featured youth wellness topics
- Order free latex condoms, non-latex condoms, dental dams, and female condoms
- Order free at-home STD testing kits
- Order free "Spawn Safely" t-shirts
- Download free educational materials
- Watch - lots of great digital stories through our [iknowmineAlaska](https://www.youtube.com/channel/UCknoWmineAlaska) YouTube channel
- Apply - to become an *iknowmine* youth editor or an *iknowmine* ambassador to promote healthy relationships in communities, classrooms, after-school programs, or at health fairs or youth group gatherings.
- Information - for parents/teachers and health care providers is coming soon as well.

Between January 2010 and January 2013, 23,887 unique visitors frequented *iknowmine.org*. Since its inception, 514 visitors have registered as *iknowmine* users. *Iknowmine.org* has received 226 condom orders, which equals approximately 4,520 condoms that were mailed to rural and urban Alaska residents. Non-latex condoms, dental dams, and female condoms have only recently been added to the host of available resources; however, data regarding the uptake of these new resources are not yet available.

For additional information about *iknowmine.org*, please contact Cornelia "Connie" Jessen, STD Program Manager, at cmjessen@anthc.org or telephone (907) 729-3955.

Practical Strategies for Improving Chlamydia and Gonorrhea Retesting

Wendy Nakatsukasa-Ono, MPH, Cardea, Seattle, Washington; and Holly Howard, MPH, California Department of Public Health, Richmond, California

Prevention and management of chlamydial and gonococcal infections are priorities for women's health. The Centers for Disease Control and Prevention (CDC) highlights the prevention and early detection of repeat infections in females as a key strategy to avert STD-related infertility.

Two interventions recommended by CDC to effectively tackle reinfections include empirically treating all recent sex partners and retesting patients post treatment. Data suggest that best practices for both partner management and retesting are greatly underutilized. This article focuses on feasible and effective interventions for improving retesting rates among patients in your practice.

Why is CT/GC retesting a priority?

- Retesting patients -within a few months following treatment is a cornerstone in the fight against chlamydia (CT) and gonorrhea (GC) and resulting infertility because:
- Reinfection with CT and GC is very common. As many as 20% of females acquire a new infection within the six months following their initial positive test and treatment, and rates are consistently high across all age groups.
- Reproductive health complications are more likely with each repeat CT or GC infection. A second infection is associated with a four-fold risk of pelvic inflammatory disease and a two-fold risk of ectopic pregnancy, which, in turn, are associated with a higher risk of chronic pelvic pain and infertility.
- Risk for reinfection is not eliminated solely with partner treatment interventions.
- 70-80% of CT and GC infections are asymptomatic in women, so most women do not suspect that anything is wrong.

Systematic retesting within the few months post-treatment can detect reinfections early and reduce the risk of complications.

What are CDC's retesting recommendations?

In 2010, CDC released its latest STD treatment guidelines with new CT and GC retesting recommendations. The

recommendations state that, for both female and male patients:

- Retesting should be a "priority for providers."
- Providers should retest their patients approximately three months after treatment or whenever the patient next seeks care during the 12 months post-treatment.
- Retesting should not occur during the first three weeks post treatment, due to the risk of false positive test results.
- Retesting -should occur regardless of whether sex partners were treated.
- Retesting is not the same as "test of cure"; test-of-cure is not recommended except in certain, special circumstances (e.g., pregnant women).]

What can be done now to increase retesting?

Despite the CDC's recommendations and abundant evidence to support the importance of this intervention, retesting remains very low in the majority of clinical settings. Interventions targeted to various levels may be needed to address specific barriers to retesting:

- Organization-level interventions: get buy-in from senior leaders
 - Ensure policies prioritize retesting services
 - Mine your data — look at CT/GC reinfection rates, return rates for patients due for retesting, and missed opportunities for retesting
 - Pilot at least one intervention and share your successes
- Clinic-Level - Interventions: Reduce Missed Opportunities for Retesting
 - Retest patients "opportunistically," regardless of the reason for visit and as long as the return visit is greater than three weeks post-treatment.
 - Add medical record chart prompts including paper chart flags, or electronic "pop-ups" to inform staff at intake that a presenting patient is due for retesting.
 - Institute clinic protocols to allow any level of clinic staff — including medical assistants — to collect test specimens at all visit types, including limited service visits that normally do not require clinician interaction with the patient.
 - Offer drop-in visits for STD testing to expand access to retesting for asymptomatic patients.
 - Assess CT/GC risk and need for retesting for all

female patients at all visit types (e.g., affix risk assessment cards to intake computers with a few key questions to help determine if CT/GC screening or retesting is due).

- Patient-Level Interventions:
 - Improve Understanding of Reinfection Risk
 - Train clinical staff to provide comprehensive counseling of CT- and GC-positive patients that includes messages about why retesting is important, the high risk and dangers of reinfection, the importance of getting partners treated, options to get partners treated, and strategies to support patients to remember retesting appointments (e.g., entering date into cell phone calendar)
 - Improve existing patient materials to reinforce new messaging around reinfection, partner treatment options, and the importance of retesting, as well as to improve the overall literacy level and user-friendliness of materials.
 - Develop new patient materials specific to retesting such as flip cards that explain why retesting is important and include a place to indicate when retesting is due.
 - Increase Patient Return Rate
 - Offer retest reminder options including self-addressed postcards, text message, and e-mail reminders.
 - Counsel patients to return for retesting earlier than three months post treatment in populations with known low adherence to clinical follow-up recommendations, such as those who are transient, STD clinic patients, and adolescents who are not established clinic patients.
 - Establish a home-testing option, if resources and logistics permit, allowing patients to self-collect and mail in specimens (e.g., using a vaginal swab that is FDA-approved for self-collection and where laboratory validation has been completed).

For More Information and Resources

1. CDC. *Sexually Transmitted Diseases Treatment*

KEY POINTS:

- ✓ **The prevention and early detection of repeat infections in females is a key strategy to avert STD-related infertility.**
- ✓ **Reinfection of chlamydia and gonorrhea is very common, with as many as 20% of females acquiring a new infection within six months of treatment.**
- ✓ **Reproductive complications are more likely with each repeat infection.**
- ✓ **Retesting should be a priority for providers.**

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3. Office of Population Affairs. Customizable CT and GC patient fact sheets and other resources at: www.intouch4health.org.

Native VOICES: Developing an Evidence-Based HIV/STD Intervention for Native Teens and Young Adults

Wendee Gardner, MPH, Northwest Tribal Epidemiology Center, Northwest Portland Area Indian Health Board, Portland, Oregon; and Stephanie Craig Rushing, PhD, MPH, Northwest Portland Tribal Epidemiology Center, Northwest Portland Area Indian Health Board, Portland

In response to high rates of sexually transmitted diseases (STDs) and teen pregnancy among American Indian and Alaska Native (AI/AN) youth, the Northwest Portland Area Indian Health Board's STD/HIV prevention project, Project Red Talon, is developing an evidence-based sexual health video for Native teens and young adults. The Native VOICES adaptation project is supported by a four-year grant from the Indian Health Service, issued through the Native American Research Centers for Health (NARCH) program.

The project is working closely with tribal, urban, and Indian Health Service partners to adapt a CDC-recognized intervention, *Video Opportunities for Innovative Condom Education and Safer Sex* (VOICES), and to evaluate its effectiveness as a sexual health resource for AI/AN teens and young adults 15 - 24 years old.

In its current form, the VOICES intervention is a single-session, video-based STD/HIV prevention intervention designed for African American and Latino adults. There are several culturally specific videos available. Skills in condom use and negotiation are modeled in the videos, then role-played and practiced by participants in small groups. At the end of the 45-minute facilitator-led session, participants are given condoms, based on their individual preference. Evaluation studies found that VOICES participants demonstrated 1) an increased knowledge about the transmission of STD/HIV; 2) a more realistic assessment of their own personal risk; 3) a greater likelihood of getting condoms and intending to use them regularly; and 4) fewer repeat STD infections.¹⁻³

During the first two years of the Native VOICES project, NPAIHB staff and regional partners worked to adapt the VOICES intervention for Native youth and young adults. The project hosted eight talking circles (n=49), ten individual interviews with clinical staff and staff at youth-serving organizations, 13 individual interviews with youth who identified as LGBTQ (lesbian, gay, bisexual, transgendered, or queer) or two spirit, as well as several community feedback

sessions with tribal and urban-based partners in the Pacific Northwest.

Project staff are now in the process of collaborating with the original developers of the VOICES intervention, staff at the CDC, and NW Native youth to adapt the VOICES script to make it more culturally-relevant and age-appropriate for Native teens and young adults. With the help of a Native media communications firm, we will shoot and edit the Native VOICES video this summer.

Once complete, NPAIHB staff and project partners will then evaluate the adapted intervention at tribal and urban sites across Indian Country. If the Native VOICES video is shown to be effective, it will be submitted to the CDC for use as a supplemental VOICES video intervention.

As always, Project Red Talon is committed to supporting healthy decision-making among Native teens and young adults. By taking a community-based, youth-centered approach, the Native VOICES project is improving our understanding of sexual norms and behaviors among Native teens and young adults in the Pacific Northwest. Our ultimate goal is to produce an evidence-based video that will reduce youth's risk for STD/HIV and unintended pregnancy, while offering tribal communities an intervention choice that is cost-effective and easily integrated into existing health and social services. If found to be effective, the *Native VOICES* intervention will be a one-of-a-kind, culturally-appropriate resource for tribes and tribal organizations throughout the US.

For additional information about the *Native VOICES* adaptation project, please contact Wendee Gardner, Project Coordinator, at wgardner@npaihb.org or telephone (503) 416-3275.

For additional information about the Native-specific sexual health resources offered by Project Red Talon, visit http://www.npaihb.org/epicenter/project/project_red_talon/ or contact Stephanie Craig Rushing, Project Director, at scraig@npaihb.org or telephone (503) 416-3290.

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Colorectal Cancer Screening Reference Guide

On the following two pages you will find a colorectal cancer screening reference guide that, if copied back-to-back on a single sheet of paper, can be folded into a trifold brochure for easy storage and distribution. Please note that the version printed in the March issue had a misprinted graph on the second page, and we should use the version found in this issue for reproduction.

Tips for better screening rates at your facility

1. Recommend CRC Screening to Patients
 - Discuss multiple screening options with patients (not only colonoscopy)
1. Develop a CRC Screening Policy
 - Fit the policy to your practice
 - ◆ Determine patient risk level
 - ◆ Identify local medical resources
 - ◆ Assess insurance coverage
 - ◆ Consider patient preference
 - ◆ Engage your team in following the policy
3. Be Persistent with CRC Reminders
 - Use patient tools:
 - ◆ Education and cues to action
 - Use provider tools:
 - ◆ Chart prompts
 - ◆ Audits and feedback
 - ◆ Ticklers and logs
 - ◆ Staff assignments
 - ◆ Track test results
4. Measure Practice Progress
 - Have staff conduct a screening audit
 - Establish a baseline screening rate
 - Discuss how the screening system is working

Learn more at : <http://www.ucaare.org/providers/Documents/IncreaseCancerScreeningRates.pdf>

Avoid these errors:

- ✗ Not assessing a patient's level of risk for developing CRC, based on personal, family, and medical history, to determine appropriate screening approach.
- ✗ Screening patients with a digital rectal exam (DRE).
- ✗ Screening patients in the clinic with guaiac-based FOBT, using only a single stool sample following a DRE.
- ✗ Not ordering diagnostic colonoscopy for patients with a positive gFOBT, iFOBT, or flexible sigmoidoscopy.
- ✗ Not following up on patients referred for colonoscopy.
- ✗ Recommending screening with colonoscopy at intervals shorter than every 10 years, or flexible sigmoidoscopy at intervals shorter than every 5 years, for average-risk persons.
- ✗ Starting screening earlier than age 50 for average-risk, asymptomatic individuals.
- ✗ Applying recommendations for average-risk persons to patients that are at increased risk for developing CRC.

Adapted from: "How to Increase CRC Rates in Practice: A Primary Care Clinician's Evidence-based Toolbox and Guide, 2008", available at : <http://www.cancer.org/acs/groups/content/documents/document/acspc-024588.pdf>

Subscribe to the IHS CRC listserv at:

http://www.ihs.gov/listserv/index.cfm?module=signUpForm&list_id=138

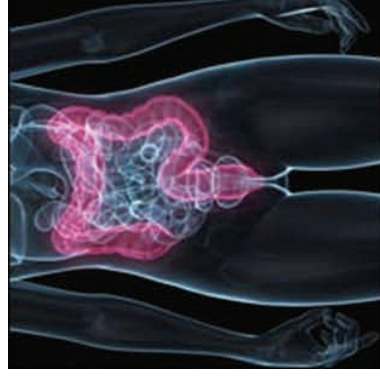
For further information, please contact

Donald Haverkamp, MPH at (505) 248-4422

donald.haverkamp@ihs.gov

Colorectal Cancer (CRC) Screening

A Reference Guide for IHS and Tribal Healthcare Providers



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May 2013



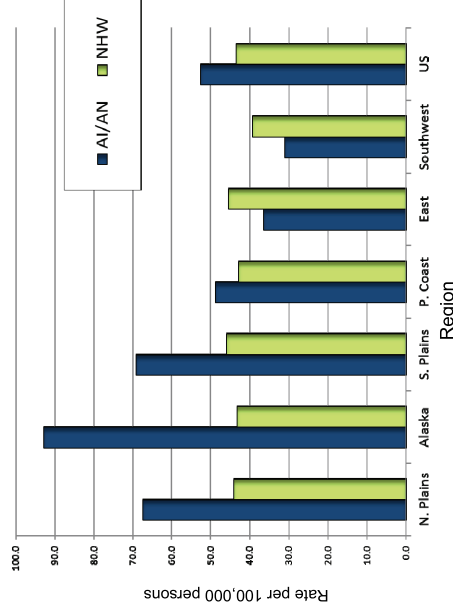
Colorectal cancer in American Indian and Alaska Native (AI/AN) communities

Did you know?

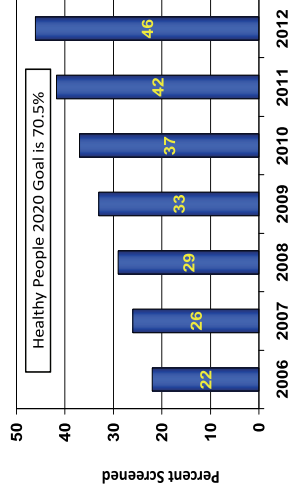
Of all AI/AN men and women who are currently cancer free at age 50, an estimated 4.1% (1 in 24) will develop CRC in their lifetime.

Source: Surveillance, Epidemiology, and End Results (SEER) Program (www.seer.cancer.gov) DevCan database: "SEER 18 Incidence and Mortality, 2000-2009, with Kaposi Sarcoma and Mesothelioma". National Cancer Institute, DCCPS, Surveillance Research Program, Cancer Statistics Branch, released April 2012, based on the November 2011 submission.

Colorectal cancer incidence rates, AI/AN and non-Hispanic Whites (NHW), both sexes, 2005-2009



Colorectal cancer screening trend within the Indian Health Service (GPRA clinical data)



Ways to encourage patients to get screened

Utilize culturally and linguistically appropriate materials to educate patients. Check the following sites for materials and links to other resources:

- Albuquerque Area Southwest Tribal Epidemiology Center, Tribal Colorectal Health Program— <http://aaibh.org/aastec/tchp/>
- Alaska Community Health Aide Program— Cancer Education— <http://www.akchap.org/html/resources/cancer-education.html>

When recommending FOBT, include an option for immunochemical FOBTs, which offer patients several advantages over traditional guaiac-based FOBTs, including:

- No dietary or medication restrictions before or during screening
- Fewer stool samples needed
- Various stool collection methods (less stool handling)
- Detects only colorectal bleeding

Utilize the Guide to Community Preventive Services, which highlights interventions that can increase cancer screening: <http://www.thecommunityguide.org/cancer/index.html>

Who, how, and how often to screen for CRC

The United States Preventive Services Task Force recommends :

- Average-risk men and women aged 50-75 should be screened using any of the following:

YEARLY: Immunochemical fecal occult blood test (iFOBT) or high-sensitivity guaiac-based fecal occult blood test (gFOBT)

-OR-

EVERY 5 YEARS: Flexible sigmoidoscopy (along with FOBT every 3 years)

-OR-

EVERY 10 YEARS: Colonoscopy

- Routine screening is not recommended for men and women ages 76-85. Decisions about first-time screening in this age group should be made on an individual basis.
- Screening is not recommended for men and women over the age of 85.

Link to USPSTF recommendations:

<http://www.uspreventiveservicestaskforce.org/uspstf/uspsscolo.htm>

POSITION VACANCIES

Editor's note: As a service to our readers, THE IHS PROVIDER will publish notices of clinical positions available. Indian health program employers should send brief announcements as attachments by e-mail to john.saari@ihs.gov. Please include an e-mail address in the item so that there is a contact for the announcement. If there is more than one position, please combine them into one announcement per location. Submissions will be run for four months and then will be dropped, without notification, but may be renewed as many times as necessary. Tribal organizations that have taken their tribal "shares" of the CSC budget will need to reimburse CSC for the expense of this service (\$100 for four months). The Indian Health Service assumes no responsibility for the accuracy of the information in such announcements.

Family Practice Physician Jicarilla Service Unit; Dulce, New Mexico

The Jicarilla Service Unit (JSU) is a new, beautiful 65,000 square foot facility nestled in the mesas of northern New Mexico with views of the edge of the Colorado Rockies. We provide care to the Jicarilla ("Basket-maker") Apache community with a population of 4,400. Our clinic has an opening for a board certified/eligible family practice physician for purely outpatient care with a 40 hour work-week. Our site qualifies for IHS and state loan repayment programs. JSU has a fully functional electronic health record system. Our pharmacy has a robust formulary including TNF-alpha inhibitors and exenatide. The clinic also has an urgent care clinic for acute walk-in cases. Our staff currently consists of an internist, three family practice physicians, an optometrist, and three dentists. We also have a team of dedicated public health nurses who specialize in home visits for elders and prenatal follow-up. The Jicarilla Apache Nation is self-sufficient with revenues from oil and natural gas. Much has been invested in the infrastructure of the reservation, including a large fitness facility, a modern supermarket, a hotel and casino, and more. We are also located 45 minutes from the resort town of Pagosa Springs, which has year-round natural hot springs and winter skiing at renowned Wolf Creek Pass.

We welcome you to visit our facility in person. To take a video tour of the Nzh'o Na'ch'idle'ee Health Center online, go to <http://www.usphs.gov/Multimedia/VideoTours/Dulce/default.aspx>. Please call Dr. Cecilia Chao at (575) 759-3291 or (575) 759-7230; or e-mail cecilia.chao@ihs.gov if you have any questions. (4/13)

Hospitalist Gallup Indian Medical Center; Gallup, New Mexico

Gallup Indian Medical Center (GIMC) is currently

seeking energetic and collegial internists for our new hospitalist program. The hospitalists care for all adult inpatients previously taken care of by family medicine and internal medicine physicians, and provide consultation services. We have seven FTEs for hospitalists, and while we are still growing, we enjoy further inpatient staffing support from internal medicine and family medicine.

GIMC is a 99-bed hospital in Gallup, New Mexico, on the border of the Navajo Reservation. Clinical specialties at GIMC include internal medicine, family medicine, critical care, cardiology, neurology, orthopedics, ENT, radiology, OB/GYN, general surgery, ophthalmology, pathology, pediatrics, emergency medicine, and anesthesiology. The hospitalists' daily census is approximately 25 - 30. There is a six bed ICU. Our patient population includes Navajos, Zunis, and others living nearby, as well referrals from smaller clinics and hospitals.

Gallup has a diverse community and is very livable, offering a thriving art scene, excellent outdoor activities (biking, hiking, rock climbing, cross-country skiing), safe neighborhoods, diverse restaurants, national chains and local shops, and multiple public and parochial school options. The medical community is highly collegial, is committed to continuing education, has an on-going collaboration with Brigham and Women's Hospital, and has a high retention rate.

For more information, contact Eileen Barrett, MD, at (505) 722-1577 or e-mail eileen.barrett@ihs.gov. Or please consider faxing your CV to (505) 726-8557. (2/13)

Clinical Director, Family Medicine Physician Kodiak Area Native Association; Kodiak, Alaska

The Kodiak Area Native Association (KANA) is searching for an adventurous, highly motivated physician to lead our team that is committed to patient-centered care, customer service, quality improvement, and stewardship. KANA is celebrating its 47th year of providing patient and family focused health care and social services to Alaska Natives and other beneficiaries of KANA throughout Kodiak Island. KANA's award winning medical staff is comprised of four physicians who work in conjunction with two mid-level providers, dedicated nurse case managers, and ancillary staff to deliver the highest quality, team based health care to an active user population of 2800 patients. Integrated behavioral health and pharmacy services within the primary care setting also facilitate an advanced support system to ensure our patients' needs are met.

The spectacular scenic beauty of Kodiak Island offers a backdrop for an abundance of outdoor and family activities, including world-class fishing, hunting, wildlife viewing,

kayaking, and hiking just minutes from your door. Its sometimes harsh climate is balanced by mild temperatures and unparalleled wilderness splendor that provide Kodiak's residents with a unique lifestyle in a relaxed island paradise.

KANA offers competitive compensation and an excellent employee benefits package, including medical, dental, vision, flexible spending accounts, short term disability insurance, life insurance, accidental death and dismemberment insurance, 401k with employer contribution, fitness membership, and paid time off.

If you're interested in hearing more about how you can start your journey to an adventure of a lifetime, please visit our website at www.kanaweb.org, give Lindsey Howell, Human Resources Manager, a call at (907) 486-9880, or contact our HR Department at hr@kanaweb.org. Alaska's Emerald Isle awaits you! (2/13)

Pediatrician

Blackfeet Community Hospital; Browning, Montana

This hospital-based government practice is seeking a BC/BE pediatrician to work with another pediatrician and a pediatric nurse practitioner. Practice true primary care pediatrics with inpatient, outpatient, and newborn hospital care. Attractive call and rounding schedule. Competitive salary with federal government benefits. The area provides a wide variety of outdoor recreational activities, being only 12 miles from Glacier National Park. For more information, please contact Dr. Tom Herr at thomas.herr@ihs.gov or call (406) 338-6372. (1/13)

Director, Health and Human Services Ysleta Del Sur Pueblo; El Paso, Texas

The Ysleta Del Sur Pueblo (YDSP) Health and Human Services Department is a team of health care professionals and staff fully committed to their patients' physical, emotional, and spiritual wellbeing, offering a comprehensive range of health and human services that ensure a safe environment, quality service, and accessible health care in an atmosphere of respect, dignity, professionalism, and cultural sensitivity.

YDSP's HHS department is seeking a Director. This person has responsibility and accountability for the development and implementation of a plan to bring HHS to an ongoing operating success. The Director will need the flexibility to make quick and efficient business decisions, while at the same time assuring that operations respect the broad guidelines and, more importantly, the service standards expected by tribal members and tribal leadership. To get more information or to apply, contact Jason S. Booth, CEO, Ishpi, Inc., telephone (651) 308-1023; or *e-mail* jason@ishpi.biz. (1/13)

Family Medicine, Internal Medicine, Emergency Medicine Physicians Sells Service Unit; Sells, Arizona

The Sells Service Unit (SSU) in southern Arizona is

recruiting for board certified/board eligible emergency room/family physician to join our experienced medical staff. The Sells Service Unit is the primary source of health care for approximately 24,000 people of the Tohono O'odham Nation. The service unit consists of a Joint Commission accredited 34-bed hospital in Sells, Arizona and three health centers: San Xavier Health Center, located in Tucson, Arizona, the Santa Rosa Health Center, located in Santa Rosa, Arizona, and the San Simon Health Center located in San Simon, Arizona with a combined caseload of approximately 100,000 outpatient visits annually. Clinical services include family medicine, pediatrics, internal medicine, prenatal and women's health care, dental, optometry, ophthalmology, podiatry, physical therapy, nutrition and dietetics, social work services, and diabetes self-management education.

Sixty miles east of the Sells Hospital by paved highway lies Tucson, Arizona's second largest metropolitan area, and home to nearly 750,000. Tucson, or "The Old Pueblo," is one of the oldest continuously inhabited sites in North America, steeped in a rich heritage of Indian and Spanish influence. It affords all of southern Arizona's limitless entertainment, recreation, shopping, and cultural opportunities. The area is a favored tourist and retirement center, boasting sunbelt attributes and low humidity, with effortless access to Old Mexico, pine forests, snow sports, and endless sightseeing opportunities . . . all within a setting of natural splendor.

We offer competitive salary, relocation/recruitment/retention allowance, federal employment benefits package, CME leave and allowance, and loan repayment. For more information, please contact Peter Ziegler, MD, SSU Clinical Director at (520) 295-2481 or by e-mail at Peter.Ziegler@ihs.gov. (12/12)

Family Physician with Obstetrics Skills Pediatrician (or Internal Med-Peds) Physician Ethel Lund Medical Center; Juneau, Alaska

The SEARHC Ethel Lund Medical Center in Juneau, Alaska is searching for a full-time family physician with obstetrics skills and a pediatrician (or internal medicine/pediatrics physician) to join a great medical staff of 14 providers (10 physicians, four midlevels) at a unique clinic and hospital setting. Have the best of both worlds by joining our practice where we share hospitalist duties one week every 6 - 8 weeks, and spend our remaining time in an outpatient clinic with great staff and excellent quality of life. We have the opportunity to practice full spectrum medicine with easy access to consultants when we need them. Maintain all your skills learned in residency and expand them further with support from our tertiary care center, Alaska Native Medical Center.

Clinic is focused on the Patient-Centered Medical Home, quality improvement with staff development from IHI, and adopting an EHR at the clinic and hospital in the near future. We have frequent CME and opportunities for growth, with

teaching students and residents and faculty status at University of Washington available to qualified staff. This is a loan repayment site for the Indian Health Service and National Health Service Corps.

Work in southeast Alaska with access to amazing winter and summer recreational activities. Live in the state capital with access to theater, concerts, annual musical festivals, and quick travel to other communities by ferry or plane. Consider joining a well-rounded medical staff of 14 providers at a beautiful clinic with excellent benefits. For more information contact, Dr. Cate Buley, Assistant Medical Director, Ethel Lund Medical Center, Juneau, Alaska; telephone (907) 364-4485, or e-mail cbuley@searhc.org. *Locum tenens* positions also available. (12/12)

**Director
Center of American Indian and Minority Health
University of Minnesota Medical School;
Duluth, Minnesota**

The University of Minnesota Medical School in Duluth, Minnesota, invites applications for a full-time Director for the Center of American Indian and Minority Health. The Center of American Indian and Minority Health (CAIMH) at the University of Minnesota Medical School strives to raise the health status of American Indian and Alaska Native people. This is achieved in part through programming and activities for American Indian students grade K - 16 and medical school, and partnerships with American Indian communities and organizations. The CAIMH, housed on the Duluth Campus, educates American Indian and Alaska Native students in the field of health care, and more specifically, in American Indian and Alaska Native health, and collaborates on research focused on improving the health of American Indian and Alaska Native people.

For more information about the Center of American Indian and Minority Health, go to <http://www.caimh.umn.edu/>.

Required/Preferred Qualifications include an MD/DO degree; however, an alternative terminal degree may be considered in circumstances of exceptional fit. Previous employment experience in medical school. An academic background in a field relevant to medical education. All candidates must have evidence of essential verbal and written communication skills including clarity in the delivery of lectures and the writing of grants and other documents.

The Director position is a full-time time, 12-month appointment. Additional information is available online at <https://employment.umn.edu/> (Req. #182533). Review of applications will continue until the position is filled. The University of Minnesota is an Equal Opportunity Educator and Employer. Apply on-line at <https://employment.umn.edu/> Job Req # 182533. (12/12)

**Clinical Director (Primary Care)
Family Medicine Physician
White Earth Health Center; Ogema, Minnesota**

White Earth Health Center is located in northwestern central Minnesota on the White Earth Reservation, which is in the heart of lake country. The reservation is 36 by 36 square miles; its largest metropolitan location is approximately 75 miles from Fargo, North Dakota or 235 miles from the Twin Cities. We have a satellite clinic in Naytahwaush (approximately 30 minutes from the WE Service unit) operating on Monday, Tuesday, and Friday, and one in Pine Point (approximately 30 minutes from the WE service unit) that is open on Thursday. The satellite clinics have one full time family practice physician and one family practice nurse practitioner who staff them on a regular basis.

We are a Federal Indian Health Service outpatient/ambulatory care facility that had 115,699 ambulatory visits for 19,494 registered patients this past year. We offer services Monday through Friday 8:00 am to 4:30 pm; on all federal holidays we are closed. Our services include a dental department with three full time dentists; a mental health department that consists of one psychologist, four counselors, one contract psychiatrist and one mental health nurse practitioner; and an optometry department comprised of the chief of optometry, one optometry technician/receptionist, and one contract optometrist.

Our medical staff consists of three full time family practice physicians, one contract family practice physician, one podiatrist, one internal medicine physician, one audiologist, a nutritionist, one pediatrician and three family nurse practitioners. We have pediatric and same day/urgent care clinics. The clinics are operating/implementing the IPC model.

We offer competitive salary, excellent benefits (health, life, retirement) and both sick and vacation leave. For further information, please contact Mr. Tony Buckanaga, Health Professions Recruiter at (218) 444-0486, or e-mail tony.buckanaga@ihs.gov. (11/12)

**Registered Dietitian
Psychiatrist
Consolidated Tribal Health Project, Inc.;
Calpella, California**

Consolidated Tribal Health Project, Inc. is a 501(c)(3) non-profit, ambulatory health clinic that has served rural Mendocino County since 1984. CTHP is governed by a board comprised of delegates from a consortium of nine area tribes, eight of which are federally recognized, and one that is not. Eight of the tribes are Pomo and one is Cahto. The campus is situated on a five-acre parcel owned by the corporation; it is not on tribal land.

CTHP has a Title V Compact, which gives the clinic self-

governance over our Indian Health Service funding allocation. An application for any of these positions is located at www.cthp.org. Send resume and application to Karla Tuttle, HR Generalist, PO Box 387, Calpella, California 95418; fax (707) 485-7837; telephone (707) 485-5115 (ext. 5613). (11/12)

**WIC Coordinator
SEARHC; Sitka, Alaska**

The WIC Coordinator/RD works as a member of the SEARHC health promotion team to assess for, plan, implement, administer, and evaluate nutrition and health education programming that responds to Goals 8 and 9 in SEARHC's Strategic Plan. The WIC Coordinator also works to ensure high quality WIC services are provided to eligible women, infants, and children throughout southeast Alaska. Additionally, the WIC Coordinator partners with organizations working with the WIC population to make appropriate referrals and to enhance the WIC program.

Baseline Qualification Requirements include a BS in community nutrition/dietetics or a nutrition-related field, and four years of clinical nutrition and/or community nutrition work experience with specific progressive experiences in maternal/child nutrition, outpatient medical nutrition therapy, and program planning and administration. Must be both a registered dietitian and licensed dietitian/licensed nutritionist in the State of Alaska. Must adhere to the American Dietetic Association code of ethics and complete 75 continuing education credits every five years as required by registration and licensure plus keep current on registration and licensing payments. Other/Preferred Qualifications include a valid Alaska driver's license, ability to travel, including to remote southeast Alaska locations, supervision/mentoring training, public policy and advanced nutrition education strategy(ies) training, and MS/MPH in nutrition and/or dietetics or other health promotion related field

Contact Lisa Sadleir-Hart, MPH, RD, CHES, ACE, Community Nutrition Department Manager, SEARHC/Health Promotion, at telephone (907) 966-8735; facsimile (907) 966-8750; or e-mail lisa.sadleir-hart@searhc.org. (10/12)

**Clinical Nurse
Gallup Indian Medical Center; Gallup, New Mexico**

Gallup Indian Medical Center (GIMC) is currently accepting applications from experienced nurses for positions within our hospital facility. We are particularly interested in nurses with experience in the Labor and Delivery, Emergency Room, and Ambulatory Care settings.

GIMC is a 78-bed hospital in Gallup, New Mexico, on the border of the Navajo Reservation. Our patient population includes Navajos, Zunis, and others. Gallup provides outdoor activities (biking, hiking, rock climbing, and running, to name a few). As a Navajo Area Indian Health Service Hospital, we provide clinical specialties that include Internal Medicine,

Cardiology, Anesthesia, Psychiatry, Emergency Medicine, OB/GYN, General Surgery, Orthopedics, Ophthalmology, ENT, Radiology, Pathology, and Pediatrics.

Nurse employment benefits include competitive salary, comprehensive health insurance, double time pay for holidays worked, night and Sunday pay differential, no census days, and continuing education. Government housing is not available, as we are not located on the Navajo Reservation. Opportunities are available for growth and advancement depending on your personal nursing career goals. We welcome your questions, curiosity, and application submission.

For more information on how and where to apply, contact Myra Cousens, RN, BSN, Nurse Recruiter at (505) 726-8549, or e-mail myra.cousens@ihs.gov. (10/12)

**Family Practice Physician /OB
Sonoma County Indian Health Project (SCIHP);
Santa Rosa, California**

Live, work, play in the wine country. Sonoma County Indian Health Project (SCIHP) Santa Rosa, CA California, is seeking a full-time –Temporary Ffamily Practice practice Physician physician to join our team. SCIHP is a comprehensive community care clinic serving the Native American community of Sonoma County. Medical phone call 1/6 nights required, OB hospital call participation preferred but not required. Three to six month position—With the possibility of permanent hire. Obstetrics and inpatient care at the hospital required. SCIHP is a comprehensive community care clinic. Candidates must currently hold a California Physician/Surgeon (MD) or Osteopathic Physician/Surgeon (DO) license and be BE/BC in a primary care discipline. For the right candidate we offer competitive compensation. For more information, please contact Human Resources by fax (707) 526-1016; or by e-mail: welovedoctors.hr@gmail.com. (10/12)

**Primary Care Physician
Zuni Comprehensive Community Health Center;
Zuni, New Mexico**

The Zuni Comprehensive Community Health Center (Zuni-Ramah Service Unit) has openings for full-time primary care physicians starting in fall 2012. This is a family medicine model hospital and clinic providing the full range of primary care, including outpatient continuity clinics, urgent care, emergency care, inpatient (pediatrics and adults) and obstetrics, with community outreach, in a highly collaborative atmosphere. For a small community hospital, we care for a surprisingly broad range of medical issues. Our professional staff includes 17 physicians, two NPs, one CNM, a podiatrist, dentists, a psychiatrist, a psychologist, optometrists, physical therapists, and pharmacists. Our patient population consists of Zunis, Navajos, and others living in the surrounding area.

Zuni Pueblo is one of the oldest continuously inhabited American Indian villages in the US, estimated to be at least 800

- 900 years old. It is located in the northwestern region of New Mexico, along the Arizona border. It is high desert, ranging from 6000 - 7000 feet in elevation, and is surrounded by beautiful sandstone mesas and canyons with scattered sage, juniper, and pinon pine trees. Many of our medical staff have been with us for several years, reflecting the high job and lifestyle satisfaction we enjoy in this community.

For more information, contact John Bettler, MD at (505) 782-7453 (voice mail), (505) 782-4431 (to page) or by e-mail at john.bettler@ihs.gov. CVs can be faxed to (505) 782-7405, attn. John Bettler. (7/12)

Family Practice Physician (1)
Physician Assistant or Family Nurse Practitioner (2)
United Indian Health Services, Inc. (UIHS), Howonquet Clinic; Smith River, California
and
Family Practice Physician (1)

UIHS, Potawot Health Village; Arcata, California

UIHS is a premier health care organization located in beautiful northern California along the Pacific coast near the majestic redwoods. The organization is a unique nonprofit made up of a consortium of nine tribes, with a mission "To work together with our clients and community to achieve wellness through health services that reflect the traditional values of our American Indian Community." UIHS provides wraparound services that include medical, dental, behavioral health, and community services. Our focus is to empower our clients to become active participants in their care. If you value outdoor adventures such as backpacking, kayaking, biking, fishing, and surfing, and you envision yourself providing services to an underserved but deserving community in a caring and holistic manner, come join our team. Please visit our website at www.uihs.org or contact Trudy Adams for more information at (707) 825-4036 or email trudy.adams@crihb.net. (5/12)

Print Version of *The Provider* Has Ceased Publication

The federal government is always exploring ways to reduce costs. One recent initiative is an effort to reduce printing expenses. For this reason, we have stopped publishing and distributing the print edition of *The Provider*.

We will continue to publish the monthly electronic edition of our journal to the CSC website. Currently, about 900 individuals are subscribers to the listserv that notifies them when each monthly issue is posted, and lists the contents of



that issue. It is unknown how many readers simply access the website on a periodic basis without relying on the listserv for reminders that the monthly issue is available.

We encourage all our readers to subscribe to the listserv (go to <http://www.ihs.gov/provider/index.cfm?module=listserv>) so that you will receive monthly reminders about when the latest issue is posted to the website. This will also give us an improved count of the number of readers.

Electronic Subscription Available

You can subscribe to *The Provider* electronically. Any reader can now request that he or she be notified by e-mail when the latest issue of *The Provider* is available on the Internet. To start your electronic subscription, simply go to *The Provider* website (<http://www.ihs.gov/Provider>). Click on the “subscribe” link; note that the e-mail address from which you are sending this is the e-mail address to which the electronic

notifications will be sent. Do not type anything in the subject or message boxes; simply click on “send.” You will receive an e-mail from LISTSERV.IHS.GOV; open this message and follow the instruction to click on the link indicated. You will receive a second e-mail from LISTSERV.IHS.GOV confirming you are subscribed to *The Provider* listserv.



**THE IHS PRIMARY
CARE PROVIDER**
A journal for health professionals working with American Indians and Alaska Natives

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Publication of articles: Manuscripts, comments, and letters to the editor are welcome. Items submitted for publication should be no longer than 3000 words in length, typed, double-spaced, and conform to manuscript standards. PC-compatible word processor files are preferred. Manuscripts may be received via e-mail.

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