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Blameless Reporting and Why It's Important to Health Care

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Blameless Reporting Isn't About Accountability; It's About Learning . . ..

It has been noted that often the best people make the worst mistakes[1]; this is one reason, among several, why blameless reporting is important. Blameless reporting is also crucial to a culture of safety. The components of a culture of safety include non-judgmental, non-punitive reporting; transparency; being perceived as just; and a dedication to organizational learning.[2] By "culture of safety" we mean simply, "It's the way we do things around here, and safety is something we constantly do." We manifest a culture of patient safety when reporting patient errors for both learning and quality improvement is easy and natural, and represents the standard operating procedure. This is how a constant discussion of risk is kept alive, even when everything appears to be safe. As Morath has noted, risk should not be associated with reporting, risk should be associated with *failing* to report. A robust culture of safety is a climate in which the boss can hear bad news.[3]

While other industries have progressed with blameless reporting, adoption in health care has lagged, partly for cultural reasons, but also because of fear of litigation and punishment. The legal implications of blameless reporting are urgent and need to be addressed. While outside the scope of this article, we would do well to remember that the barriers and resistance to a culture of reporting in health care are formidable. Responsible discussion of this topic must acknowledge that litigation looms as an organizational and professional threat. "No matter how much we might insist that physicians have an ethical duty to report injuries resulting from medical care or to work on their prevention, fear of malpractice brings us back to the status quo."[4] The status quo means little real improvement in patient safety.

Other industries, among them aviation and nuclear power generation, have long recognized that the lack of blameless reporting drives reporting underground and results in underreporting of errors, near misses, and accidents. However, in most work settings, our efforts to create accountability with blaming and punishment encourages workers to conceal problems. A potent example of this was illustrated when the Federal Aviation Administration provided immunity from prosecution to pilots who reported near-collisions. The number of reports tripled, but when immunity was later retracted, the number of reports decreased six fold.[5] Again, blameless reporting isn't about accountability, it is about learning. Underreporting also undermines the ability to measure vulnerability accurately[6] and, much more importantly, may lead management to think the system is safer than it really is.

This gap between how management perceives work is "getting done" and the way it is actually "being done" is thought to be an important parameter of system resilience. There are theoretical reasons to believe a widening gap may indicate decreasing system resilience (that is, increasing system brittleness).[7] This gap may mask faint signals that indicate system safety is decomposing. Effective risk management depends on a thorough reporting culture. Without a detailed analysis of incidents, near misses, and "free lessons," we have no way of uncovering recurrent error traps, gaps, or knowing where the "edge" is until we fall over it.[1] Boundary areas can be especially problematic in systems, representing zones of uncertainty in which the functions of each department

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are poorly defined.[8] Thorough reporting helps illuminate these kinds of system vulnerabilities.

In fields outside health care, the following factors are important in determining the quality of incident reporting: immunity, confidentiality or data de-identification, independent outsourcing of report collection, and analysis by peer experts; also included are rapid, meaningful feedback to reporters and all interested parties, ease of reporting, and sustained leadership support.[9] This is also replicated in the general safety literature in diverse and high-risk industries. Since an estimated 17 years pass before health care adopts new evidence,[10] now is a good time to start the process. With some certainty, we can conclude the *lack* of blameless reporting will continue to interfere with understanding the changes we must make to address what has been called the "ethically compelling numerator of preventable harm."[11]

Human Error Isn't the Conclusion of an Investigation But the Starting Point for Study . . ..

In addition to providing "reality checks" and updates to people in a system, blameless reporting is also related to a new way of looking at errors. Beginning with the pioneering work of Jens Rasmussen, and continuing with the efforts of safety theorists and researchers Hollnagel, Dekker, DD Woods, Cook, Reason, Perrow, and Leveson, a new view of error in complex systems has been developed. "Errors cannot be studied as a separate category of behavior fragments independent of the context of individuals in their institutions."[12] Most health care reporting yields little insight into safety because local details of what people were doing that made sense to them at the time of the error or accident are omitted. Investigations tend to hold a standard of perfection to which all practitioners are compared. We conclude there was human error and think we've completed a satisfactory investigation. We focus a lot on counting errors and categorizing them, and we frequently project such conclusions into bar graphs, pie charts, and trend displays in an effort to contribute something significant to understanding "human" error. By and large, this approach contributes nothing to preventing the next error. Human error isn't the conclusion of an investigation but the starting point for study.[7]

An insightful observation about accidents and mishaps provided by Woods[13] outlines "first stories," that is, the first reports of an accident, and "second stories," which are the product of careful, thoughtful investigation yielding information that is invariably richer and more complex. If we stop analysis at the level of the first story, which often involves a conclusion about human error, then we will almost never understand the deeper causes. Note the use of the plural form of "cause"; we would do well to rename Root Cause Analysis to Root Causes Analysis because there is rarely a single "cause" in complex systems involving human behavior, and changing the name of the methodology may help shift our thinking. Philosophically, there is no such thing as a root cause.[14]

It's Not the Bad Apples, It's the Barrel . . . Human Error Is a Symptom of Trouble Within the System

Dekker has detailed the "Bad Apple" theory of error.[3] We attribute error to a few bad apples, which perpetuates the assumption that our systems are intrinsically safe. From the systems view,[15] it's not the bad apples, it's the barrel. Deliberate, criminal misdeeds in clinical care are rare; we must assume the vast majority of people do not show up for their work to do a bad job. There is general consensus among system safety theorists and researchers that safety is something a system *does*, not something it *has*.[16] The distinction is important. Safety has to be continually produced, and real progress in safety comes from helping people cope with complexity under pressure.[17]

Unfortunately, our propensity for punishment, blame, and assigning human error as the cause of accidents not only suppresses reporting, but blinds us to flaws inherent in the system. We know from years of research in safety, human factors, and cognitive psychology that humans perform poorly in complex systems and that the human mind is quite limited in its ability to deal with complexity.[18] "Our brains are marvelous, but are no match for the complexity of the real world that dwarfs our cognitive capability.[19] Rather than acknowledging that complex systems are typically unsafe, we tend to focus on how people made mistakes by tracking backwards through the prejudiced view of hindsight. We miss the opportunity to see that human error is a symptom of trouble within the system. Blame is the enemy of safety because it interferes with understanding. A near-miss or error is best seen as the reality of danger and cause for analysis. For example, one researcher was initially surprised to find the highest performing nursing units as measured by a variety of parameters reported more medication errors. This seemed incongruent with the other data, until the study's author realized the higher performing nursing units had a climate of openness that made people more willing to report and discuss errors and to work towards correcting them.[20]

The System Is Capable of Producing the Same Error Again With Another Person

The link between blameless reporting and a deeper understanding of vulnerabilities is based on general agreement in both general safety literature and the patient safety literature that most of our errors arise from systemic causes. The Normal Accident Theory[21] advances the idea that accidents and human error are normal, and ultimately inevitable expressions of complex systems. Reason[22] first described the sharp end (where the work is being done) and the blunt end (where management/administration/support services/regulators, professional standards, Policy and Procedures are centered). The blunt end also contributes to vulnerabilities by defining priorities, policies, procedures, and resource allocations. Our

investigations rarely extend beyond the sharp end, nor do they consider in depth how the circumstances for individual(s) at the sharp end made sense of things when they made the mistake. When we look at failures in the context of systems, the changes in our thinking are disquieting, because it challenges assumptions that our systems are basically safe. It forces the uncomfortable realization that the system is capable of producing the same error again with another person.

Safety is never the solitary goal in any system. Systems exist to make money or deliver services, and safety competes with production, budget, limited resources, and schedule. Understanding how a mistake or accident occurred requires that we understand how work is being done at the sharp end, i.e., the competing priorities, conflicting information, complexity, compromises, and pressures to work faster, better, and cheaper. Another insight into system thinking underscores our need to think expansively in terms of systems. "There are no side effects – just *effects*. Those we expected or that prove beneficial we call the main effects and claim credit. Those that undercut our policies and cause harm we claim to be side effects, hoping to excuse the failure of our intervention. "Side effects" are not a feature of reality, but a sign that the boundaries of our mental models are too narrow, our time horizons too short."[19]

A System Always Operates at Capacity. As Soon as There is Some Improvement, Some New Technology, We Stretch It

The so-called Law of Stretched Systems says "We are talking about a law of systems development, in which every system operates, that causes a system to always operate at capacity. As soon as there is some improvement, some new technology, we stretch it."[24] That our health care systems are complex and stretched is apparent, another variant of the systemic roots of human error. But knowing that, we have a tendency to ignore warnings, especially when the system is operating near the edge of economic failure, as is often the case with hospitals and other health care facilities.[25] Stretched systems contribute to error, but we tend to ignore that as a contribution to human error and blame individuals. What is remarkable is not that our systems work at all, but the resourcefulness and *resilience* of individuals that make the system continue to work in spite of the system's complexity by detecting errors and averting catastrophe in day-to-day operations.

The Fine Art of Predicting What Can Go Wrong Isn't Well Developed . . ..

The next accident is always different from the last one.[25] The fine art of predicting what can go wrong, what has been called *requisite imagination*,[26] poses challenges to everyone working in complex systems, requiring a kind of chronic mental restlessness.[27] Our best hazard analysis methodologies, such as Failure Mode Effects Analysis (FMEA), Hazard and Operability Studies (HAZOP), Action Error Analysis (AEA), Work Safety Analysis (WSA) and Management Oversight Review Technique (MORT) have not been well evaluated in terms of their predictive capabilities for accident and error contributors. What little scientific evaluation has been done is discouraging.[28,29] All of the techniques, even when used in combination, show significant shortcomings, serving to underscore the difficulties humans have in predicting problems in complex systems.

Hindsight Bias Exaggerates Our Ability to Predict an Event After It Happens

Unfortunately, our professional biases regarding errors and accidents, are longstanding. The father of modern safety science, Heinrich[30] proposed a "domino theory" that explained a linear sequence of events that led to accidents. This unfortunate oversimplification persists today, as well as the notion that education and enforcement are effective means to improve human behavior.[31] Hindsight bias, first articulated in the experimental psychology literature,[32] exaggerates our ability to predict an event after it happens. We have access to information in a much more complete and seamless form than the person at the sharp end making the error. We know the sequence of events and the outcome. We assume those events flowed smoothly and inevitably and are quick to judgment. We have access to cues that may have been hidden or confusing at the time. We have a tendency to see what we expect to find.[33] Unfortunately, our rush to judgment precludes actually explaining their behavior. We can take our pick: be indignant or do something meaningful.[7] Unfortunately, hindsight bias exists across virtually all industries, and as many clinicians will attest, some of the worst hindsight bias resides in the legal realm.[34]

In investigating mistakes, accidents, and system vulnerabilities, 'cause' is fascinating because it is so malleable. Cause is not something you find. Cause is something you construct. How you construct cause depends on the evidence you have. Cause depends on who you look at. It depends on what you look at, when you look, and where you look. It depends on why you look at it, and who you work for.[7]

There is the tendency to assign higher levels of blame with worse outcomes.[35] For example, two groups of anesthesiologists were asked to evaluate human performance in sets of cases with the same descriptive facts but with the outcomes randomly assigned to either bad or neutral. The professionals consistently rated the care in cases with bad outcomes as substandard, whereas they viewed the same behaviors with neutral outcomes as being up to standard even though the preceding medical care was identical. This finding parallels the well known medical phenomenon in which the more severe the injury from a medical mistake, the more the compensation awarded. Physicians believe that liability correlates not with the quality of the care they provide but with

outcomes over which they have little control.[36] This pattern of hindsight bias is "stark, repeatable, and strong."[37] Unfortunately, hindsight bias makes it easy to downplay organizational contributors and only pursue those people who stood closest to the failure event – nurses, physicians, pilots.[38] It becomes harder and harder to believe blame contributes to understanding, let alone justice in health care. As we begin to increasingly see blame as counterproductive and the determination of cause as highly subjective, the National Practitioner Databank becomes more onerous. It provides blame without context on a national scale, and ignores system contributors. Worse, it sometimes represents the poignant ruination of good people.

If People Are Blocked From Acting on Hazards, It's Not Long Before Their "Useless" Observations of Those Hazards Are Also Ignored or Denied

Morath[2] outlines the need for leadership engagement in patient safety, arguing the promise to "do no harm" is a powerful change lever for an organization and that leaders who are serious about patient safety begin with an uncensored view of the performance of their organization. Morath's refreshing view of accountability for leadership requires that leadership has the foresight and humility to appreciate that systems can fail, and involves leaders telling the truth about gaps in care, and leading safety with transparency. "Leaders who do not want to roll up their sleeves and lean into the clinical enterprise and improvement of safety and quality had best choose another industry in which to work. The work of leaders at the top of the organization is to translate the values of harm-free care and transparency into action, throughout all aspects of the organizations that they have the privilege to lead." To Morath's view, we can add the three perishables: credibility, trust, and attentiveness[39] and a reminder that if people are blocked from acting on hazards, it's not long before their "useless" observations of those hazards are also ignored or denied, and errors accumulate unnoticed.[40]

Freedom From Stakeholder Influence and Technical Grounding

Wreathall[41] argues "there is a clear need for health care to develop and maintain a competent investigative body . . . aviation accident investigation boards are cited as a useful model for such a body that is independent of stakeholder biases." The result is a lack of reliable, authoritative, scientific investigations of medical accidents, and especially lacking is a systematic analysis of multiple causes. Health care has abrogated this function to the realm of litigation. In comparison, the accident reports from the National Transportation Safety Board are first-hand investigations by professionals, and the reports are recognizably free from stakeholder control. This freedom from stakeholder influence and technical grounding make the NTSB the definitive source for information about specific transportation accidents.

To make real progress in patient safety we need to institutionalize blameless reporting, while recognizing this is only one part of an overall plan to improve patient safety. Blameless reporting is the next best step in building a more resilient system of safety for health care. With acceptance of blameless reporting, it must be recognized that a culture of opening communication and reporting, alone, will not create a learning organization. The creation of a learning culture requires a fundamental commitment from our health care leaders. We also need a new view on accountability and just culture; Sidney Dekker's book *Just Culture*[42] will be a fine place to start.

True leadership often involves relinquishing authority. Creating a scientifically based independent investigative review process that is free of stakeholder involvement in which professionals are able to identify the origins of errors, vulnerabilities, and system "traps" is another rational step. Such findings have to be distributed widely to facilitate learning, and we have to figure out ways to protect our ability to share learning. As noted previously, the alternative is "business as usual" in which the litigation system provides health care with defacto "reporting," investigation, analysis, and (frequently) judgment. Finally, to paraphrase Pietro,[43] if we continue to hold perfection as the standard, we risk becoming villains in the growing patient safety movement instead of leaders in it.

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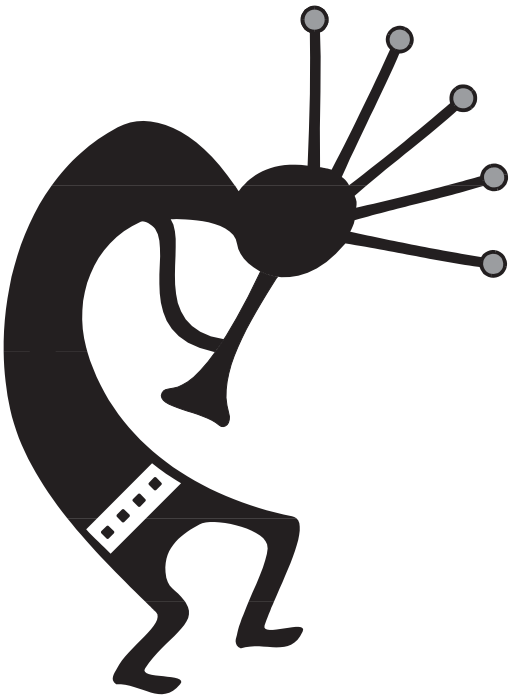

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The Indian Health Service Chronic Care Initiative: Innovations in Planned Care for the Indian Health System

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American Indian and Alaska Native people continue to face unacceptably high rates of illness, disability, and death from chronic and preventable conditions, injury, and suicide.[1] The IHS initiatives in Health Promotion and Disease Prevention, Behavioral Health, and Chronic Care provide a framework and strategy for addressing these health disparities and for improving the health status of all those cared for in the Indian health system (IHS, tribal, and urban Indian health programs).

In 2006 the IHS, through the Chronic Care Initiative, developed a partnership with the Institute for Healthcare Improvement (IHI) to use modern improvement methodologies to fundamentally transform our system of care for clinical prevention and for the management of chronic conditions. The ideas that guide this transformation come from the Chronic Care Model (Care Model), developed at the MacColl Institute for Healthcare Innovation, adopted by the World Health Organization and tested and implemented widely in the US and abroad.

The Care Model captures and defines the essential features of a system of care that focuses on the relationship between an informed and activated patient, family, and community and their prepared and proactive health care team. The Indian health system has extensive experience with the Care Model in diabetes care. In the Chronic Care Initiative, the Care Model is applied across conditions, including clinical prevention, for the entire population (see Table 1). The measurement plan is equally broad and comprehensive, and aims to guide improvement in four domains: clinical prevention, care of chronic conditions, patient experience of care, and the cost of care (see Table 2).

In 2007, 14 pilot sites representing a slice of the Indian health system began work on the Innovations in Planned Care[2] (IPC) for the Indian health system. This first prototype phase (IPC I) developed an adaptation of the Care Model and developed a set of changes designed to improve care across conditions. In fall 2009 an additional 25 sites joined the initial 14 sites in the second prototype phase (IPC II) to test and refine the changes derived from IPC I as well as the set of measures that will guide improvement. These sites have been building improvement capacity into their systems of care and using measurement to guide improvement efforts. In a process known as the "Breakthrough Collaborative,[3]" the IPC learning community engages every other week in 1 hour web-based seminars (action period calls), with more intensive two-day meetings (learning sessions) at 8-12 week intervals (some held in-person and others web-based). In these, IPC teams share learning with each other through reporting of common measures as well as changes, and exchanging ideas and questions on a website and listserv. Measurements are used to guide improvement, not to judge performance, with measures for monthly reporting introduced in phases. The intake screening bundle is comprised of six measures: Alcohol Misuse Screening, Depression Screening, Domestic Violence (DV)/Intimate Partner Violence (IPV) Screening, Tobacco Use and Assessment, BMI (Obesity) Assessed, and Blood Pressure Assessed. IPC I sites began reporting on these measures in

Table 1. The scope of IPC covers a large set of chronic conditions and clinical prevention activities

Chronic Disease Management	
Diabetes, type 1 and 2	Obesity
Cardiovascular disease	Diet and behavioral
Uncomplicated depression	counseling
	Asthma
Clinical prevention activities	
Screening	
Depression	Breast cancers
Obesity	Cervical cancer
Tobacco use	Colorectal cancer
Hypertension	Diabetes
Alcohol misuse	Dyslipidemia
Domestic violence/IPV	Fall risk
Preventive Services	
Tobacco cessation	Dental fluoride
Immunizations	Dental sealants

Table 2. IPC measurement plan outlining four domains and the areas of focus/coverage within each measurement domain.

IPC Measurement Plan	
Measurement Domains	**Areas of Focus/Coverage**
Clinical Prevention	Keeping Current on Preventive Screenings Keeping Current on Cancer-related Screenings Keeping Current on Immunizations
Management and Prevention of Chronic Conditions	Control of Blood Pressure Control of Lipids Tobacco Cessation Treatment Diabetes Care Obesity Assessment and Treatment Asthma on Appropriate Controller Medication Physical Activity Level Depression Outcome Functional Assessment
Costs	Revenue Generation Workforce Measures Cost Measure
Patient Experience	Experience and Efficiency Patient Activation Patient Satisfaction Building Relationships for Care Access

September 2007 and have seen a steady increase in the percentage of patients receiving all components of the intake screening bundle (see Figure 1). The teams are also making progress in screening patients for DV/IPV (see Figure 2).

Spotlight: Indian Health Council, Inc.

The Indian Health Council, Inc. (IHC) is located in San Diego County, California and provides services for nine tribes in 38 GPRA communities. One of the original pilot sites in the IPC collaborative, IHC has been testing and implementing changes within their health care system. The clinic has set very aggressive goals to improve efficiencies, close the gap between provider and patient, and streamline processes. Almost two years into their participation, IHC is seeing the rewards of their work with the collaborative in improved clinical measures and improved patient-provider relationships.

Prior to the collaborative, IHC had begun an effort to ensure that improved care was woven into the fabric of their organization. The aim of IHC is to redesign and standardize the delivery of care to decrease morbidity and mortality in the community they serve. Efforts will be made to advance both preventive strategies and the treatment of chronic conditions across the population. The clinic plans to partner with their community to support education and empower patients to become active partners in their health care planning.

Teams at IHC start their day differently than two years ago. In the past, staff would come to work not knowing who they would be working with that day. In the new system, an identified care team, called a pod, cares for their own set of impanelled patients. Each of the three pods hosts a care team comprised of providers, nurses, and medical assistants. As a result, staff now come to work knowing with whom they are working, the kind of team they have, what the team has to do, and what patients they will be seeing that day. Continuity of care is enhanced by ensuring that patients are seeing providers from the same pod each time they come to the clinic.

The first task of the day for the care team is to do pre-visit planning, which they accomplish during a 30-minute "huddle" prior to the clinic opening. During this huddle time, the care team reviews reports generated by the iCare application in RPMS to see who is and who is not up to date with screenings and what care is needed. IHC has also been able to improve care for their patients by integrating their community health program, housing, public health nursing, and Community Health Representatives (CHRs). The field nurses join the morning huddle, are actively engaged in the pre-planning process, and are able to reach beyond the clinic to meet patient needs.

Getting started in the collaborative can be intimidating. The iCare reports can be lengthy due to needed screenings and assessments, but as the teams work together the reports get smaller, and it doesn't feel like a game of catch-up. Another benefit is that patients are updated on health screens and GPRA requirements. Slowly, patients are becoming more interested in their own care and have been asking to see their charts. Providers are able to open up charts and say, "Here is where you were, here is where you are, and this is how we can work together to help you reach your goals."

Other departments at IHC are also noticing that patients are starting to be more active with their self care. Physical activity and exercise referrals have increased, and staff have noted that patients are taking control of their own personal

health and well being. In the past, patients would come to their appointment because their doctor told them to do so, without being able to verbalize why they were there. As the collaborative has progressed, patients now know not only that their cholesterol is high, but what their level is and the level they want to reach, and that exercise and diet will help them reach their goal. A next step for the collaborative is to create individual scorecards outlining standards of care based on diagnosis, in hopes that patients will demand more of the care team. Patients will expect certain kinds of treatment and tests and will be able to ask questions about their treatment plan.

The result of this work has been consistent improvement in alcohol misuse screening, colorectal cancer screening, and childhood immunizations; decreasing office visit cycle time; and improved continuity of care. More importantly, the staff members can see the changes and know that they are able to improve the care they provide to their community.

References

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2. Kabcenell AI, Langley J, Hupke C. Innovations in Planned Care. Innovation Series. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2006. (Available on www.IHI.org).
3. *The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement*. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003. (Available on www.IHI.org).

Figure 1. IPC I weighted average of the Intake Screening Bundle

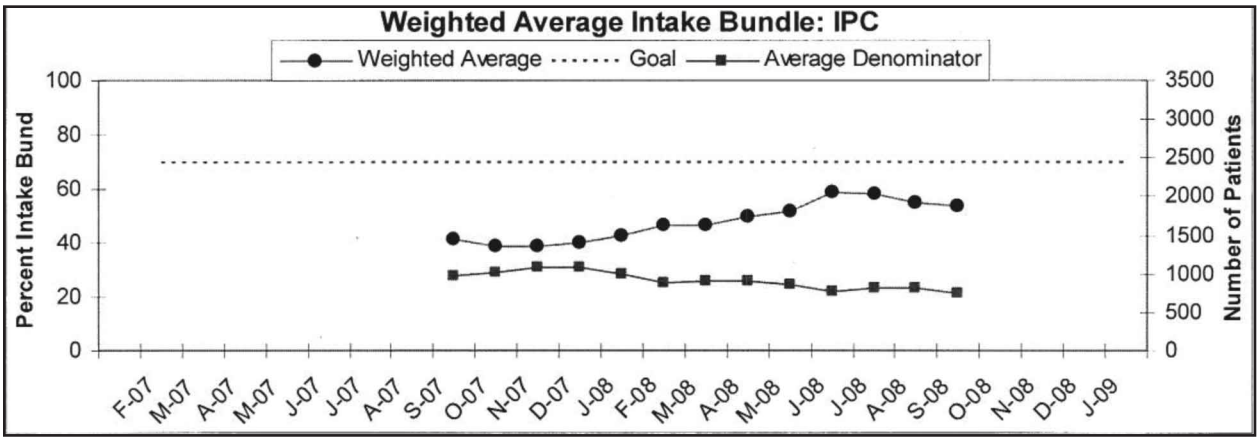
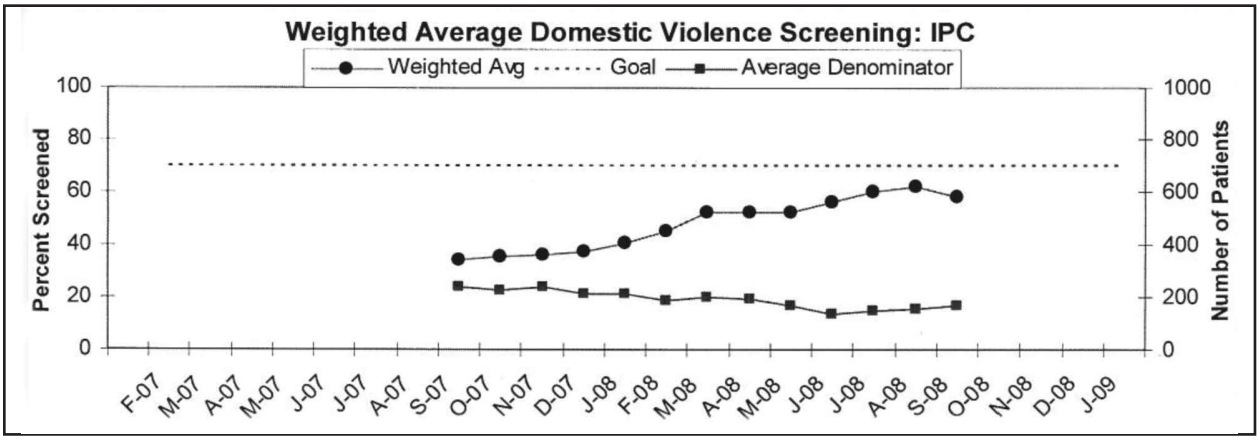


Figure 2. IPC I weighted average of Domestic Violence/Intimate Partner Violence screening



Resources to Help Your Patients Quit Smoking

LCDR Megan S. Wohr, RPh, NCPS, Tobacco Control Specialist, IHS Division of Epidemiology and Disease Prevention, Phoenix Indian Medical Center Centers of Excellence, Phoenix, Arizona

The smoking prevalence of the American Indian and Alaska Native population is the highest of the US Adult Ethic/Racial Groups, 32.0% (37.5% of men and 26.8% of women, according to 2006 CDC statistics). The American Indian population also holds the highest prevalence of smokeless tobacco use; fourteen percent of American Indian males and two percent (2%) of American Indian females use smokeless tobacco, as compared to 5.9% of males and .01% of females in the general population. (Hodge, Frederick, & Kipnis, 1999)

Commercial tobacco use is the chief preventable cause of illness and death in our society, responsible for more than 430,000 deaths in the US each year (Fiore et al, 2000). Smoking is a known cause of cancer, heart disease, stroke, and chronic obstructive pulmonary disease (CDC, 2002). The National Cancer Institute projects that if physicians assisted even 10% of their patients who use tobacco to quit, the number of people who use tobacco in the United States would drop by an additional 2 million people annually (Fiore et al, 1990).

Delivering a stage-appropriate "Five A" model brief intervention can potentially increase a patient's likelihood of quitting tobacco by at least 60% (Fiore et al., 2000). Sadly, only half of all smokers seeing a primary care physician in the past year report being asked about their tobacco use and advised to quit (Goldstein et al, 1997; Robinson et al, 1995; CDC, 1993). The structure of the Indian Health Service (IHS) health care system provides the unique opportunity for our health care teams to be able to develop a "tobacco intervention system." A brief intervention with a tobacco user does not need to lie solely in the hands of the provider. **Asking** about tobacco use can be incorporated into the vital signs and should be documented at every visit. The **Advise** to quit and the **Assess**ment of the patient's readiness to quit can be addressed during the visit and is often relevant to the purpose of visit. **Assist**ing with treatment and **Arranging** for follow up will vary based on local protocols and available resources.

The IHS Tobacco Control Task Force (TCTF) is currently developing a workable model for clinical nicotine dependence treatment that can be easily adopted by IHS, tribal, and urban Indian clinics. The model includes integration of the efforts of medical, dental, pharmacy, behavioral health, nursing, and health education professionals within the system and has specific aims for clinical tobacco cessation, policy change, provider training, and education. The IHS Tobacco Control Task Force Fieldbook, "*Implementing Tobacco Control into the Primary Healthcare Setting*" has been developed to integrate the model. Based on the US Public Health Service Guideline, "Treating Tobacco Use and Dependence," the field book is a clinical tool designed to meet all levels of tobacco treatment in the primary health care setting. The "all-inclusive" reference has a concrete framework with adaptable ideas and materials to reach the community it is serving.

In order to create systems and processes that are self-sustaining, it is crucial that sufficient training to treat tobacco dependence be in place. The TCTF offers Basic Tobacco Intervention Skills and Instructor Certification to all levels of health care professionals. The certification program provides participants with the basis for understanding tobacco dependence as a chronic condition. Participants learn to deliver brief, evidence-based interventions using an integrated "Five A" model specific to the individual's readiness to quit. The program is based on the best research evidence available, including the US Public Health Service Clinical Practice Guideline, *Treating Tobacco Use and Dependence*. The Alaska Native Tribal Health Consortium offers a one week Tobacco Treatment Specialist training. The training is designed for those who will be conducting intense interventions; it covers motivational interviewing, pharmacotherapy, etc. The Mayo Clinic in Minnesota offers a Tobacco Treatment Specialist Certification program for professionals with a bachelor's degree or higher.

If you have any questions regarding the IHS Tobacco Task Force or certifications, please contact, LCDR Megan Wohr at *megan.wohr@ihs.gov*. For more information about the references cited, you may also contact Ms. Wohr.

Through our contractor, the HealthCare Partnership at the University of Arizona, we offer Tobacco Intervention Skills training and certification at Basic and Instructor levels.

Instructional Materials	Cost
Basic Skills for Medical & Allied Health Professionals *Includes Medical Basic Skills Program Materials, Participant Resource Folder, Data Management, Certificate, and CE/CME issuance*	$177/unit
Instructor of Basic Skills for Medical & Allied Health Professionals *Includes Medical Basic Skills Program Materials, Participant Resource Folder, Data Management, Certificate, and CE/CME issuance*	$210/unit

This is a page for sharing "what works" as seen in the published literature, as well as what is being done at sites that care for American Indian/Alaskan Native children. If you have any suggestions, comments, or questions, please contact Steve Holve, MD, Chief Clinical Consultant in Pediatrics at sholve@tcimc.ihs.gov.

IHS Child Health Notes

Quote of the month

"We believe that the death of a child is a tragedy, but the death of a child from a preventable cause is an injustice."

Paul Wise

Article of Interest

Oral prednisolone for preschool children with acute virus-induced wheezing. *N Engl J Med*. 2009 Jan 22;360(4):329-38. *http://content.nejm.org/cgi/content/abstract/360/4/329*

A short course of oral prednisolone is widely used to treat preschool children with viral induced wheezing, but evidence is contradictory if this is effective. The authors conducted a randomized controlled clinical trial of a five-day course of oral prednisolone for children ages ten months to six years with wheezing associated with a viral URI. There was no significant difference in hospitalization, respiratory symptom scores, albuterol use, or symptoms at seven days.

Preemptive use of high-dose fluticasone for virus-induced wheezing in young children. *N Engl J Med*. 2009 Jan 22;360(4):339 *http://content.nejm.org/cgi/content/abstract/360/4/339*

The authors examined the utility and safety of high dose, pre-emptive fluticasone in reducing the severity of recurrent wheezing in preschool children. This was a randomized controlled trial using fluticasone 750ug BID versus placebo at the onset of URI symptoms and continued for a maximum of ten days. The use of high dose fluticasone decreased the use of rescue oral corticosteroids versus the placebo group (8% compared to 18%, a 50% reduction). However, the fluticasone group had smaller mean gains in height over 1 year, although there was no difference in basal cortisol levels or bone density.

Editor's Comment

The previous two articles suggest that "nothing" is better than "something," or at least the "something" we have been doing for the past few decades. Preschool children get 6 - 10 URIs each year, and 30% of preschool children will wheeze with intercurrent viral illnesses. While the disease is usually mild and self-limited, viral induced wheezing creates much distress for parents and children, and the use of considerable medical resources. The treatment for viral induced wheezing has been the same as that used for asthma. Even in the face of evidence that shows that such treatments have little effect, most physicians use inhaled bronchodilators and oral steroids for all patients with viral induced wheezing in the hope that there is a subgroup with atopic disease that will benefit. At present our ability to predict which wheezing preschoolers have atopic disease is poor.

What should we do for children who wheeze only with colds? Inhaled bronchodilators may be of benefit. Oral steroids are best reserved for those ill enough to be hospitalized or those with atopic disease. The use of leukotriene antagonists and inhaled corticosteroids requires further study. At present the side effects of high dose fluticasone appear to outweigh the small benefits and can not be routinely recommended.

Infectious Disease Updates.

Rosalyn Singleton, MD, MPH

Reason starts to prevail in the "Vaccines and Autism Debate"

Two occurrences in the past three weeks suggest that reasonable people are beginning to prevail in the unsubstantiated claim that vaccines cause autism.

In February, the US Court on Federal Claims in the Omnibus Autism Proceeding found that there was no association between vaccines and autism. The following website contains a review of this decision: *http://www.cdc.gov/Features/AutismDecision/*. The March 2, 2009 edition of *Newsweek* magazine contained a balanced article, "Anatomy of a Scare" that outlines the unscientific bias in the Wakefield 1998 *Lancet* article that claimed that measles vaccine virus infected the guts of children and leaked neurotoxic compounds into the brain leading to autism. Most providers aren't aware of the rest of the Wakefield story: 10 of the 13 original authors retracted the article's conclusion, Wakefield's financial incentive has come into scrutiny, and every study conducted to test Wakefield's MMR hypothesis has found "no evidence that MMR vaccination is associated with autism." The article can be read online at *http://www.newseek.com/id/185853/output/print*.

Hopefully this ruling and article will help to turn the tide of negative press about vaccines. In 2008, parental refusal of

vaccines resulted in the largest number of measles cases in the US, 131 cases, in 15 years.

Recent literature on American Indian/Alaskan Native Health

Michael L. Bartholomew, MD

Kvigne VL, Leonardson GR, Borzelleca J, Neff-Smith M, Welty TK. Characteristics of children whose siblings have fetal alcohol syndrome or incomplete fetal alcohol syndrome. *Pediatrics*. 2009 Mar;123(3):e526-33. *http://www.ncbi.nlm.nih.gov/pubmed/19254987?ordinalpos=4&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_DefaultReportPanel.Pubmed_RVDocSum*

Fetal alcohol syndrome (FAS) continues to be a prevalent, and preventable cause of mental retardation in the US. Rates of FAS are higher among American Indians and Alaska Natives (AI/AN) than in the general population. The prevalence of FAS in AI/AN populations is well above other ethnicities. Rates of FAS range from 9.8 per 1,000 live births among southwestern Indians, to 5.6 per 1,000 in Alaska, and 2.5 per 1,000 in Arizona.[1] In the Northern Plains American Indians, the prevalence of FAS was estimated at 8.5 children per 1000 live births in 1993.[2] Among AI/AN populations, FAS is a common diagnosis. In this study, the authors conducted two retrospective case control studies of Northern Plains Native American children with FAS and incomplete FAS to characterize children born before and after a child diagnosed with FAS or incomplete FAS. The aim of the study was to define factors or characteristics in older siblings of FAS children that might predict FAS in subsequent children.

The results of the study show that siblings born just before children with FAS and incomplete FAS had more facial dysmorphology, growth delay, central nervous system impairment, maternal alcohol history, and prenatal alcohol exposure, and were more often diagnosed with FAS by physicians compared to controls. Both sibling groups born just after children with FAS and incomplete FAS had more facial dysmorphology, growth delay, and central nervous system impairment than the control siblings as well. On average, before and after siblings of a child with FAS met 2.0 FAS criteria while before and after siblings of a child with incomplete FAS met 1.2 FAS criteria. Before siblings of a child with FAS had significantly greater growth delay than before siblings of a child with incomplete FAS and controls.

Maternal alcohol use during pregnancy decreased in mothers with children with FAS and incomplete FAS. 64.1% of mothers of children with FAS used alcohol in the before sibling pregnancy while 46.7% of mothers of children with incomplete FAS used alcohol in the before sibling pregnancy. The percentages of mothers using alcohol during after sibling pregnancies decreased in both groups (45% of mothers with children with FAS and 40.9% of mothers with children with incomplete FAS).

This study is not without limitations. This is a retrospective chart review study in which mothers were not interviewed and children were not examined. In defining predictive factors or characteristics of children with FAS, authors had to rely on provider documentation in the medical record. Because the before siblings had certain identifiable characteristics of FAS, the authors concluded that predicting subsequent FAS at risk pregnancies is possible. The authors recommended that medical providers receive additional training to recognize features of Fetal Alcohol Spectrum Disorders and that they "screen and intervene with all pregnant women who drink alcohol during pregnancy."

References

1. Indian Health Service. *www.ihs.gov*
2. Duimstra C, Johnson D, Kutsch C, et al. A fetal alcohol syndrome surveillance pilot project in American Indian communities in the Northern Plains, *Public Health Rep*. 108 (1993), pp. 225–229.

Announcements from the AAP Indian Health Special Interest Group

Sunnah Kim, MS

Locums Tenens and Job Opportunities

If you have a short or long term opportunity in an IHS, tribal or urban facility that you'd like for us to publicize (i.e., AAP website or complimentary ad on Ped Jobs, the official AAP on-line job board), please forward the information to *indianhealth@aap.org* or complete the on-line locum tenens form at *http://www.aap.org/nach/locumtenens.htm*.

A NEW PROGRAM FOR CURRENT AND FUTURE INDIAN HEALTHCARE EXECUTIVES

WHAT?
A concentrated executive leadership program designed specifically for current and future leaders. The program will benefit individuals who are either serving in or aspire to be in leadership positions.

WHO WOULD BENEFIT?
Chief Executive Officer · Service Unit Director · Health Director · Medical/Clinical Director · Nursing Executive · Director of Nursing · Administrative Officer

Individuals who are program coordinators or managers of clinical, community, environmental or engineering programs will find this beneficial.

The interactive curriculum includes topics that will be integrated through the use of exercises, case studies, and team projects.

Challenges in Indian Healthcare
Change and Transition
Personnel
Motivation
Organizational Skills
Personal Vision & Goal Settings

Financing Health Care
Budgets and Financing
Data & Information Technology

Law
Integrity and Ethics

Conflict Resolution
Critical Thinking
Negotiation
Executive Communications
Partnerships, Collaborations
Decision Making
Visionary Strategic Planning
Building Constructive Relationships

WHY?
The purpose of the Executive Leadership Development Program is to provide a forum where participants learn new skills and encounter different approaches to reduce barriers, increase innovation, ensure a better flow of information and ideas, and lead change. The goal is to provide essential leadership training and support for Indian healthcare executives whether they work in Federal, Tribal, or Urban settings.

WHO?
Faculty for the Executive Leadership Development Program have been selected from the private, public, and academic sectors. They have experience teaching in executive programs and understand the unique needs of the Indian healthcare system. Coordination of the Executive Leadership Development Program is through the Indian Health Service, Clinical Support Center in Phoenix, Arizona in partnership with different universities and foundations.

HOW?
The Executive Leadership Development Program will be presented in three 4 ½ day sessions over 12 months. Each session builds on the previous session. Participants should anticipate an intense experience to develop and practice skills to be an effective leader. Independent time is used for reading assignments or working with fellow team members on business simulations, cases, or presentations. At the end of each session, participants will receive certificates of accomplishment from the academic institutions that sponsored the training. After all three sessions have been completed, participants will receive a certificate of completion from the Indian Health Service.

WHEN/WHERE*?

Session One (05/09)	**May 4-8, 2009** Western Management Development Center Aurora, Colorado
Session Two (06/09)	**June 15-19, 2009** Western Management Development Center Aurora, Colorado
Session Three (07/09	**July 20-24, 2009** Western Management Development Center Aurora, Colorado

*Note: Attendees must enroll for all three sessions.

CONTINUING EDUCATION CREDITS ACCREDITATION
The Indian Health Service (IHS) Clinical Support Center is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

The IHS Clinical Support Center designates this continuing education activity for up to 28 hours of Category 1 credit toward the Physician's Recognition Award of the American Medical Association. Each physician should claim only those hours of credit he or she actually spent in the education activity.

The Indian Health Service Clinical Support Center is approved by the American Council on Pharmaceutical Education as a provider of continuing pharmaceutical education.

The Indian Health Service is accredited as a provider of continuing education in nursing by American Nurses Credentialing Center Commission on Accreditation, and designates this program for 36 contact hours for nurses.

Continuing Education Units for Chief Executive Officers, Administrative Officers and Dentists designates this program for
36 CEUs.

TUITION:
Tuition for all three sessions is **$4500**. The tuition includes three (3) 4 ½ day-session, books, instructional handouts, leadership assessments, and continuing education credits. Payment should be by Tribal organization check or approved SF-182 Form. Travel and per diem are not included in the tuition.

CONTACT:

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FAX: (602) 364-7788
Email: gigi.holmes@ihs.gov
http://www.ihs.gov/nonmedicalprograms/eldp/

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Clinical Support Center
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Last update: October 6, 2006

Please email questions and comments related to content to: Gigi Holmes

MEETINGS OF INTEREST

Available EHR Courses

EHR is the Indian Health Service's Electronic Health Record software that is based on the Resource and Patient Management System (RPMS) clinical information system. For more information about any of these courses described below, please visit the EHR website at *http://www.ihs.gov/CIO/EHR/index.cfm?module=rpms_ehr_training*. To see registration information for any of these courses, go to *http://www.ihs.gov/Cio/RPMS/index.cfm?module=Training&option=index*.

Intensive Case-Based Training in Palliative Care

May 4 - 8, 2009; Rochester, Minnesota

This new and innovative intensive program will build on the principles and practice of palliative care previously introduced at the ***Education in Palliative and End-of-Life Care-Oncology (EPEC-O ™)*** conferences. It is designed to address some of the suggestions for additional training made by participants. This course will be taught at the Mayo Clinic by its faculty and IHS experts in palliative care. Actual cases will be presented and examined in detail, with an emphasis on an interdisciplinary approach to palliative care. Trainees will gain hands-on experience in dealing with real-life scenarios in the state-of-the-art Simulation Center. Trainees will also round with palliative care and pain management teams and attend weekly interdisciplinary case conferences.

A portion of the course will be presented by telemedicine as part of the *International Telehealth Palliative Care Symposium* sponsored by the Alaska Native Tribal Health Consortium. Cultural considerations in providing palliative care for indigenous people will be emphasized.

There is no cost to attend. Funding, provided through the generosity of the Fort Defiance Service Unit, under the direction of Dr. Franklin Freeland CEO, will cover travel and per diem for teams of three or four individuals. Teams should be drawn from individual facilities or service units and include a physician, nurse, and a social worker. Additionally, a pharmacist or other involved professional will be considered as part of a team. Approximately eight teams, 28 - 32 individuals, will be accepted. Teams with individuals who attended one of the previous EPEC-O™ conferences are strongly encouraged to attend, although this is not a prerequisite.

The deadline for applications is February 28, 2009. Applications will be accepted on a first request, first served basis. Register on line at *http://www.csc.ihs.gov*. For questions or more information, please contact Timothy Domer, MD at *Timothy.domer@ihs.gov*.

The Indian Health Service Clinical Support Center (CSC) is providing meeting support and will serve as the accredited sponsor.

2009 Clinical Update on Substance Abuse and Dependency

(Formerly known as the Primary Care Provider Training on Chemical Dependency)

May 5 - 8, 2009; Phoenix, Arizona

This three-and-a-half day intensive workshop includes both didactic and experiential training. The curriculum is updated annually with the most current nursing, addiction medicine, and prevention information. This training is available to Indian health providers (physicians, physician assistants, nurses, and advanced practice nurses). Enrollment is limited to 30 providers (preferably 2 - 3 person teams from the same facility representing the various disciplines targeted). The conference site is the Native American Connections Inc., 4520 North Central Avenue, Suite 600, Phoenix, Arizona 85012. For more information or to register, contact Cheryl Begay at (602) 364-7777 or e-mail *cheryl.begay@ihs.gov*. To register on-line, go to the CSC website at *http://www.csc.ihs.gov*.

Evidence-Based Practice in Indian Country: A Journey to Excellence

A Research Symposium and Evidence-Based Practice Workshop

May 27-29, 2009; Fort Belknap College, Fort Belknap, Montana

Fort Belknap Tribal Public Health Nursing Program and IHS Headquarters Division of Nursing in collaboration with the National Institutes of Health (NIH) Nursing Research and Practice Service (RAPDS) are hosting a research symposium and evidence-based practice (EBP) workshop May 27 - 29, 2009 at Fort Belknap College, Fort Belknap, Montana. The event is free, and CEUs will be provided. The overall purpose of the three day event is to improve patient outcomes by linking research to practice.

The *Research Symposium* is intended to inform practitioners about significant research findings related to the Native American experience with Suicide/Mental Health, Family and Community Violence, Methamphetamine Abuse, and Case-Management, all clinical and public health areas of concern in the Billings IHS Area. Further, it will serve as a forum for the exchange of ideas among scholars and practitioners of tribal, urban and IHS programs to promote the use of research in practice.

Distinguished speakers include Jacquelyn C. Campbell, PhD, RN, FAAN of the Johns Hopkins University School of Nursing; Lawrence Wissow, MD, MPH of the Johns Hopkins Bloomberg School of Public Health, and John M. Roll, PhD,

Associate Dean for Research and the Director of the Program of Excellence in the Addictions, Washington State University College of Nursing.

A poster presentation and discussion will be held on current EBP Projects from Quentin N. Burdick Memorial Hospital in Belcourt, ND and Northern Navajo Medical Center in Shiprock, NM, as well as from other current or in-progress projects from workshop participants.

The overall goal of the interactive EBP workshop is to facilitate and encourage the implementation of evidence-based practice in Nursing in IHS, tribal, and urban health facilities. Participants will gain tangible skills and knowledge specifically pertaining to articulating the evolution and importance of EBP, formulation of a clinical question using "PICO" methodology, application of pre-appraised evidence to address clinical questions, as well as the development of a preliminary plan for integrating EBP in existing and future policies and practice.

The *Evidence-Based Practice Workshop* will be facilitated by Gwenyth Wallen, PhD, RN, Chief/Clinical Nurse Scientist at the NIH CC RAPDS in Bethesda, Maryland. She, with a team of other NIH nurse researchers, conducted a successful training in Shiprock last year, and we are fortunate to have them for this upcoming event.

The intended audience is clinical and public health nursing staff, but is open to all who are interested in promoting future EBP and community-based participatory research efforts in American Indian/Alaska Native communities. For further information contact Teresa Brockie at (301) 594-4563, e-mail *brockiet@cc.nih.gov*; Dawn Halver at (406) 247-7121, e-mail *Dawn.Halver@ihs.gov*; or Kathleen Adams at (406) 353-3258, e-mail *Kathleen.Adams@ihs.gov*. To register contact Delores Little Owl at (406) 353-3244 or e-mail *Delores.Littleowl@ihs.gov*. Limited space is available; please register as soon as possible. We hope you can join us for this excellent opportunity.

New York/New Jersey AIDS Education and Training Center Native American HIV/AIDS Conference

June 2, 2009; Niagara Falls, New York

The first annual Native American HIV/AIDS Conference for upstate New York will be June 2, 2009. The conference is for health care providers, including nurses, social workers, substance use specialists, and case managers who treat Native Americans. The conference will be at the Seneca Niagara Casino and Hotel; it is free and includes lunch. The deadline to register is Monday, May 25, 2009.

Our keynote session will be "Ten Big Challenges to Care in HIV Medicine" given by Dr. Judith Lightfoot, an Infectious Disease Specialist from Garden State Infectious Disease Associates in New Jersey.

This conference is sponsored by the New York/New Jersey AIDS Education and Training Center, Erie County Medical Center, and Albany Medical College. For more information and to register, contact Laura Glazer at (518) 262-8640 or *GlazerL@mail.amc.edu*.

2009 Nurse Leaders in Native Care (NLiNC) Conference

June 15 - 19, 2009; Phoenix, Arizona

The theme of this year's conference is "Linking Yesterday, Today, and Tomorrow through Leadership, Teamwork, and Evidence-Based Practice." IHS, tribal, and urban nurses are encouraged to attend the '09 NLiNC Conference to be held at the Sheraton Crescent Hotel, 2620 W. Dunlap Avenue, Phoenix, Arizona 85021. Please make your room reservations by May 31, 2009 by calling toll-free 1-800-423-4126 or (602)-943-8200, and ask for the "2009 Nurse Leaders in Native Care Conference" to secure the special rate of $89 + tax single or double occupancy per night. Reservations may also be made on-line at: *http://www.starwoodmeeting.com/Book/2009 NurseLeaders*.

The IHS Clinical Support Center is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. For more information, please contact LCDR Lisa Palucci, MSN, RN, Nurse Educator/Lead Nurse Planner, IHS Clinical Support Center, Office of Continuing Education, at *lisa.palucci@ihs.gov*, or (602) 364-7740. You can also visit the NNLC website for additional information at *http://www.ihs.gov/MedicalPrograms/nnlc/nnlc_conferences.asp.*

Indian Health Summit

July 7 - 9, 2009; Denver, Colorado

The Indian Health Summit is scheduled for July 7 - 9, 2009 in Denver, Colorado. The Health Summit will be a national gathering of Indian health professionals and administrative leadership, community health advocates, and tribal leadership. Tribal partners include the National Indian Health Board and the National Council of Urban Indian Health, Direct Service Tribes and the Tribal Self-Governance Advisory Committee. The theme for the Health Summit is *Celebrating the Tapestry of Health and Wellness: Sharing wisdom and showcasing innovation in Indian Health*.

The Health Summit will be patterned after the Institute for Healthcare Improvement (IHI) Forums to include a variety of mini sessions or learning labs (2.5 hour skill building sessions) as well as plenary and abstracted sessions that focus on the care model, the improvement model, and health care system transformation. Sessions will focus on the Director's Health Initiatives, the Special Diabetes Program for Indians, public health and partnerships, urban health issues, traditional medicine, tribal leadership, injury prevention, trauma care, telehealth, and many other topics. There will be story board and networking sessions as well as social events such as an Indian comedy duo and Indian dance troupe.

Please make your hotel room reservations at the Hyatt

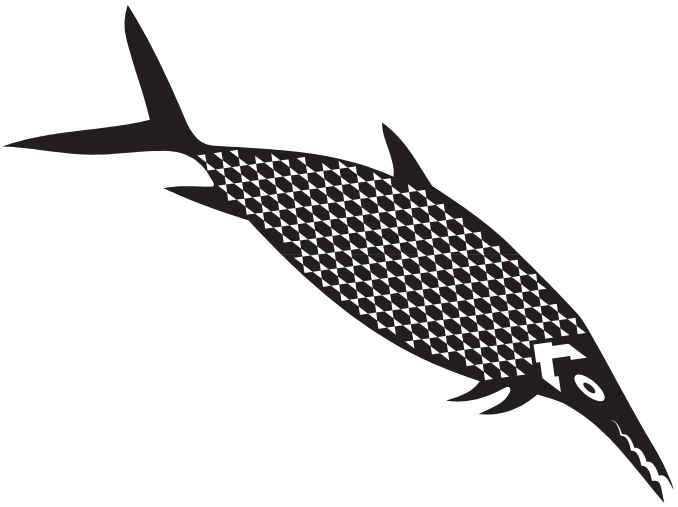
Regency Denver Convention Center, 650 15th Street, Denver, Colorado 80202 (*www.denverregency.hyatt.com*). Reservations can also be made by calling the hotel directly at (303) 436-1234 or (800) 633-7313. Online reservations can be made at *http://denverregency.hyatt.com/groupbooking/denccindi2009*. For online registration and the most current conference agenda and information, please visit the conference website at *http://conferences.thehillgroup.com/healthsummit/index.html*.

For more information, contact CAPT Candace Jones at (505) 248-4961; e-mail *Candace.jones@ihs.gov* or Kimi DeLeon at the Hill Group at (301) 897-2789 x 132; e-mail *kdeleon@thehillgroup.com*.

August 2009 Clinical Update on Substance Abuse and Dependency (Formerly known as the Primary Care Provider Training on Chemical Dependency)

August 25 - 27, 2009; Bemidji, Minnesota

This three day intensive workshop includes both didactic and experiential training. The curriculum is updated annually with the most current nursing, addiction medicine, and prevention information. This training is available to Indian health providers (physicians, physician assistants, nurses, and advanced practice nurses). Enrollment is limited to 30 providers (preferably 2 - 3 person teams from the same facility representing the various disciplines targeted). The conference site is the Hampton Inn & Suites, 1019 Paul Bunyan Drive S, Bemidji, Minnesota 56601; telephone (218) 751-3600. For more information or to register, contact Cheryl Begay at (602) 364-7777 or e-mail *cheryl.begay@ihs.gov*. To register on-line, go to the CSC website at *http://www.csc.ihs.gov*.



Why is My Mailed Issue Late? What Can I do About It?

Due to delayed payments to some vendors that have occurred with the transition to the UFMS system, there have been problems with distribution of the mailed issues of *The Provider*. We are attempting to resolve these. Until we have this under control, readers are encouraged to take advantage of the opportunity to sign up for the listserv that gives notification as soon as the electronic version is posted on our website – usually in the middle of the month. Issues may be read in their entirety as soon as they are posted, and so no time-sensitive information will be missed. To join the listserv, go to *http://www.ihs.gov/PublicInfo/Publications/HealthProvider/provform.asp* and subscribe.

Electronic Subscription Available

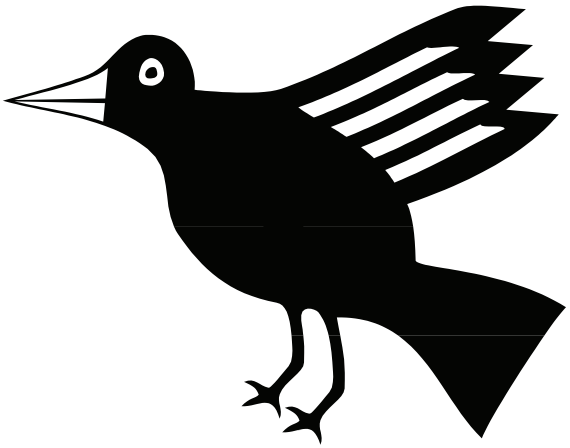
You can subscribe to *The Provider* electronically. Any reader can now request that he or she be notified by e-mail when the latest issue of *The Provider* is available at the Clinical Support Center website (*http://www.ihs.gov/MedicalPrograms/ClinicalSupportCenter/*). To start your electronic subscription, simply go to The Provider website (*http://www.ihs.gov/publicinfo/publications/healthprovider/provider.asp*) and complete the subscription form. This address can easily be reached from the Clinical Support Center website by clicking the "Publications" link and then clicking the "How To Subscribe" link. You are encouraged to try downloading the current issue to see how well this works at your site.

If you also want to discontinue your hard copy subscription of the newsletter, please contact us by e-mail at *the.provider@ihs.gov*. Your name will be flagged telling us not to send a hard copy to you. Since the same list is often used to send other vital information to you, you will not be dropped from our mailing list. You may reactivate your hard copy subscription at any time.

Sources of Needs Assessment Data That Can Be Used to Plan CE Activities

The new focus in planning continuing education activities is the identification of gaps in provider knowledge, competence, or performance that can be addressed with your activity. Ideally, these gaps should apply specifically to the American Indian and Alaska Native population and the providers who serve them. Where can you obtain data that help you identify these gaps? From time to time, we will publish items that either give you such data or show you where you can find them. When you are asked about the sources of your needs assessment data in your CE planning process, it will be easy enough to refer to these specific resources.

The article by LCDR Wohr on page 115 offers not only data to support the need for continuing professional education about smoking cessation, it also gives you resources with which to conduct such activities.



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.

Internal Medicine/Hospitalist
Phoenix Indian Medical Center; Phoenix, Arizona

The Internal Medicine department is recruiting for a hospitalist, BC/BE in either Internal Medicine or Family Medicine, at the Phoenix Indian Medical Center; position available now. PIMC is one of the largest sites in the IHS, with over 150 multi-specialty physicians. Our five-member hospitalist group provides both general medical and intermediate level care for approximately 40 hospitalized patients. Very reasonable schedule with 40 - 45 hour weeks. Electronic Health Record is being implemented. This position would be open to either a civil service or Commissioned Corps physician. The Phoenix metropolitan area offers a variety of cultural, sports, educational, and family-oriented opportunities.

For more information, please contact/send CV to Amy Light MD, Chief of Medicine, Phoenix Indian Medical Center, 4212 North 16th Street, Phoenix, Arizona 85016. Telephone (602) 263-1537; fax (602) 263-1593 or e-mail *amy.light@ihs.gov*. (4/09)

Psychiatrist
White Earth Health Center; White Earth, Minnesota

The White Earth Health Center is currently recruiting a psychiatrist to provide psychiatric assessment for diagnosis of mental health disorders for children, adolescents, and adults and provide medication management services to children, adolescents, and adults, in an outpatient setting. The White Earth Health Center is located in central Minnesota. Enjoy four seasons filled with plenty of lakes for fishing, swimming, canoeing, skiing, skating; area fitness centers; shopping, hunting, snowmobiling, four-wheeling, clear skies, golf courses, horse trail rides.

The ideal candidate for this position will be an outgoing, energetic team player who is compassionate and focused on patient care. This individual will be working in a beautiful, modern facility. For the right candidate, we offer a competitive salary, excellent benefits, and an opportunity for loan repayment. Please contact Darryl Zitzow, PhD, LP, Director, Mental Health Department, telephone (218) 983-6325; fax (218) 983-6336); or e-mail *darryl.zitzow@ihs.gov* for further information. The mailing address is White Earth Health Center, 40520 County Highway 34, Ogema, Minnesota 56569. (4/09)

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

The Sells Service Unit (SSU) in southern Arizona is recruiting for board certified/board eligible family medicine, internal medicine, and emergency medicine physicians to join our experienced medical staff. The SSU 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 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 in a setting of natural splendor.

We offer competitive salary, relocation/recruitment/retention allowance, federal employment benefits package, CME leave and allowance, and loan repayment. Commuter van pool from Tucson is available for a monthly fee. For more information, please contact Peter Ziegler, MD, SSU Clinical Director at (520) 383-7211 or by e-mail at *Peter.Ziegler@ihs.gov*. (3/09)

Family Nurse Practitioners
San Simon Health Center, Sells Service Unit; Sells, Arizona

The Sells Service Unit (SSU) in southern Arizona is recruiting for a family nurse practitioner to provide ambulatory care in the recently opened San Simon Health Center and another family or pediatric nurse practitioner to provide ambulatory care in our school health program. The SSU 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 and three health centers: San Xavier Health Center, located in Tucson, the Santa Rosa Health Center, located in Santa Rosa, and the San Simon Health Center located in San Simon, 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.

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Family Physician
Staff Dentist
Consolidated Tribal Health Project, Inc.; Calpella, California

The Native American Health Center in northern California wine country is seeking a doctor and a dentist to join our dedicated team. For twenty five years, Consolidated Tribal Health Project, Inc. has been providing health, dental, behavioral health, and community outreach services to the eight consortium tribes of Mendocino County.

We are seeking two providers:

- Family Practice Physician, BC/BE, to provide direct patient care (90%) and administration (10%)
- Staff Dentist to provide comprehensive, public health oriented dental services and all general clinic services

Candidates must currently hold a California license. Qualified applicants, please fax resume, cover letter, and salary requirements to Human Resources at (707) 485-7837. For the right candidate, we offer a competitive salary, excellent benefits, and an opportunity for loan repayment. Native American preference in hiring; all qualified applicants will be considered. For more information, please contact Annie Kavanagh at (707) 467-5685, or by e-mail at *akavanagh@cthp.org*. (2/09)

Family Practice Physician
Nurse Practitioner
Pawhuska IHS Health Center; Pawhuska, Oklahoma

The Pawhuska IHS Health Center has openings for a family practice physician and a nurse practitioner. Our facility is a JCAHO accredited, multidisciplinary outpatient clinic with medical, dental, optometry, behavioral health, an on-site lab, and pharmacy. Our medical staff enjoy regular work hours with no night or weekend call.

Pawhuska is located 55 miles from Tulsa, Oklahoma. It is home to the Osage Nation, with a rich heritage of tribal culture, oil money, and even cowboys. So if you have a passion for small town life on the plains, you may want to check us out.

Interested parties can contact Wehnona Stabler, 715 Grandview, Pawhuska, Oklahoma 74056; telephone (918) 287-4491; or e-mail to *wehnona.stabler@ihs.gov*. (2/09)

Family Practice Physician
Gallup Indian Medical Center; Gallup, New Mexico

The Gallup Indian Medical Center has an immediate opening for a family medicine physician. GIMC is one of the largest Indian Health Service sites. The IHS has great benefits packages for both Civil Service and Commissioned Corps providers. We are an NHSC scholarship and an IHS Loan Repayment site as well. The Department of Family Medicine offers the opportunity for full spectrum family medicine care. There are currently nine physicians, two physician assistants, and one pharmacist clinician in the department. Chronic disease management and prevention are the focus for continued development and expansion of this department and program. The hospital has a multi-specialty group, and family medicine physicians have inpatient privileges at GIMC as well as at the community hospital, Rehoboth McKinley Christian Hospital.

Please contact Dr. Alma Alford, Chief of Family Medicine, if you are interested in pursuing an opportunity here. The address is Gallup Indian Medical Center, 516 E. Nizhoni Blvd., P.O. Box 1337, Gallup, New Mexico 87301-1337; telephone (505) 722-1000; fax (505) 726-8740; office number (505) 722-1280 or 722-1775; e-mail *alma.alford@ihs.gov*. (1/09)

Physicians
Belcourt Comprehensive Health Care Facility; Belcourt, North Dakota

The Belcourt Comprehensive Health Care Facility is seeking experienced pediatric, emergency medicine, obstetrics and gynecology, family practice and psychiatry professionals. Belcourt is located in Rolette County in the north-central part of the state near the Canadian border in rural North Dakota. The Turtle Mountain Reservation has approximately 26,000 enrolled tribal members of the Turtle Mountain Band of Chippewa. The area consists of low rolling hills and a wide variety of trees. About 40% of the land is covered with small ponds and lakes for those who love fishing, boating, and water skiing and, in the winter, snowmobiling, ice fishing, as well as downhill skiing. We are a 27-bed facility with a busy clinic and a 24-hour emergency room, as well as the following services: Family Practice, OB/GYN, Emergency Medicine, General Surgery, Behavioral Health, Mid-Level Services, Dentistry, Pharmacy, Optometry, Physical Therapy, and Nursing.

For more information, contact Kimberlin K. Lawrence, Recruitment Specialist, Aberdeen Area Indian Health Service, Office of Professional Service, 115 4th Ave. SE, Aberdeen, South Dakota; telephone (605) 226-7532; fax (605) 226-7321; e-mail *kim.lawrence@ihs.gov*. (1/09)

Physicians
Eagle Butte IHS Hospital, Eagle Butte, South Dakota

The Eagle Butte IHS Hospital is seeking experienced emergency medicine and family practice professionals. Eagle Butte is located in Dewey County in rural western South Dakota. The Cheyenne River Reservation has about 15,000 enrolled tribal members of the Cheyenne River Sioux Tribe. The mighty Missouri River borders its eastern edge, the rugged Cheyenne forms its southern border, and the Moreau River flows through the heart of the reservation. This land of sprawling prairies and abundant waters is home to the Cheyenne River Sioux Tribe. Hunting opportunities on the Cheyenne River Reservation include elk, whitetail deer, mule deer, pronghorn antelope, duck, goose, turkey, rabbit, and prairie dog. Anglers can catch trout, walleye, salmon, large and smallmouth bass, white bass, northern pike, and catfish. The stark, solitary beauty of the prairie will amaze visitors. In some places, you can drive for miles with only nature and wildlife as company. We are a 13 bed facility with a busy clinic and a 24-hour emergency room, as well as the following services: Family Practice, Emergency Medicine, Mid-Level Services, Dentistry, Pharmacy, Optometry, and Nursing.

For more information, contact Kimberlin K. Lawrence, Recruitment Specialist, Aberdeen Area Indian Health Service, Office of Professional Service, 115 4th Ave. SE, Aberdeen, South Dakota; telephone (605) 226-7532; fax (605) 226-7321; e-mail *kim.lawrence@ihs.gov*. (1/09)

Medical Director
Physician
Mid-Level Provider
Nimiipuu Health; Lapwai, Idaho

Caring people making a difference. Nimiipuu Health is an agency of the Nez Perce Tribe, with ambulatory health care facilities in Lapwai and Kamiah located in beautiful northern Idaho near the confluence of the Snake and Clearwater Rivers, an area rich in history, natural beauty, and amiable communities. We provide excellent benefits and opportunity for personal and professional growth. Nimiipuu Health's caring team is looking for individuals making a difference in the health care field and is now accepting applications for three positions.

Medical Director (Salary/DOE/Full-Time/Lapwai). MD or DO with current certification in family practice or internal medicine. Must have completed an internship, be board certified, with at least five years of clinical experience. Must be licensed to practice medicine in Idaho, or obtain state of Idaho license within one year of appointment. Must have BLS and ACLS certification. Knowledge of history, culture, and health needs of Native American communities preferred. Must maintain current license and certification, have a valid driver's license with insurable record, and will be required to pass extensive background. Closes 1/09/09. Tribal preference applies.

Physician (Salary/DOE/Full-Time/Lapwai). Idaho licensed MD or DO, prefer board certified in family practice or internal medicine. Incumbent can obtain Idaho license within one year of appointment. Must have DEA number or obtain within three months of appointment. Knowledge of history, culture, and health needs of Native American communities preferred. Must maintain appropriate board certification, have a valid driver's license with insurable record, and will be required to pass extensive background. Closes 1/09/09. Tribal preference applies.

Mid-Level Provider (Salary/DOE/Full-Time/Lapwai). Idaho licensed FNP or PA. Incumbent can obtain Idaho license within one year of appointment. Must have BLS and obtain ACLS within six months of appointment. Knowledge of history, culture, and health needs of Native American communities preferred. Must have valid driver's license with insurable record and will be required to pass extensive background check. Closes 1/09/09. Tribal preference applies.

A complete application packet for these positions includes NMPH job application, copy of current credentials, two reference letters, resume or CV, a copy of your tribal ID or Certification of Indian Blood (CIB), if applicable. Send to Nimiipuu Health, Attn: Human Resources, PO Drawer 367, Lapwai, ID 83540. For more information call (208) 843-2271 or e-mail *carmb@nimiipuu.org*. For more information about our community and area please go to *www.nezperce.org* or *www.zipskinny.com*.

Pharmacist
Juneau, Alaska

The Southeast Alaska Regional Health Consortium has an opening for a staff pharmacist at our Joint Commission accredited ambulatory care facility located in Juneau. Pharmacists interact with medical and nursing staff to achieve positive patient outcomes and are active members of the health-care team. Prescriptions are filled using Scriptpro Robotic Systems. Responsibilities include drug selection, compounding, and dispensing, as well as P&T and other committee participation, formulary management, drug information, education, and mentoring. We also provide pharmacist managed anticoagulation monitoring services.

Experience living in beautiful southeast Alaska. Juneau is located in Alaska's panhandle on a channel of salt water 70 air miles from the open ocean. Juneau is Alaska's capital and the third largest city in Alaska (30,000 people). Vast areas of recreational wilderness and opportunity surround us. Juneau and much of southeast Alaska are located within the Tongass National forest, the largest expanse of temperate rainforest in the world.

The Southeast Alaska Regional Health Consortium is a nonprofit health corporation established in 1975 by the Board of Directors, comprised of tribal members of 18 Native communities in the southeast region, to serve the Alaska Native and Native American people of southeast Alaska. Our clinic is committed to providing high quality health services in partnership with Native people.

Successful candidates should be self motivated and committed to providing excellent patient care. This is a Commissioned Officer 04 billet or a direct hire with a competitive salary and a generous benefit package. For more information please go to *https://searhc.org/common/pages/hr/nativehire/index.php* or contact the SEARHC Human Resources office by telephone at (907) 364-4415; fax (907) 463-6605.

Applications and additional information about this vacancy are available on-line at *www.searhc.org*, or you may contact Teresa Bruce, Pharmacy Director at (907) 463-4004; or e-mail *teresa.bruce@searhc.org*.

Family Practice Physician
Pediatrician (Outpatient and Hospitalist)
Obstetrician/Gynecologist
Anchorage, Alaska

Multidisciplinary teams with physicians, master's level therapists, RN case managers, nurse practitioners and physician assistants. Integrated into the system: family medicine, behavioral health, pediatrics, obstetrics and gynecology, health educators, nutritionists, social workers, midwives, pharmacists, home health, and easy access to specialists. This integrated model also includes complementary health and traditional Native healing. Eligibility verification, insurance, and billing are handled by administrative staff.

Amazing benefits including 4 to 6 weeks of vacation, one week of paid CME time, plus 12 paid holidays. CME funding; excellent insurance coverage – malpractice, health, life, short and long term disability – and subsidized health insurance for family. Employer 401K with matching contribution to retirement, fees paid for medical license, registration, etc.

New, modern state of the art facilities. Innovative practice system featured on front page of New York Times, JAMA, etc. Clinical quality improvement team. Practice management data monthly.

We currently employ 25 family physicians, 16 pediatricians, 10 obstetrician/gynecologists, and 6 psychiatrists, and we are adding additional positions.

Anchorage is a city of 330,000, the largest city in Alaska. Lots of cultural activities including a performing arts center that hosts national and regional troops, the Anchorage Museum of Natural History, and the Alaska Native Heritage Center. Alaska is known as the land of the midnight sun, as we bask in 19.5 hours of daylight on summer solstice. Our summer temperatures reach into the upper 70s, and the landscape transforms into green trees and flower blossoms. On winter solstice, we enjoy beautiful sunrises and sunsets over snowcapped mountains, and darkness brings the possibility of breathtaking displays of the northern lights. Hundreds of kilometers of groomed, interconnected cross country ski trails in town are lit at night by artificial light and the incredible moonlight reflecting off of the snow; these trails are perfect for running and biking in the summer. There are good public schools, good community, and incredible outdoor activity opportunities.

For more specific specialty information please contact Larisa Lucca, Physician Recruiter, Southcentral Foundation; telephone (888) 700-6966 ext. 1 or (907) 729-4999; fax (907) 729-4978; e-mail *llucca@scf.cc*.

Family Nurse Practitioner/Physician Assistant
Family Practice Physician
PharmD
Wind River Service Unit, Wyoming

The Wind River Service Unit has an immediate opening for a family nurse practitioner/physician assistant and a pharmacist (PharmD), as well as a fall 2009 opening for a family practice physician to provide care across the life span and to manage panel of patients from the Shoshone and Arapahoe Tribes on the Wind River Reservation. Located in the central part of pristine Wyoming, climbing, hiking, hunting, fishing, and water sports are minutes away. Out patient care is provided at two sites, one located in Arapahoe and one located in Ft. Washakie. Dedicated, dynamic staff includes ten RNs, six family physicians, one pediatrician, four family nurse practitioners, psychologists, social workers, four dentists, a certified diabetic educator, a diabetes educator, a

health educator, five public health nurses, three PharmDs, two pharmacists, and two optometrists. Specialty clinics include orthopedics, podiatry, nephrology, obstetrics, and audiology. An open access model is used. Inpatient care is provided by the physicians at an excellent 83-bed community hospital in nearby Lander, with a fully staffed inpatient psychiatric hospital and rehabilitation unit.

For more information, contact Marilyn Scott at (307) 335-5963 (voice mail), or by e-mail at *marilyn.scott@ihs.gov*.

Tribal Data Coordinator (Level II)
The United South & Eastern Tribes, Inc. (USET)

United South and Eastern Tribes, Inc. is a non-profit, inter-tribal organization that collectively represents its member tribes at the regional and national level. USET has grown to include twenty-five federally recognized tribes in the southern and eastern parts of the United States from northern Maine to Florida and as far west as east Texas. USET is dedicated to promoting Indian leadership, improving the quality of life for American Indians, and protecting Indian rights and natural resources on tribal lands. Although its guiding principle is unity, USET plays a major role in the self-determination of all its member tribes by working to improve the capabilities of tribal governments.

We are recruiting to fill the Tribal Data Coordinator (Level II) position vacancy in the tribal health program support department. Qualifications for this vacancy require a minimum of an Associate Degree in a related discipline (e.g., computer science, statistics, math, biological sciences, education) from an accredited college or university, with relevant job experience. Documented three years experience in a paid position related to the use of health systems in the collection and analysis of health data will be considered in lieu of a degree. The Tribal Data Coordinator position also requires at least two years of RPMS experience as a user.

So if you have at least two years of RPMS experience, this could be a great opportunity for you. The Tribal Data Coordinator provides RPMS software training to USET member tribes. He/she also works on data quality improvement initiatives and provides data collection and analysis.

We offer flexible schedules and a competitive salary and benefit package. Hiring preference will be given to American Indians/Alaska Natives. If you are interested, you can get additional information about USET and the job announcement at our web site, *www.usetinc.org*, or you can contact Tammy Neptune at (615) 872-7900 or e-mail *tneptune@USETInc.org*.

Certified Diabetes Educator
Dietitian
Pediatrician
Chief Medical Officer
Family Practice Physician
Nurse
Medical Technologist
Chief Redstone Health Clinic, Fort Peck Service Unit; Wolf Point, Montana

Fort Peck Service Unit in Wolf Point, Montana is looking for family practice physicians to work at the Chief Redstone Indian Health Service clinic. This unique opportunity allows physicians to care for individuals and families, including newborns, their parents, grandparents, and extended family. Applicants must be culturally conscious and work well within a team environment. The Fort Peck Service Unit is located in the north east corner of Montana along the Missouri river. Fort Peck Service Unit has two primary care clinics, one in the town of Poplar and one in the town of Wolf Point.

Our Medical Staff is composed of five family practice physicians, two internal medicine physicians, one pediatrician, one podiatrist, and four family nurse practitioners/physician assistants. We have a full complement of support services, which include dental, optometry, audiology, psychology, social work, radiology, lab, public health nursing, and very active Diabetes Department. These are ambulatory clinics; however, our providers have privileges in the local community hospital. We have approximately 80,000 patient contacts per year. We work very closely with the private sector. IHS and the private hospital have a cardiac rehabilitation center. By cooperating with IHS, the hospital has been able to get a CT scanner and a mammography unit. The Tribal Health Program has a dialysis unit attached to the Poplar IHS clinic. Customer service is our priority. The IHS has excellent benefits for Civil Service and Commissioned Corps employees. There are loan repayment options, and we are a designated NHSC site. We strive to provide quality care through a strong multidisciplinary team approach; we believe in being closely involved in our population to encourage a healthier community.

There are many opportunities for recreation, as we are a short distance from the Fort Peck Dam and Reservoir. For more information about our area and community please go the website at *http://www.ihs.gov/FacilitiesServices/AreaOffices/Billings/FtPeck/index.asp*. Fort Peck Tribes also can be found on *www.fortpecktribes.org*, and the Fort Peck Community College on www.fpcc.edu. North east Montana offers many amenities one might not expect this far off the beaten path. If you are interested please contact our provider recruiter, CDR Karen Kajiwara-Nelson, MS, CCC-A at (406) 768-3491 or by e-mail at *karen.kajiwara@ihs.gov*. Alternately, you can contact the Billings Area Physician Recruiter, Audrey Jones, at (406) 247-7126 or by e-mail at *audrey.jones@ihs.gov*. We look forward to communicating with you.

Family Practice Physician
Pharmacists
PHS Indian Hospital, Harlem, Montana

The Fort Belknap Service Unit is seeking family practice physicians and pharmacist to join their dedicated staff. The service unit is home to a critical access hospital (CAH) with six inpatient beds, two observation beds, and a 24-hour emergency room, as well as an 8 AM to 5 PM outpatient clinic. The service unit also operates another outpatient clinic 35 miles south of Fort Belknap Agency in Hays. The Fort Belknap CAH outpatient visits average 39,000 per year. The new clinic in Hays, the Eagle Child Health Center, can adequately serve 13,000 per year. The medical staff includes four family practice positions, two physician assistants, and one nurse practitioner, and has implemented the Electronic Health Record in the outpatient clinic. The service unit also has a full-time staffed emergency medical services program. The staff is complemented by contract locum tenens physicians for weekend emergency room coverage.

The medical staff is supported by and works with a staff of nurses, behavior health personnel, physical therapist, lab and x-ray personnel, pharmacists, dentists, administrators, housekeepers, supply specialists, and contract practitioners to provide the best possible care to patients. The staff works as team to make a difference. Contract (private) hospitals are from 45 to 210 miles from the facility.

There are loan repayment options, excellent benefits, and we are a designated NHSC site. The area is primarily rural, and a friendly small-town atmosphere prevails here. The reservation communities promote various local activities such as rodeos, church socials, and basketball. The tribe also manages its own buffalo herd. Bigger events fill in the calendar as well, such as the Milk River Indian Days, Hays Powwow, and the Chief Joseph Memorial Days, featuring cultural activities and traditional dancing. The Fort Belknap Tribe has hunting and fishing available both on and off the reservation. The Little Rocky Mountains and the Missouri River provides scenic and enjoyable areas for the outdoor-minded. If you are interested in joining our medical team, contact Dr. Dennis Callendar at *Dennis.callendar@ihs.gov* or telephone (406) 353-3195; or contact physician recruiter Audrey Jones, at *Audrey.jones@ihs.gov*; telephone (406) 247-7126.

Family Practice Physician
Emergency Medicine Physician
Nurse Anesthetist
Nurse
PHS Indian Hospital; Browning, Montana

The Blackfeet Service Unit is recruiting for health practitioners who want to join the staff at the PHS Indian Hospital in Browning, Montana. The Blackfeet Service Unit is home to the Blackfeet Community Hospital, a 27-bed hospital, active outpatient clinic, and well-equipped emergency department. Inpatient care includes obstetrics and elective general surgery. We also offer community health nursing, have an active diabetes program, and offer optometry, laboratory, dental, and ENT services along with behavioral and social services and women's health. We are seeking candidates who are committed to improving the health of the local community and being part of a team approach to medicine. The hospital is located 13 miles from Glacier National Park. This area offer spectacular mountains and incredible outdoor activities year round. There are loan repayment options, excellent benefits, and we are a designated NHSC site. If you are interested in joining our team, contact Mr. Timothy Davis at *timothy.davis@ihs.gov* or telephone (406) 338-6365; or contact physician recruiter Audrey Jones, at *Audrey.jones@ihs.gov* or telephone (406) 247-7126. We look forward to hearing from interested candidates.

Family Practice Physician
Nurse Practitioner/Physician Assistant
ER Nurse Specialist
Northern Cheyenne Service Unit; Lame Deer, Montana

The Northern Cheyenne Service Unit is seeking health practitioners to come work with their dedicated staff on the Northern Cheyenne Indian Reservation. The Northern Cheyenne Service Unit consists of a modern outpatient clinic with family practice physicians, a pediatrician and an internist in Lame Deer, Montana. The well-equipped emergency room provides medical services to a high volume of trauma patients. The nearest medical back-up services are located in Billings, Montana and Sheridan, Wyoming. The medical staff enjoys close cooperation with the tribe. The positive interactions with this tight knit people result in high morale and overall retention of its medical staff.

Though more isolated than other service units, the reservation is within close range of three larger towns: Forsyth, Colstrip, and Hardin, all which provide shopping and other services for residents. The rugged hills and pine woods of the reservation provide plenty of outdoor recreation. Other interesting features are the Tongue River Reservoir, the St. Labre Indian School in Ashland, and the Dull Knife College fun.

For additional information, please contact Audrey Jones, Physician Recruiter at *Audrey.jones@ihs.gov*; telephone (406) 247-7126 or Beverly Stiller at *beverly.stiller@ihs.gov*; telephone (406) 477-4402.

Internal Medicine, Family Practice, and ER Physicians
Pharmacists
Dentists
Medical Technologists
ER, OR, OB Nurses
Crow Service Unit; Crow Agency, Montana

The Crow Service Unit is seeking health practitioners to come work with their dedicated staff on the Crow Indian

Reservation. The Crow Service Unit consists of a small 24-bed hospital located in Crow Agency and two satellite clinics, Lodge Grass Health Center, located approximately 20 miles south of Crow Agency, and Pryor Health Station, located about 70 miles northwest of Crow Agency.

The hospital is a multidisciplinary facility that includes inpatient, outpatient, urgent care, emergency room, dental, behavioral health, substance abuse, public health nursing, physical therapy, pharmacy, dietary, obstetrics, surgery, and optometry services. Our medical staff includes nine family practice positions, two ER physician positions, one general surgeon, two obstetrician/gynecologists, one podiatrist, one internist/pediatrician, one pediatrician, one radiologist, one nurse midwife, and six mid-level provider positions (NP or PA). Family practice physicians and the internist share the hospitalist responsibilities, and each primary care physician shares the daytime ER call duties. The staff is complemented by contract *locum tenens* physicians for nighttime, weekend, and holiday coverage. OB call is shared between the obstetrician/gynecologists, the midwife and the FP physicians. The two outlying clinics in Lodge Grass and Pryor are primarily staffed by midlevel providers.

The Crow Tribe is a close, proud people. They maintain their own buffalo herd and proudly display their cultural heritage during events such as the well-known Crow Fair. Other points of cultural interest in the "Tipi Capital of the World" are The Little Big Horn Battlefield National Monument, Chief Plenty Coup State Park, and the Little Big Horn College.

For those who enjoy the outdoors, Red Lodge Mountain Resort offers great skiing. The Big Horn Canyon National Recreation Area offers great fishing, camping, and boating fun. The area offers spectacular mountains and mountain activities, and world class hunting and fishing. Billings, Montana, a city of 100,000, is less than an hour away.

For additional information, please contact Audrey Jones, Physician Recruiter, at *Audrey.jones@ihs.gov*; telephone (406) 247-7126; or Dr. Michael Wilcox at *Michael.wilcox@ihs.gov*; telephone (406) 638-3309.

Obstetrician/Gynecologists
W. W. Hastings Hospital; Tahlequah, Oklahoma

W. W. Hastings Hospital is looking for two obstetrician/gynecologist physicians to come to work in one of America's friendliest small towns. The successful candidate would be joining a group of six obstetrician/gynecologist physicians and seven certified nurse midwives. Call is approximately 1:5 with an excellent CNM staff providing primary in-house coverage. Post call days are schedule time off with no clinic patient responsibilities.

W. W. Hastings hospital is located in Tahlequah, Oklahoma, within commuting distance of Tulsa. It is the home of the Cherokee Nation and is primarily responsible for providing care to tribal members of the Cherokee Nation as well as other federally recognized tribes.

Interested candidates can call (918) 458-3347 for more information or fax a CV to Dr. Gregg Woitte at (918) 458-3315; e-mail *greggory.woitte@ihs.gov*.

Nurse Specialist - Diabetes
Whiteriver Service Unit; Whiteriver, Arizona

The Nurse Specialist (Diabetes) is to establish, develop, coordinate, monitor, and evaluate the clinical diabetic education program. The incumbent is responsible for establishing, providing, facilitating, promoting, and evaluating a comprehensive education program for patients with diabetes, as well as prevention of and education about diabetes. Candidate must provide proof that they have Certified Diabetes Educator (CDE) certification and certification from the National Certification Board for Diabetes Educators.

The Whiteriver Service Unit is located on the White Mountain Apache Indian Reservation. The hospital is a multidisciplinary facility that includes emergency room, urgent care, inpatient, outpatient, dental, social services, physical therapy, optometry, obstetrics, podiatry, dietary, ambulatory surgery, and public health nursing. We are just a short distance from Sunrise Ski Resort which offers great snow skiing. We are surrounded by tall ponderosa pine trees and beautiful mountains where you can experience the four seasons, and great outdoor activities such as mountain biking, hiking, hunting, fishing, camping, and boating. We are just three hours northeast of the Phoenix metropolitan area.

For additional information, please contact CAPT Steve Williams, Director of Diabetes Self-Management, by e-mail at *stevenj.williams@ihs.gov*; telephone (928) 338-3707.

Other RN vacancy positions include Family Care Unit, Birthing Center, Outpatient, Emergency Room, and Ambulatory Surgery. Please contact Human Resources at (928) 338-3545 for more information.

Physicians
Emergency Medicine PA-Cs
Family Practice PA-Cs/ Family Nurse Practitioners
Rosebud Comprehensive Health Care Facility; Rosebud, South Dakota

The Rosebud Comprehensive Health Care Facility in Rosebud, South Dakota is seeking board eligible/board certified family practice physicians, pediatricians, emergency medicine physicians, an internist, and an ob/gyn with at least five years post-residency experience. We are also in need of ER PA-Cs, family practice PA-Cs, and family nurse practitioners. Rosebud is located in rural south central South Dakota west of the Missouri River on the Rosebud Indian Reservation and is approximately 30 miles from the Nebraska boarder. We are a 35 bed facility that has a 24 hour emergency department, and a busy clinic that offers the following services: family practice, internal medicine, ob/gyn, pediatrics, general surgery, oral surgery, optometry, dentistry, physical therapy,

dietary counseling, and behavioral health. Our staff is devoted to providing quality patient care and we have several medical staff members that have been employed here ten or more years.

The beautiful Black Hills, Badlands, Custer State Park, Mount Rushmore, and Crazy Horse Memorial are just 2- 3 hours away. South Dakota is an outdoorsman's paradise with plenty of sites for skiing, hiking, hunting, fishing, boating, and horseback riding. Steeped in western folklore, Lakota culture, history, and land of such famous movies as "Dances with Wolves" and "Into the West" there is plenty for the history buff to explore. If you are interested in applying for a position, please contact Dr. Valerie Parker, Clinical Director, at (605) 660-1801 or e-mail her at *valerie.parker@ihs.gov*.

Physician/Medical Director
Physician Assistant or Family Nurse Practitioner
Dentist
Dental Hygienist
SVT Health Center; Homer, Alaska

SVT Health Center has immediate openings for a medical director (MD, DO; OB preferred), family nurse practitioner or physician assistant, dentist, and dental hygienist (21 - 28 hours per week). The ideal candidate for each position will be an outgoing, energetic team player who is compassionate and focused on patient care. The individual will be working in a modern, progressive health center and enjoy a wide variety of patients.

The Health Center is located in southcentral Alaska on scenic Kachemak Bay. There are many outdoor activities available including clam digging, hiking, world-class fishing, kayaking, camping, and boating. The community is an easy 4 hour drive south of Anchorage, at the tip of the Kenai Peninsula.

SVTHC offers competitive salary and a generous benefit package. Candidates may submit an application or resume to Beckie Noble, SVT Health Center, 880 East End Road,, Homer, Alaska 99603; telephone (907) 226-2228; fax (907) 226-2230.

Family Practice Physician
Physician Assistant/Nurse Practitioner
Fort Hall IHS Clinic; Fort Hall, Idaho

The Fort Hall IHS Clinic has openings for a family practice physician and a physician assistant or nurse practitioner. Our facility is an AAAHC-accredited multidisciplinary outpatient clinic with medical, dental, optometry, and mental health services, and an on-site lab and pharmacy. Our medical staff includes five family practice providers who enjoy regular work hours with no night or weekend call. We fully utilize the IHS Electronic Health Record and work in provider-nurse teams with panels of patients.

Fort Hall is located 150 miles north of Salt Lake City and 10 miles north of Pocatello, Idaho, a city of 75,000 that is home to Idaho State University. The clinic is very accessible, as it is only one mile from the Fort Hall exit off of I-15. Recreational activities abound nearby, and Yellowstone National Park, the Tetons, and several world class ski resorts are within 2½ hours driving distance.

Please contact our clinical director, Chris Nield, for more information at *christopher.nield@ihs.gov*; telephone (208)238-5455).

Family Physician/Medical Director
The Native American Community Health Center, Inc.; Phoenix, Arizona

The Native American Community Health Center, Inc. (Native Health), centrally located in the heart of Phoenix, Arizona, is currently seeking a skilled and energetic family physician/medical director who would enjoy the opportunity of working with diverse cultures. The family physician/medical director is a key element in providing quality, culturally competent health care services to patients of varied backgrounds and ages within a unique client-focused setting that offers many ancillary services. Native Health offers excellent, competitive benefits and, as an added bonus, an amazing health-based experience within the beautiful culture of Native Americans. Arizona license Preferred. For more information, contact the HR Coordinator, Matilda Duran, by telephone at (602) 279-5262, ext. 3103; or e-mail *mduran@nachci.com*. For more information, check our website at *www.nativehealthphoenix.org*.

Family Medicine Physician
Norton Sound Health Corporation; Nome, Alaska

Practice full spectrum family medicine where others come for vacation: fishing, hunting, hiking, skiing, snowmobiling, dog mushing, and more.

The Gateway to Siberia. The Last Frontier. Nome, Alaska is 150 miles below the Arctic Circle on the coast of the Bering Sea and 120 miles from Russia. It was the home of the 1901 Gold Rush, and still is home to three operating gold dredges, and innumerable amateur miners. There are over 300 miles of roads that lead you through the surrounding country. A drive may take you past large herds of reindeer, moose, bear, fox, otter, and musk ox, or through miles of beautiful tundra and rolling mountains, pristine rivers, lakes, and boiling hot springs.

The Norton Sound Health Corporation is a 638 Alaskan Native run corporation. It provides the health care to the entire region. This encompasses an area about the size of Oregon, and includes 15 surrounding villages. We provide all aspects of family medicine, including deliveries, minor surgery, EGDs, colposcopies, colonoscopies, and exercise treadmills. Our closest referral center is in Anchorage. Our Medical Staff consists of seven board certified family practice physicians, one certified internist, one certified psychiatrist, and several PAs. This allows a very comfortable lifestyle with ample time

off for family or personal activities.

Starting salary is very competitive, with ample vacation, paid holidays, two weeks and $6,000 for CME activities, and a generous retirement program with full vesting in five years. In addition to the compensation, student loan repayment is available.

The practice of medicine in Nome, Alaska is not for everyone. But if you are looking for a place where you can still make a difference; a place where your kids can play in the tundra or walk down to the river to go fishing; a place where everyone knows everyone else, and enjoys it that way, a place where your work week could include a trip to an ancient Eskimo village, giving advice to health aids over the phone, or flying to Russia to medivacs a patient having a heart attack, then maybe you'll know what we mean when we say, "There is no place like Nome."

If you are interested, please contact David Head, MD, by telephone at (907) 443-3311, or (907) 443-3407; PO Box 966, Nome, Alaska 99762; or e-mail at *head@nshcorp.org*.

Family Practice Physician
Central Valley Indian Health, Inc.; Clovis, California

Central Valley Indian Health, Inc. is recruiting for a BC/BE, full-time physician for our Clovis, California clinic. The physician will be in a family practice setting and provide qualified medical care to the Native American population in the Central Valley. The physician must be willing to treat patients of all ages. The physician will be working with an energetic and experienced staff of nurses and medical assistants. Central Valley Indian Health, Inc. also provides an excellent benefits package that consists of a competitive annual salary; group health insurance/life insurance at no cost; 401k profit sharing and retirement; CME reimbursement and leave; 12 major holidays off; personal leave; loan repayment options; and regular hours Monday through Friday 8 am to 5pm (no on-call hours required). For more information or to send your CV, please contact Julie Ramsey, MPH, 20 N. Dewitt Ave., Clovis, California 93612. Telephone (559) 299-2578, ext. 117; fax (559) 299-0245; e-mail *jramsey@cvih.org*.

Family Practice Physician
Tulalip Tribes Health Clinic; Tulalip, Washington

The Tulalip Tribes Health Clinic in Tulalip, Washington, is seeking two family practice physicians to join our Family Practice Outpatient clinic. We are a six physician outpatient clinic which sits on the edge of Tulalip Bay, 12 miles east of Marysville, Washington. Tulalip is known as an ideal area, situated 30 miles north of Seattle, with all types of shopping facilities located on the reservation. Sound Family Medicine is committed to providing excellent, comprehensive, and compassionate medicine to our patients. The Tulalip Tribes offer an excellent compensation package, group health plan, and retirement benefits. For more information, visit us on the web at *employment.tulaliptribes-nsn.gov/tulalip-positions.asp*. Please e-mail letters of interest and resumes to *wpaisano@tulaliptribes-nsn.gov*.

Family Practice Physician
Seattle Indian Health Board; Seattle, Washington

Live, work, and play in beautiful Seattle, Washington. Our clinic is located just south of downtown Seattle, close to a wide variety of sport and cultural events. Enjoy views of the Olympic Mountains across Puget Sound. The Seattle Indian Health Board is recruiting for a full-time family practice physician to join our team. We are a multiservice community health center for urban Indians. Services include medical, dental, mental health, nutrition, inpatient and outpatient substance abuse treatment, onsite pharmacy and lab, and a wide variety of community education services. Enjoy all the amenities a large urban center has to offer physicians. Our practice consists of four physicians and two mid-level providers. The Seattle Indian Health Board is a clinical site for the Swedish Cherry Hill Family Practice Residency program. Physicians have the opportunity to precept residents in both clinical and didactic activities. The Seattle Indian Health Board is part of a call group at Swedish Cherry Hill (just 5 minutes from the clinic). After hour call is 1 in 10. Program development and leadership opportunities are available.

Seattle is a great family town with good schools and a wide variety of great neighborhoods to live in. Enjoy all the benefits the Puget Sound region has to offer: hiking, boating, biking, camping, skiing, the arts, dining, shopping, and much more! Come join our growing clinic in a fantastic location. The Seattle Indian Health Board offers competitive salaries and benefits. For more information please contact Human Resources at (206) 324-9360, ext. 1105 or 1123; contact Maile Robidoux by e-mail at *mailer@sihb.org*; or visit our website at *www.sihb.org*.

Psychiatrist
Psychiatric Nurse Practitioner
Four Corners Regional Health Center; Red Mesa, Arizona

The Four Corners Regional Health Center, located in Red Mesa, Arizona is currently recruiting a psychiatrist. The health center is a six-bed ambulatory care clinic providing ambulatory and inpatient services to Indian beneficiaries in the Red Mesa area. The psychiatrist will provide psychiatric services for mental health patients. The psychiatric nurse practitioner will provide psychiatric nursing services. The incumbents will be responsible for assuring that basic health care needs of psychiatric patients are monitored and will provide medication management and consultation-liaison services. Incumbents will serve as liaison between the mental health program and medical staff as needed. Incumbents will work with patients of all ages, and will provide diagnostic assessments, pharmacotherapy, psychotherapy, and psychoeducation. Relocation benefits are available.

For more information, please contact Michelle

Eaglehawk, LISW/LCSW, Director of Behavioral Health Services at (928) 656-5150 or e-mail *Michelle.Eaglehawk@ihs.gov*.

Pediatrician
Fort Defiance Indian Hospital; Fort Defiance, Arizona

Fort Defiance Indian Hospital is recruiting for pediatricians to fill permanent positions for summer 2008 as well as *locum tenens* positions for the remainder of this year. The pediatric service at Fort Defiance has seven physician positions and serves a population of over 30,000 residents of the Navajo Nation, half of which are under 21 years old! Located at the historic community of Fort Defiance just 15 minutes from the capital of the Navajo Nation, the unparalleled beauty of the Colorado Plateau is seen from every window in the hospital. With a new facility just opened in 2002, the working environment and living quarters for staff are the best in the Navajo Area.

The pediatric practice at Fort Defiance is a comprehensive program including ambulatory care and well child care, inpatient care, Level I nursery and high risk stabilization, and emergency room consultation services for pediatrics. As part of a medical staff of 80 active providers and 50 consulting providers, the call is for pediatrics only, as there is a full time ED staff. Pediatrics has the unique opportunity to participate in the health care of residents of the Adolescent Care Unit, the only adolescent inpatient mental health care facility in all of IHS, incorporating western medicine into traditional culture. Our department also participates in adolescent health care, care for special needs children, medical home programs, school based clinics, community wellness activities, and other public health programs in addition to clinical services.

Pediatricians are eligible for IHS loan repayment, and we are a NHSC eligible site for payback and loan repayment. Salaries are competitive with market rates, and there are opportunities for long term positions in the federal Civil Service system or Commissioned Corps of the USPHS. Housing is available as part of the duty assignment.

While located in a rural, "frontier" region, there is a lot that is "freeway close." The recreational and off duty activities in the local area are numerous, especially for those who like wide open spaces, clean air, and fantastic scenery. There are eight National Parks and Monuments within a half day's drive, and world class downhill and cross country skiing, river rafting, fly fishing, organized local hikes and outings from March through October, and great mountain biking. Albuquerque, with its unique culture, an international airport, and a university, is the nearest major city, but is an easy day trip or weekend destination. Most important, there are colleagues and a close knit, family oriented hospital community who enjoy these activities together.

For more information, contact Michael Bartholomew, MD, Chief of Pediatrics, at (928) 729-8720; e-mail *michael.bartholomew@ihs.gov*.

Family Practice Physician
Warm Springs Health and Wellness Center; Warm Springs, Oregon

The Warm Springs Health and Wellness Center has an immediate opening for a board certified/eligible family physician. We have a clinic that we are very proud of. Our facility has been known for innovation and providing high quality care. We have positions for five family physicians, of which one position is open. Our remaining four doctors have a combined 79 years of experience in Warm Springs. This makes us one of the most stable physician staffs in IHS. Our clinic primarily serves the Confederate Tribes of Warm Springs in Central Oregon. We have a moderately busy outpatient practice with our doctors seeing about 16 - 18 patients per day under an open access appointment system. Currently we are a pilot site for the IHS Director's Initiative on Chronic Disease Management. We fully utilize the IHS Electronic Health Record, having been an alpha test site for the program when it was created. We provide hospital care, including obstetrics and a small nursing home practice, at Mountain View Hospital, a community hospital in Madras, Oregon. Our call averages 1 in 5 when fully staffed. For more information, please call our Clinical Director, Miles Rudd, MD, at (541) 553-1196, ext 4626.

Chief Pharmacist
Staff Pharmacist
Zuni Comprehensive Healthcare Center; Zuni, New Mexico

The ZCHCC, within the Indian Health Service, is located on the Zuni Indian Reservation in beautiful western New Mexico. ZCHCC is a critical access hospital with an inpatient unit consisting of 30 plus beds, labor and delivery suites, emergency department, and a large outpatient clinic. The center serves the Zuni and Navajo Tribes. Housing and moving expenses available for eligible applicants. The Zuni are a Pueblo people with rich culture, customs, and traditions. Applicants may contact Cordy Tsadiasi at (505) 782-7516 or CDR David Bates at (505) 782-7517.

Psychiatrist
SouthEast Alaska Regional Health Consortium; Sitka, Alaska

Cross cultural psychiatry in beautiful southeastern Alaska. Positions available in Sitka for BE/BC psychiatrist in our innovative Native Alaskan Tribal Health Consortium with a state-of-the-art EHR in the coming year. Join a team of committed professionals. Inpatient, general outpatient, telepsychiatric, C/L, and child/adolescent work available. Excellent salary and benefit pkg. Loan repayment option. Live, hike, and kayak among snow capped mountains, an island studded coastline, whales, and bald eagles. CV and questions to *tina.lee@searhc.org* or (907) 966-8611. Visit us at *www.searhc.org*.

Family Practice Physician
Sonoma County Indian Health Project; Santa Rosa, California

The Sonoma County Indian Health Project (SCIHP) in Santa Rosa, California is seeking a full-time BC/BE Family Practice Physician to join our team. SCIHP is a comprehensive community care clinic located in the northern Californian wine country. Candidates must currently hold a California Physician/Surgeon license. Inpatient care at the hospital is required. For the right candidate, we offer a competitive salary, excellent benefits, and an opportunity for loan repayment. For more information, please contact Bob Orr at (707) 521-4654; or by e-mail at *Bob.Orr@crihb.net*.

Family Practice Physician/Medical Director
American Indian Health and Family Services of Southeastern Michigan; Dearborn, Michigan

American Indian Health and Family Services of Southeastern Michigan (*Minobinmaadziwin*) (AIHFS) is a non-profit ambulatory health center, founded 1978. AIHFS provides quality, culturally integrated, medical and preventative dental care in addition to comprehensive diabetes prevention and treatment. All of AIHFS programs integrate traditional Native American healing and spiritual practices with contemporary western medicine in both treatment and prevention.

AIHFS is seeking a full time primary care and family practice physician/medical director. This involves the delivery of family oriented medical care services as well as general professional guidance of primary care staff. The incumbent will also function as the Medical Director, who will collaborate with fellow physicians and the Executive Director on administrative operations of the medical, dental, and behavioral health services.

Please send a cover letter (include the position that you are applying for, a summary of your interests and qualifications for position), minimum salary requirement, resume, and a list of three professional references with contact information to American Indian Health and Family Services of Southeastern Michigan, Inc., Attn: Jerilyn Church, Executive Director, P.O. Box 810, Dearborn, Michigan; fax: (313) 846-0150 or e-mail *humanresources@aihfs.org*.

Pediatrician
Nooksack Community Clinic; Everson, Washington

The Nooksack Community Clinic in Everson, Washington is seeking an experienced pediatrician to take over the successful practice of a retiring physician. The clinic provides outpatient care to approximately 2,000 members of the Nooksack Indian Tribe and their families. The position includes some administrative/supervisory duties as well as part-time direct patient care. We are seeking a dedicated, experienced pediatrician with a special interest in child advocacy and complex psychosocial issues. This is a full time position with a competitive salary and benefits. There are no on-call, no inpatient duties, and no obstetrics. We currently are staffed with one family practitioner, one internist, one pediatrician, and one nurse practitioner. Additionally we have three mental health counselors, a state-of-the-art four-chair dental clinic, a nutritionist, a diabetic nurse educator, and an exercise counselor. We provide high quality care in an environment that prides itself on treating our patients like family.

The clinic is located in a very desirable semi-rural area of Northwest Washington, renown for its scenic beauty, quality of life, and year 'round outdoor recreation. The beautiful city of Bellingham is 20 minutes away. Vancouver, Canada is less than 90 minutes away, and Seattle is approximately a two-hour drive away. St. Joseph Hospital in nearby Bellingham offers a wide range of specialist and inpatient services, an excellent hospitalist program, as well as emergency care, lab, and imaging services, all easily accessible for our patients.

For further information, please send your CV or contact Dr. MaryEllen Shields at *nooksackclinic@gmail.com*, or write c/o Nooksack Community Health Center, PO Box 647, Everson, Washington 98247; telephone (360) 966-2106; fax (360) 966-2304.

Director of Nursing
Acoma-Canoncito Laguna Hospital; San Fidel, New Mexico

Acoma-Canoncito Laguna Hospital has an opening for a director of nursing. The Acoma-Cononcito Laguna Service Unit (ACL) serves three tribal groups in the immediate area: the Acoma Pueblo (population 3,500), the Laguna Pueblo (5,500) and the Canoncito Navajos (1,100). The ACL Hospital is located approximately 60 miles west of Albuquerque, New Mexico. The hospital provides general medical, pediatric, and obstetric care with 25 beds. The director of nursing is responsible for planning, organizing, managing, and evaluating all nursing services at ACL. This includes both the inpatient and outpatient areas of the service unit. The director of nursing participates in executive level decision making regarding nursing services and serves as the chief advisor to the chief executive officer (CEO) on nursing issues. Other responsibilities include management of the budget for nursing services. For more information about the area and community, go to http://home.Abuquerque.ihs.gov/serviceunit/ACLSU.html.

For details regarding this great employment opportunity, please contact Dr. Martin Kileen at (505) 552-5300; or e-mail *martin.kileen@ihs.gov*.

Primary Care Physician
(Family Practice Physician/General Internist)
Family Practice Physician Assistant/Nurse Practitioner
Kyle Health Center; Kyle, South Dakota

Kyle Health Center, a PHS/IHS outpatient clinic, is recruiting for the position of general internal medicine/family practice physician and a position of family practice physician assistant/nurse practitioner. The clinic is south of Rapid City, South Dakota, and is located in the heart of the Badlands and the Black Hills – an area that is a favorite tourist destination. It is currently staffed with physicians and mid-level practitioners. It provides comprehensive chronic and acute primary and preventive care. In-house services include radiology, laboratory, pharmacy, optometry, podiatry, primary obstetrics/gynecology, diabetic program, and dentistry. There is no call duty for practitioners. We offer competitive salary, federal employee benefits package, CME leave and allowance, and loan repayment. For further information, please contact K.T Tran, MD, MHA, at (605) 455-8244 or 455-8211.

New Policy for Position Vacancies

Through the years, the number of position vacancies published every month has grown, such that now it includes as many as 15 pages per issue. In the past, we tried to contact those who submitted these on a periodic basis, but this is very labor intensive, and many failed to respond to confirm that they, indeed, needed their item to continue.

Our plan to try to alleviate this situation is to run all submitted items for four months, and then remove them from the section. Those who wish to continue their position vacancy announcements may resubmit them at this time, and they will run for another four months. We will not be contacting you, though, so we ask that you keep an eye on your announcements to be sure you know when they are about to expire.

This will assure that all vacancy announcements we publish remain "fresh" and current and eliminate items that are no longer necessary.

It is not our intention to remove items that are still pertinent; we are merely trying to encourage those who submit these to assume the responsibility to keep them up to date. As always, if you have suggestions about how we can make this or any other feature of *The Provider* more useful, we want to hear from you.

Change of Address or Request for New Subscription Form

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Worksite: ☐ **IHS** ☐ **Tribal** ☐ **Urban Indian** ☐ **Other**

Service Unit (if applicable) _____ **Last Four Digits of SSN** _____

Check one: ☐ **New Subscription** ☐ **Change of address**

If change of address, please include old address, below, or attach address label.

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THE IHS PRIMARY CARE PROVIDER

A journal for health professionals working with American Indians and Alaska Natives

THE IHS PROVIDER is published monthly by the Indian Health Service Clinical Support Center (CSC). Telephone: (602) 364-7777; fax: (602) 364-7788; e-mail: *the.provider@phx.ihs.gov.* Previous issues of THE PROVIDER (beginning with the December 1994 issue) can be found on the CSC Internet home page *(http://www.ihs.gov/PublicInfo/Publications/HealthProvider/Provider.asp)*.

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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.

Authors should submit at least one hard copy with each electronic copy. References should be included. All manuscripts are subject to editorial and peer review. Responsibility for obtaining permission from appropriate tribal authorities and Area Publications Committees to publish manuscripts rests with the author. For those who would like more information, a packet entitled "Information for Authors" is available by contacting the CSC at the address below or on our website at *www.csc.ihs.gov*.

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