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Lessons Learned from the IHS and Tribal Health Care Medical Malpractice Tort Claim Experience

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Introduction

The Indian Health Service (IHS) Risk Management Program (RMP) is responsible for coordinating the clinical peer reviews of all medical malpractice tort claims filed against the Federal government that involve care provided at facilities directly operated by the IHS or by a tribe carrying out contracts, grants, or cooperative agreements pursuant to Public Law 93-638, the Indian Self-Determination and Education Assistance Act. Since the mid-1980s, the IHS-RMP has maintained a database of information on all tort claims that it has processed; by the end of fiscal year (FY) 2006, data had been accumulated on over 1440 cases. Although analyses of portions of the data have been accomplished in the past, former reviews focused primarily on claim volume, regional incidence, and outcome information. This article is based on an assessment of our agency's 20-year experience of processing medical malpractice tort claims, with the intent to identify what types of care and adverse outcomes most commonly give rise to allegations of medical malpractice, and from where within the network of IHS- and tribally-operated facilities do the majority of these tort claims arise. Finally, the authors of this article will share their experience with respect to the recurring risk management issues that have been identified during the reviews of these medical malpractice allegations.

Although it is not uncommon for individuals to file multiple claims with respect to one incident of alleged malpractice, the focus of the RMP database and this review reflect the number of incidents (cases), rather than the number of total claims filed. This is an important distinction, because it is the incident itself that deserves the scrutiny of a risk management program; the number of claims filed by various parties affected by an alleged malpractice incident is a poor indicator of the merits of the case in question. It is also important to note that this review includes all *alleged* cases of medical malpractice during the 20-year period, even though many of the claims were determined to have little or no merit after careful and considered review. All of the recorded tort claims were included because often significant risk management issues can also be uncovered from cases where the accusations of improper care were shown to be invalid during the medical review process.

Methods

There were a total of 1,444 cases of alleged medical malpractice in the database from FY 1987 through FY 2006. The database query feature was used to extract and compile the data of interest, and in turn this information was transferred to a spreadsheet for manipulation and tallying. The most common examples of each allegation category were determined by examining the allegation text entry for each claim. Information on the number and types of IHS and tribal facilities was provided by the Office of Clinical and Preventive Services, IHS Headquarters.

Allegation Classification. When a tort claim is entered into the RMP database, the claim allegation is classified using one of eight categories. Table 1 shows the number and percentage of tort claim cases within each category, listed in descending order of prevalence.

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Table 1. Number and percentage of FY 1987-2006 tort claim cases classified by allegation category

Allegation Class	Number	Percent
Diagnosis-related	523	36.2%
Treatment-related	332	23.0%
Surgery-related	249	17.2%
Perinatal care-related	142	9.8%
Medication-related	90	6.2%
Dental-related	50	3.5%
Other	49	3.4%
Anesthesia-related	9	0.6%

The most common allegation type was the alleged failure to timely or properly *diagnose* a condition, which accounted for 36% of cases. The most common examples included missed/delayed diagnosis of a cancer, an infectious disease (such as meningitis, sepsis, or pneumonia), an acute coronary event, an acute abdomen (especially appendicitis), and bone and joint injuries. The next most common allegation type was the alleged failure to timely or properly *treat* a condition, representing 23% of cases. In this category, the most common entities included the improper management of an infectious condition, traumatic injuries including wounds with retained foreign bodies (e.g., glass or wood fragments), respiratory illnesses such as asthma or pneumonia, and gastrointestinal illnesses including gallbladder disease. Since many tort claims allege both the failure to timely or properly diagnose *and* treat, these two categories overlap considerably. Combined, they accounted for 59% of all cases.

The *surgery* classification refers to cases that involved an allegation of improper surgical intervention or peri-operative care (excluding obstetrical surgeries). These cases accounted for 17% of the total cases. The most frequent conditions included damage to the biliary ducts during gallbladder surgery (primarily laparoscopic), improper surgical management of orthopedic conditions, improper surgical management of other abdominal conditions such as colon surgery or appendectomy, and retained foreign bodies at surgery (primarily surgical sponges).

Cases alleging improper *perinatal care* (during the prenatal, labor, delivery, and post-partum periods) accounted for 10% of cases. Most commonly, this included improper labor management with an inadequate assessment of fetal wellbeing. Other examples relate to the improper choice of delivery method, failure to properly perform a delivery, and improper prenatal care with inadequate assessment of fetal wellbeing.

The *medication-related* category refers to the alleged improper prescribing or dispensing of a drug, or the alleged adverse reaction to a drug. These accounted for 6% of the total cases. The most common examples included the wrong medication prescribed (often related to not assessing drug allergies) and dispensing errors.

The *dental* category reflects care provided by dental clinic staff, primarily dentists and oral surgeons. These cases accounted for 3.5% of total cases. Common examples include the alleged improper performance of extractions resulting in complications, infections as a consequence of various dental procedures, and the wrong tooth being extracted.

The "*other*" category was used to classify cases that did not fit into any of the specific categories; these accounted for 3% of cases. Examples included allegations related to the response from emergency medical services, a delay in or failure to transport, and the failure to properly monitor or care for a patient resulting in injury-sustaining falls.

Only nine cases (less than 1% of the total) had been coded as *anesthesia-related*, most having to do with airway management at the time of surgery. Two others involved the use of fluids or sedation during surgery, and another two involved alleged complications from spinal anesthesia. It should be noted that there were several surgery and perinatal cases where a component of the allegation also referred to anesthesia-related issues.

Injury Classification. Knowledge of the degree of the alleged injuries provides an appreciation for the severity of the adverse outcomes that resulted in a tort claim being filed. Table 2 shows the number and percentage of cases for each alleged injury type, in order of decreasing prevalence. The most common injury class was *permanent physical injury*, which accounted for 39% of the cases. Second was *death*, with 29%, then *temporary physical injury* with 26% of cases. *Non-physical injury* accounted for less than 4% of cases; this code was used for cases alleging primarily psychological harm or purely economic damages. The *undetermined injury* category was used for cases where the alleged injury was unclearly stated or could not specifically be determined from a review of the available material. Three cases involved *wrongful birth injury*, alleging improper management of contraceptives or improper performance of a sterilization procedure.

Table 2. Number and percentage of FY 1987-2006 tort claim cases classified by type of injury

Injury Class	Number	Percent
Perm physical	566	39.2%
Death	421	29.2%
Temp physical	373	25.8%
Non-physical	53	3.7%
Undetermined	28	1.9%
Wrongful birth	3	0.2%

Now that we have seen what types of circumstances commonly led to tort claim allegations of medical malpractice in the IHS/tribal health care system, let's look at *where* these incidents tended to occur.

Patient Care Area. Table 3 shows the number and percentage of cases coded by the patient care area where the predominance of care was provided. A little more than one-third of cases involved primarily *inpatient* care, while the remaining two-thirds involved care primarily rendered in an *outpatient* clinic settling (56%) or an *emergency room* setting (11%). The "*other*" category refers to cases involving care primarily in the field, such as emergency medical services at the scene of an accident, or home health care; less than 1% of cases fell into this category.

Table 3. Number and percentage of FY 1987-2006 tort claim cases classified by patient care area

Pt. Care Area	Number	Percent
Outpatient	750	51.9%
Inpatient	522	36.1%
Emergency room	159	11.0%
Other	13	0.9%

Facility Type. Within the IHS and tribal network of health care facilities, there are 304 "*health centers*" that provide only ambulatory services and there are 46 "*hospital-based*" facilities that provide both inpatient and outpatient services. For the purposes of this analysis the 46 hospital-based facilities were further divided into two groups: "limited service" and "extended service" hospital-based facilities. The limited service hospital designation refers to the smaller, more remote inpatient facilities with limited obstetrical care, no inpatient surgery, and no intensive care unit. The full service hospital designation refers to facilities that provide surgical obstetrical deliveries, inpatient general surgery, intensive care, and a few that have additional specialty services such as orthopedics, ophthalmology, otorhinolaryngology, etc.

Table 4 shows the number and percentage of tort claim cases for the three categories of health care facilities common to the IHS and tribal health care systems. Two hundred and eleven cases involved care at health centers, accounting for 14.6% of the total cases. These cases were spread out over 92 different facilities; the average number of cases per facility over the 20-year period was only 2 - 3 cases per facility, with a range of 1 to 14. Those ambulatory facilities involved with a higher number of cases tended to be larger health centers that offered extended hours with emergency room services. Generally, the prevalence of tort claims is low at IHS- or tribally-operated health centers.

Hospital-based facilities accounted for the remaining 1,233 cases, or 85.4% of the total cases. These cases included all the inpatient care cases, most of the emergency room cases, as well as a majority of the outpatient care cases. Incidents at limited service hospital-based programs accounted for 315 cases (22% of the total) spread out over 28 facilities. The range of cases per facility was from 1 to 59, with an average of 11 - 12 cases per facility for the 20-year period. Extended service hospital-based facilities accounted for the remaining 918 cases (64% of the total) spread over 16 facilities. The range of cases per facility was from 18 to 114 for the 20- year period, with an average of 57 - 58 cases per facility. In general, the larger the facility and the more services offered, the higher the prevalence of tort claims.

Table 4. Number and percentage of FY 1987-2006 tort claim cases classified by facility type (see text for definitions)

Facility Type	Total Cases	Percent of Total	No. of Facilities	Avg. No. Cases per Facility
Ambulatory Health Center	211	14.6%	92	2.3
Limited Service Hospital-based	315	21.8%	28	11.25
Extended Service Hospital-based	918	63.5%	16	57.4

Risk Management

Medical risk management practices examine alleged incidents of medical malpractice to assess what factors may have led to the adverse event, to help determine how the system can be improved to prevent recurrences of the problems identified, and how the care that *is* provided can be made more defensible in the medico-legal arena. The risk management issues related to each incident of alleged medical malpractice are recorded into the IHS-RMP database as free text notes in a memo field. There was no facile way to electronically query the database to compile a list of common risk management issues. However, what follows (in no specific order) are short explanations of 24 commonly encountered risk management concerns, in accordance with the experience of this article's authors (SWH and EYH), who have collectively been involved with these activities for over 24 years.

1. Know and conscientiously practice the standard of care for your discipline. This goes without saying, but it is worth emphasizing. It is difficult to defend care that is outdated or does not conform to accepted standards of practice. Ensure that you are properly credentialed and privileged to provide the services required.
2. All new health care practitioners (including all temporary hires) should receive orientation with respect to the recognition and treatment of locally prevalent disease entities, such as hanta virus and plague in the southwest and tick-borne diseases in Oklahoma.
3. Acknowledge and respond appropriately to abnormal vital signs identified during the screening or monitoring of patients. If an adverse outcome does

occur, significantly abnormal vital signs on a nurse's screening profile that do not receive any documented recognition by the patient's provider create major challenges for the defense of a claim. Especially in the acute care setting, it is extremely important to both acknowledge and then reassess any abnormal vital signs before discharging a patient from your care, including documentation of what was done to address them.

4. Similarly, the chief complaint, as identified by the triage health professional during the screening process, must be acknowledged and fully addressed by the examining practitioner, including a review of systems appropriate for all the symptoms expressed by the patient.
5. Acknowledge and respond appropriately to all abnormal laboratory values and imaging studies. In the acute care setting, all abnormal studies must be commented on, and your facility must have a workable process that enables all practitioners to be notified of abnormal lab results that are generated after a patient leaves the facility. Initial and date laboratory slips, medical imaging reports, electrocardiograms, etc. when they are reviewed. The system must also accommodate notification of the patient to return for reevaluation of abnormal studies when necessary.
6. Avoid focused diagnoses in the setting of an acute illness or new patient complaint, but rather consider and document a differential approach to the management of the patient's signs and symptoms. When a particular disease entity is being considered (such as cardiac origin of chest pain), the patient must then be appropriately screened for that diagnosis.
7. Chart comprehensively and legibly, whether it be a hand written paper record or a typed electronic health record (EHR). Legible signatures are also critical – print or rubber-stamp your name below all written signatures. As the EHR becomes more commonplace (at least in the outpatient clinic setting) illegibility will become less of an issue, but accurate and complete documentation may still be a challenge for providers who are poor keyboarders.
8. All entries should be timed, including inpatient and outpatient notes and orders. Always indicate the time when medications are administered.
9. All encounters should have follow-up plans that are clearly documented in the medical record, and (when appropriate) discharge instructions provided to patients – this holds true for all clinic visits and hospital discharges. Carefully document patient education efforts, and who received the information (patient, parent, guardian, etc).
10. Chart as soon after the care event as possible. Entries must be reasonably contemporaneous with the care that was given, including operative and procedure notes. If necessary, a late entry must always be identified as such, dated and timed accordingly.
11. Never attempt to alter a medical record after an episode of care. When a correction needs to be made to the medical record, use acceptable practices to make those changes.
12. Fetal monitor and cardiac monitor tracings should be carefully dated and timed, and note on the strips all interactions performed during the monitoring process (e.g., when medications were given, or when a procedure was performed).
13. Obtain proper written, informed consent prior to any non-emergency invasive procedure. Every facility should have a formal written policy regarding informed consent, indicating those procedures that require written consent.
14. Before any invasive procedure is initiated, follow prescribed "time-out" protocols to ensure the correct procedure is being performed on the correct patient, and that the correct side (left versus right) has been clearly identified.
15. Be cognizant of the known complications for all the procedures you perform. It is not necessarily negligence when a known complication occurs, but the failure to recognize and treat complications in a timely manner when they do occur may often be considered below the standard of practice.
16. Treat all injuries related to possible glass and/or wood fragments, i.e., foreign bodies, with due diligence. Document a thorough exam and cleansing of the wound and always consider appropriate medical imaging.
17. The appropriate choice of medical imaging is also important when evaluating bone and joint injuries (plain films, CT, MRI). Non-improvement in the patient's symptoms should prompt additional imaging and/or timely consultation.
18. Reference past medical records, or attempts to locate past medical information that is not available. Regularly seek written summaries of all outside care relevant to the patient's ongoing medical problems, including past specialty consultations, procedures, and surgeries.
19. Document in the chart all consultations and/or advice obtained by phone or other means from in-house or outside colleagues and specialists.
20. Advice to patients given over the phone should be documented in the chart, including the date and time the information was given.
21. Medication prescribing and dispensing errors are an increasingly common target for tort claims. Each facility should have an active patient safety program

to monitor and minimize the incidence of medication errors. Individuals who prescribe, dispense and administer medications should work as a team to ensure drug allergies and drug interactions are carefully appraised before any medicinal is given to a patient. Use of the EHR will be of great benefit in this regard.

22. A child who will not bear weight or who has hip or knee pain without antecedent trauma should receive careful consideration for the possibility of occult infection, Osgood-Schlatter disease, or slipped capital femoral epiphysis.
23. Younger males with genitourinary complaints: if a urinary tract infection is diagnosed, further testing may be indicated for an underlying cause; if testicular torsion is part of the differential diagnosis, it must be ruled in or out emergently.
24. Ensure that your facility has an active inpatient and outpatient fall-prevention program for all patients, but especially frail elders. Never leave an incapacitated adult or minor child in a clinic room unattended.

Conclusions

Missed or delayed diagnosis and/or mismanagement of commonly encountered medical conditions account for the majority of tort claims filed in relation to care provided at IHS and tribal facilities. Surgical and perinatal incidents account for an additional 27% of the tort claims. Most tort claims reflect adverse outcomes that result in permanent injury or death of the involved patient. Most tort claims arise from incidents at hospital-based facilities with a wider rage of services, including emergency room care, operating rooms, and higher volume obstetrical deliveries. Ambulatory health centers only encounter an occasional tort claim, reflecting the lower volume of care and lack of higher-risk patient interventions. However, no facility or provider is immune from being involved in a federal malpractice tort claim, and many risk management issues are common to allegations of improper medical care. Better awareness of these common issues may help to improve patient care outcomes and protect health care practitioners from clinical performance that is not defensible in a court of law.

Additional information about risk management, medical liability, and the tort processes followed in the Federal health care system can be found in the following references:

1. Heath SW. *Risk Management and Medical Liability*. A Manual for Indian Health Service and Tribal Health Care Professionals, Second Edition, April 2006. Posted on the IHS Internet website at: *http://www.ihs.gov/NonMedicalPrograms/NC4/Documents/RM2_a.pdf.*
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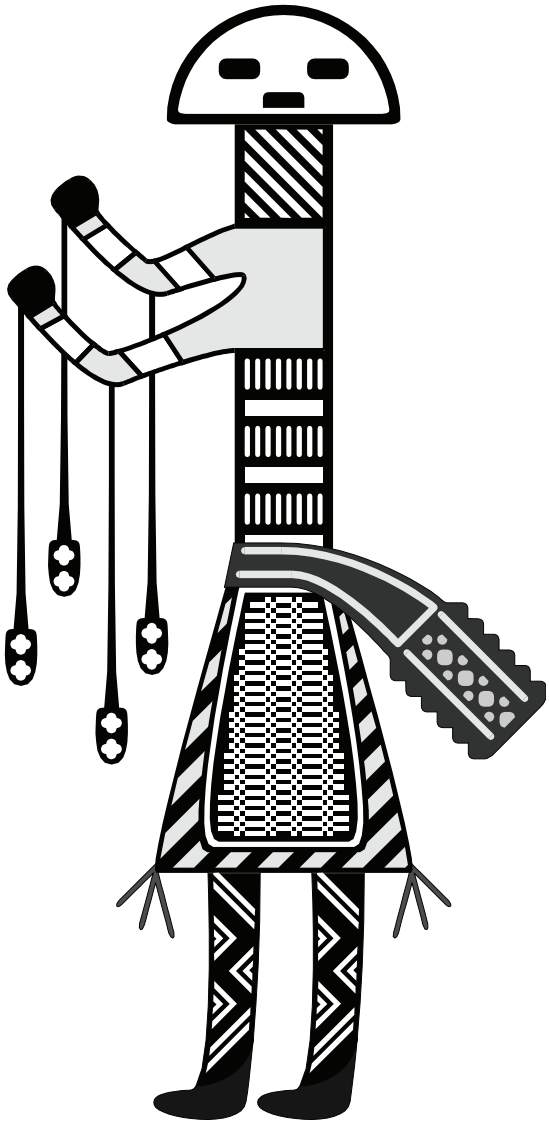

An Innovative Patient-Centered and Culturally Sensitive Health Education Program for an American Indian/Alaska Native Patient Population

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Introduction

The Indian Health Service (IHS) is an agency within the US Department of Health and Human Services that operates a comprehensive health service delivery system for approximately 1.5 million of the nation's American Indians and Alaska Natives.[1] The agency's electronic health information system, the Resource Patient Management System (RPMS), manages clinical and administrative information from health care facilities of all types, providing cradle-to-grave data on the IHS patient population.

The IHS Health Education Program has developed a unique, interdisciplinary approach to standardizing the provision and documentation of health education services, which can be easily replicated in other settings. This comprehensive program utilizes nationally developed protocols based on published articles, clinical guidelines, and standards of practice, in coordination with locally developed, culturally sensitive lesson plans and an innovative procedure for documenting the education provided to individual patients.

All patient education is documented in the RPMS system. The process of documenting patient education enables clinicians to receive "credit" for the education they provide, provides a means of evaluating the workload of various disciplines providing patient education, and provides data for performance improvement efforts. This documentation is part of the patient's medical record and informs others that a given patient received education on a specific topic(s). Consistent use of these codes encourages subsequent health professionals to perform appropriate follow-up.

National Protocols and Local Lesson Plans

Education protocols, developed by IHS clinicians across the country, serve as guidelines or templates for providing patient education. The Patient Education Protocols and Codes (PEPC) Committee is a multidisciplinary team that includes physicians, pharmacists, dieticians, health educators, and quality management coordinators, which meets regularly to establish and review submitted patient education protocols for clinical appropriateness and cultural sensitivity. Figure 1 shows an example, the protocol for an asthma self-management plan. Each protocol contains an objective and from two to six standards that provide the educational points that should be reviewed with the patient or family member. Protocols are detailed in a manual titled *Indian Health Service Patient and Family Education Protocols and Codes* (PEPC manual),[2] which is easily accessible from the IHS website.

Figure 1. Sample Protocol

ASM-SMP SELF MANAGEMENT PLAN
OUTCOME: The patient/family will understand the importance of an asthma management plan.

STANDARDS:
1. Explain that an asthma management plan helps to treat asthma symptoms promptly when used in combination with routine peak flow monitoring.
2. Explain that an asthma management plan provides the patient/family with instructions on how to manage asthma based upon peak flow meter results and symptoms.
3. Green Zone (80-100% personal best peak flow): represents times when the patient is breathing well, not coughing or wheezing, and can work/play normally. Instruct the patient to continue their current treatment plan.
4. Yellow Zone (50-80% personal best peak flow): represents times when the patient is coughing or wheezing, having difficulty breathing, or is waking up at night from asthma symptoms. Patients should receive instructions on appropriate therapy.
5. Red Zone (< 50% peak flow): represents times when the patient is breathing hard and fast, cannot talk/walk well, and is not receiving relief from their current treatment plan. Patients should receive instructions on appropriate therapy and advice to seek medical attention immediately.
6. Provide the patient/family with a copy and discuss appropriate use of the asthma management plan.

Lesson plans are strategies detailing specifically how patient education is provided to the target population, as well as the handouts or educational aids to be used. Lesson plans are developed by local programs and are designed to be culturally relevant and specific for the population served. For example, the Cherokee Indian Hospital has created a lesson plan to ensure delivery of consistent and complete education on insulin administration and glucometer use across care settings, including the outpatient clinic, the inpatient ward, and an off-site diabetes education program. Sample patient education handouts developed and submitted from IHS sites across the country are available on the IHS website[3]; handouts that are targeted to a less than 6th grade reading level are identified, and all handouts are correlated to appropriate education protocols and standardized patient education codes.

Standardized Codes

An innovative coding system is used to document health education encounters. The patient education code consists of a string of mnemonics, as defined in the PEPC manual.[2] Documentation is simple and efficient, and use of codes reduces the time required to document the provision of patient education in either the paper or electronic medical record. Five required and three optional components of the patient education documentation coincide with recommendations made by the Joint Commission on providing patient education[4] as well as with billing requirements established by the Centers for Medicare and Medicaid Services (CMS). The eight components are defined in Figure 2. A hypothetical patient education encounter might be documented as:

ASM-SMP-RCPT-G-[Provider identification]-5min-GS-will check twice daily

In this example, ASM is the code for asthma, SMP is the code for self-management plan, RCPT is the code for a patient who is "receptive," G represents a "good" level of understanding, and GS indicates that the patient has set a goal; the goal (checking peak flow twice a day) is specified in a free-text comment field.

Figure 2. Components of the Patient Education Code

Topic
The diagnosis or condition that is the focus of the patient education, documented as an IHS-approved mnemonic, an ICD-9 code, or a CPT code.

Subtopic
The content of the education. The system offers 17 general topics that can be used with any condition: anatomy and physiology; complications; disease process; equipment; exercise; follow-up; home management; hygiene; lifestyle adaptation; literature; medication; nutrition; prevention; procedures; safety; testing; and treatment.

Readiness to learn (optional)
Factors that may increase or decrease the patient's ability to understand the information provided. Six codes are available to document readiness to learn: eager to learn; receptive; unreceptive; in pain; severity of illness; distraction; and intoxicated.

Level of understanding
The patient's understanding of the education provided, documented as good, fair, poor, refused, or group (i.e., education was provided to a group of patients and an individual assessment of level of understanding could not be performed).

Provider
The full name or provider education code of the clinician who provided the education; each clinician has a code that consists of three numbers or letters.

Time spent providing education
The amount of time spent providing face-to-face patient education, documented in minutes.

Education Comment (optional)
Additional information pertinent to the education encounter, documented by the provider in a free-text field.

Goal Status (optional)
One or more goals set by the patient to aid in the improvement of their health. The goal-setting process can be documented using GS for "goal set," GNS for "goal not set," GM for "goal met," or GNM for "goal not met."

Goal Comment (optional)
Clinicians may further describe the goal identified by the patient in a free-text field following the documentation of the goal.

Implementation

Implementation of patient education protocols and coding procedures, including development of the standardized codes and their adoption by clinicians, requires an ongoing process of training, monitoring, and evaluation. Extensive training efforts are provided throughout the IHS to increase documentation of patient education. Barriers to documentation that have been cited by IHS clinicians in the field include: 1) providers' perception of documentation as a time-consuming activity that encroaches on the limited time they have with their patients; 2) providers' perception that documentation of patient education is not essential to providing good patient care; and 3) misconceptions about the difficulty of completing the documentation. These barriers are addressed through live meetings, presentations at conferences, and incorporation of patient education documentation with other training topics.

The IHS is able to utilize the documentation of these codes in national reporting as well as local monitoring of clinical performance measures. Through an RPMS application called the Clinical Reporting System (CRS), the agency routinely participates in national quality data collection efforts including collection of Government Performance and Results Act (GPRA), ORYX, and Health Plan Employer Data and Information Set (HEDIS) data. For several outcome measures, reporting is based on documentation of patient education codes, e.g., those for tobacco use assessment, tobacco cessation, alcohol education, intimate partner/domestic violence screening, depression and anxiety screening, nutrition and exercise education, comprehensive cardiovascular disease assessment, and medication education/counselling. A new "patient education report" has become available in 2007 that enables sites to view, for a given time period, the number of education codes recorded, time spent providing patient education, patient level of understanding of education provided, top diagnoses and/or topics for which education is documented, and type of provider who gave the education.

In addition to allowing the IHS to track achievement of national clinical benchmarks, the system allows tracking of how many patients met their personally established goals, at the facility, Area, or national level.

Discussion, Evaluation, and Next Steps

Patient education has become a standardized component of documentation in the patient's medical record. Currently, more than 3,900 patient education code topics are available for documentation, each one submitted by IHS clinicians in the field and reviewed by the PEPC Committee. The IHS Director included increasing the documentation of patient education by five percent as a part of his performance measures in fiscal year 2006. Documentation exceeded this target, with a mean increase of 17 percent across facilities nationally. Documentation has increased from 101,410 codes documented in 1998 to 3,130,000 documented in 2006. Initially meeting yearly, the PEPC has been meeting at least quarterly to update

education codes and to address new ideas and requests from the field. One of the next projects is to refine the coding process to allow documentation of specific clinical outcome measures established by collaboration between clinicians and patients.

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Key Findings

- The IHS has successfully implemented a process for documenting health education that can be easily adopted in other clinical settings.
- Information on health education encounters and patient-set goals can be documented, viewed, and updated using a uniform set of codes.
- Health care workers in the field have provided input into the development of local lesson plans and national protocols.
- Use of this system is essential for national reporting and local monitoring of clinical performance measure data.

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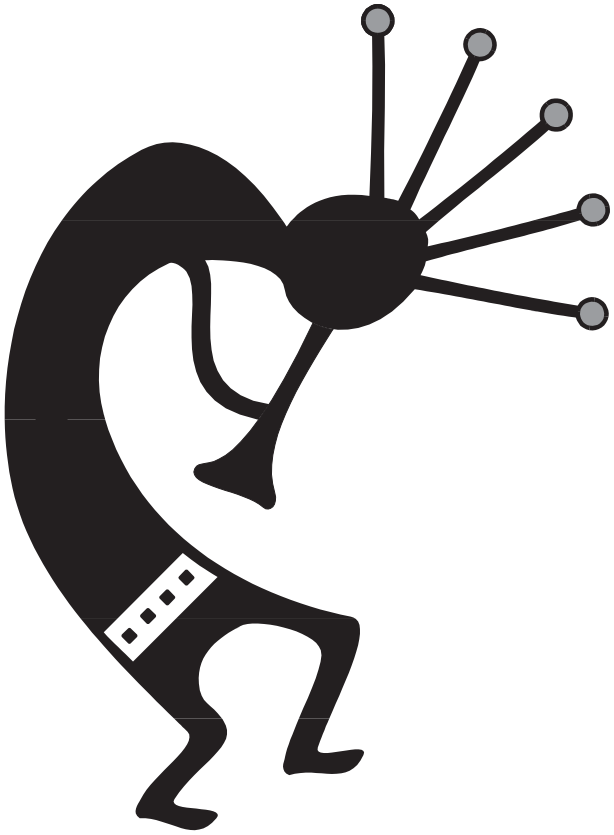

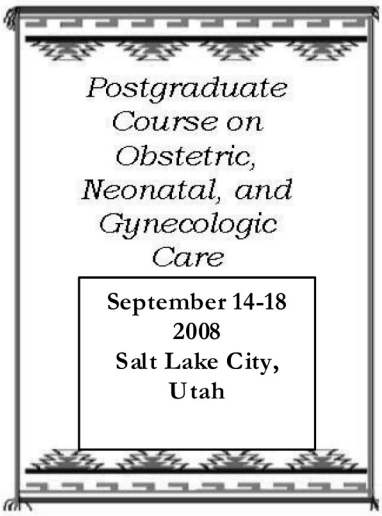

TARGET AUDIENCE

This course is directed to primary care providers, including physicians, clinical nurses, nurse practitioners, nurse midwives, and physician assistants caring for women and infants in Indian Health Service settings and tribally-operated health care facilities.

COURSE DESCRIPTION

The curriculum is designed to encourage a team approach to the care of women and their newborns, with a strong emphasis on the realities and limitations of care in the rural, isolated settings that are common to many Indian health facilities. The text gives a clinically-oriented approach to care in facilities where the nearest specialist may be 50 to 800 miles away. Like the course focus and text, the faculty for the course is experienced with care in the Indian health setting.

OPTIONAL NEONATAL RESUSCITATION PROGRAM (NRP) COURSE

The NRP provider course will be offered in conjunction with the regular course. This four and a half hour course will be held on Sunday morning September 14 from 8am to 12:30pm.

CONTINUING EDUCATION CREDIT

The American College of Obstetricians and Gynecologists (ACOG) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

This activity has been approved for AMA PRA Credit

The Indian Health Service Clinical Support Center (CSC) is accredited as a provider of continuing education for nurses by the American Nurses Credentialing Center (ANCC) Commission on Accreditation.

REGISTRATION

Registration will be on a first come first served basis. Tuition, travel, and per diem expenses are the responsibility of the attendee or the sponsoring Indian health program. Scholarships covering tuition and lodging are available. Register now for the best scholarship opportunity! *Send your completed registration form to* Yvonne Malloy, ACOG, 409 12th Street SW Washington, DC 20024 (phone: 202-863-2580; fax: 202-484-3917).

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Please register me for the postgraduate course to be held September 14-18, 2008. I have checked the appropriate registration boxes below:

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☐ **Please enroll me in the NRP course for an additional early registration fee of $75.**

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Achieving Excellence, Harmony, and Balance

Transforming health professions education in American Indian and Alaska Native communities

Pathways Into Health is a grassroots collaboration of more than 200 individuals and organizations dedicated to improving the health, health care and health care education of American Indians and Alaska Natives (AI/AN). We are combining the expertise, resources, and strength of Tribes and AI/AN organizations, tribal colleges, prominent universities, the Indian Health Service and American Indian and Alaska Native communities as we work together to solve a major problem that exists today — the shortage of AI/AN healthcare professionals.

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1 Cultural Attunement
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Location: Alyeska Resort
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Questions? Contact Lesley Craig, Lesley.Craig@hhs.gov

The Effects of an Employee Incentive Program on Patient Visits and Revenue in an Urban Dental Clinic

Greg Goddard, DDS, Consultant to the CEO, The Native American Health Center, Inc.; Carolyn Brown, DDS, San Francisco Dental Director, The Native American Health Center, Inc.; and Sridevi Ponnala, DDS, San Francisco Assistant Dental Director, Clinical Services, The Native American Health Center, Inc.; San Francisco, California

Abstract

Two employee incentive programs in two Urban Dental Clinics are instituted in order to investigate the effects on revenue and patient visits. At the outset, the Oakland Clinic served as a control clinic while the San Francisco clinic incentive program was being initiated. This prospective study then compares pre-incentive and post-incentive productivity and revenue data in the two urban Indian community clinics once the incentive were available at both locations. The study demonstrates that the revenue collected was increased by 49 % in San Francisco and 59 % in Oakland. The number of patient visits increases by 38 % in San Francisco and 67 % in Oakland under the incentive program. The Oakland Clinic had a stable flow of revenue and patient visits during the time that the SF Clinic was being evaluated but before its incentive program began. This study suggests that an employee incentive program can be an effective tool to increase productivity and revenue while maintaining patient satisfaction with oral health services.

Introduction

The American Indian community in the Bay Area organized and incorporated the Urban Indian Health Board (UIHB) in 1972 to open its first Native American Health Center in San Francisco. In 1976, a second site was opened in Oakland. Today Native American Health Center (NAHC) is a full-service clinic with locations in Oakland, San Francisco, and Alameda dedicated to making health services available to American Indians and non-Indians in the Bay Area. The Native American Health Center has 17 different funding sources, local, state, Federal, and private. The major source of funding is revenue collected from services provided through Medicaid.

The ethnicity of patients served in 2005 (San Francisco and Oakland clinics) was as follows: Native American, 20%; African American, 16%; Latino, 30%; Asian\Pacific Islander, 11%; Caucasian, 18%; and Other\unknown, 5%. The total numbers of patients served in 2005 were as follows: San Francisco Clinic, 3,313 patients with 10,504 total visits; Oakland Clinic, 12,051 patients with 16,350 total visits; total 15,364 patients with 26,854 total visit.

An employee incentive program was implemented in Native American Health Center, San Francisco, in January 2003. During this time the Oakland clinic did not have an incentive program and acted as a control. This incentive program was put in place to guide the dental team of salaried dentists and dental auxiliaries in achieving their goals and to motivate the staff. The problems faced during the pre-incentive period were the following:

1. Providers preferred to reschedule their patients who were late rather than attempting to accommodate them.
2. Dental staff members were unwilling to see walk-in patients.
3. The no-show rate was 45%.

The Dental Employee Incentive program plan was to collect and analyze data to measure the increase of income and patient visits. In May 2004, the same incentive program with similar goals and pre-incentive problems was instituted at the Native American Health Center, Oakland. The two dental programs are operated by the same entity, but are considered separate sites. Both sites had two full time salaried dentists, two dental assistants, and a receptionist.

A Medline search (1981-2006) utilizing the key words incentive plans, bonuses, financial rewards, productivity, dental/dentist/dentistry/ other health professions was performed. The search returned 79 articles related to incentive programs in health clinics. There were none on urban dental clinics, but there were some articles addressing private dental clinics.[1,2,3,4] The current paper addresses these shortcomings by examining the effect of an incentive program in an urban Indian clinic focusing mainly on increasing revenue to clinic and increasing patient visits.

Methods

To qualify for the employee incentive program for the day, the staff member must be on time and be present the whole day. The dentist's incentive compensation of $5 per patient begins with the 10th patient of the day. Each auxiliary staff is compensated $2 per patient per dentist starting with the tenth patient. If, for example, two dentists treat eleven patients each (two incentive patients each) on a given day, the auxiliary staff who are on time and present all day would receive $2 per patient for four incentive patients, an $8 incentive compensation for the day. Auxiliary staff, under this program,

includes dental assistants, and front and back office staff. Each dentist, in this example, would receive $10 for the day for the two incentive patients. The Health-Pro™ software system was used to track patient visits, and our fiscal department tracks revenue. A prospective study was designed at the time of implementing the Dental Incentive program. The pre-incentive data and the post-incentive data were analyzed and compared on a quarterly basis. Staffing patterns for both the pre-incentive and post-incentive years were the same: 2.0 FTE dentists and 3.0 FTE dental assistants for each clinic.

Results

In Table 1, the San Francisco pre-incentive revenue averaged $102,376 per quarter. Since the incentive program was initiated, the amount of revenue collected has averaged $152,579 per quarter, an increase of 49%, or $50,203 more per quarter. In San Francisco, the average number of patient visits increased from 946 patient visits per quarter before the incentive program to 1,311 patient visits under the incentive program (Table 2). This is an increase in patient visits of 365 per quarter, a 39% increase.

As seen in Table 3, the Oakland pre-incentive revenue averaged $114,698 per quarter. Since the incentive program was initiated, the amount of revenue collected averages $182,762 per quarter, an increase of 59%, or an average of $68,069 increase per quarter. In Oakland, the average number of patients seen increased from 984 patient visits per quarter pre-incentive program to 1,474 patient visits per quarter under the incentive program (Table 4). This is an increase of 490 patient visits per quarter, a 40% increase.

The Oakland clinic acted as a control for the San Francisco incentive program during the first three quarters of 2003 while the San Francisco clinic was implementing the incentive program. The Oakland clinics patient visits remained consistent during that time period, and revenue stayed consistent for the first and third quarters and rose during the second quarter (see Table 5).

Table 1. NAHC- San Francisco Dental Dept. Quarterly Revenue Comparison 2002-2003

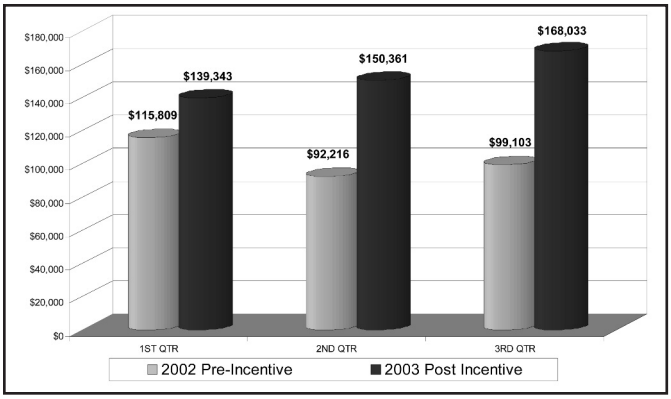


Table 2. NAHC- San Francisco Dental Dept. Pts Served Comparison 2002-2003

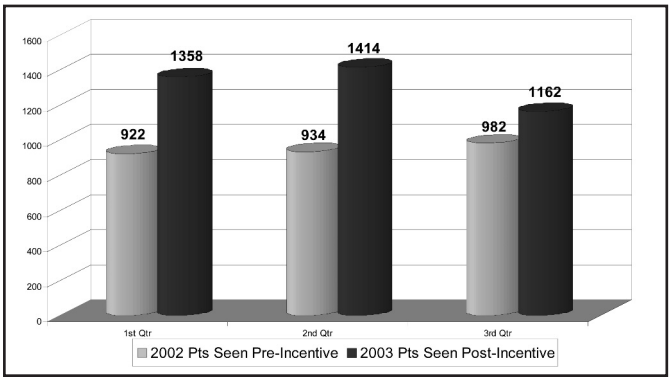


Table 3. NAHC- Oakland Dental Dept. Pts Served 2002-2003

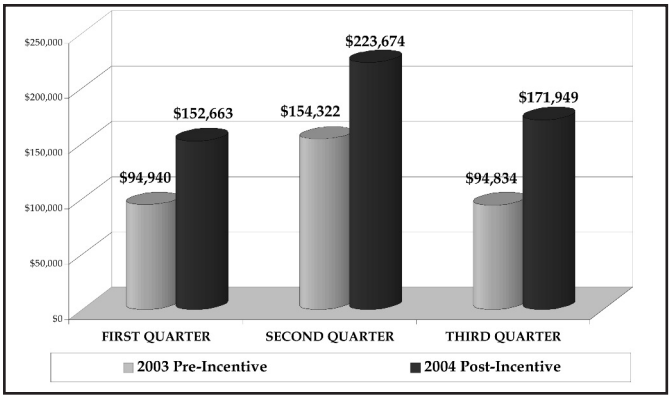


Table 4. NAHC- Oakland Dental Dept.Pts Served 2003-2004

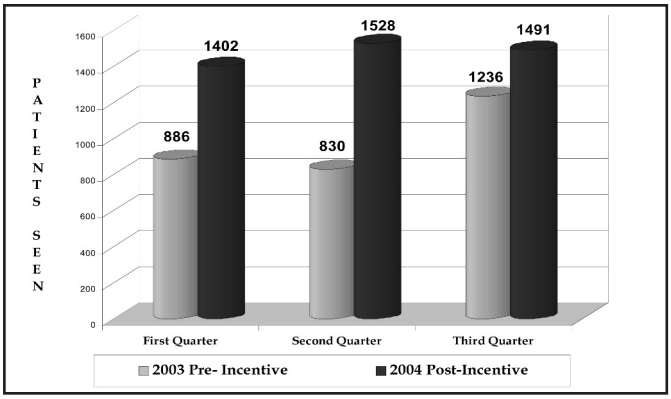
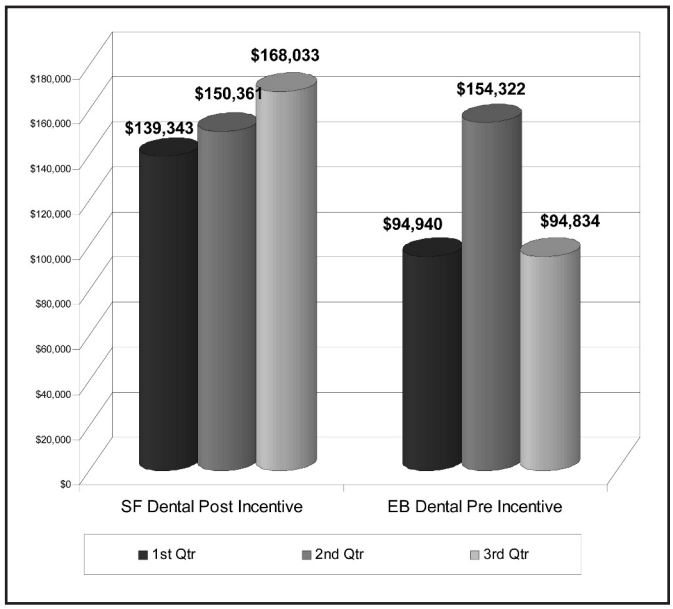


Table 5. NAHC Quarterly Revenue Comparison SF Dental vs Dental Year 2003



Discussion

Roger Levin, in an article entitled *Employee Incentive Program*, states that one great benefit of employee incentive programs is that they connect team compensation with practice performance. Options are always available to keep the program exciting and motivating.[2] In order to encourage desired staff behaviors, incentive systems can be designed for any or all employee dentists, assistants, hygienists, and managers.[4]

Our Dental Incentive program positively affected revenue and patient visits, and maintained a high level of patient satisfaction. Under the plan, the staff functions as a team, united in the goal of increasing production in order to receive their incentive bonus pay. As a negative, the staff reported an unexpected tax bill at the end of the 1st year of the incentive program, as taxes were not taken out of incentive checks. This problem was remedied by having taxes deducted out of the incentive pay. Incentive paid out on average for the whole staff was about $1,200 per month, equaling about 5 % of the increased revenue generated that month. Our incentive program helped in decreasing the no-show rate of patients, even though we did not measure those rates.

The pre-incentive revenue ranges from as low as $92,216 to as high as $154,322 per quarter. Please note that the revenue collected from the third parties rolls over to subsequent months due to billing issues. Patient visits and revenues vary from month to month, typically being lowest during the holiday months of November and December, when patients are reluctant to come in and there are many days that the clinics are closed.

Patient satisfaction surveys are taken annually. During each year of the incentive program, the patient satisfaction surveys demonstrated that patients were very satisfied with their care and treatment; 92 % of patients responded positively.

The incentive program was only studied over a 9-month period because there was an increase in staffing after the 9 months.

There is always the risk that providers would provide fewer services in order to see more patients and receive more incentive pay. However, the amount of incentive paid, $5, was not a very significant percentage of the dentist salaries, so it did not seem to motivate them to do less. On the other hand, the $2 incentive that the dental auxiliaries received was a significant monthly bonus for them, ranging between $150 and $200 per month. It seems that the dental team, which is mainly made up of auxiliaries, controls patient flow into the clinic. The receptionist made sure patients showed up for their appointments, and if not, then scheduled other patients in their place. The dental assistants did not complain when an extra emergency or a late patient was taken into the clinic. The dental team worked as a whole to see more patients and this increased revenue and provided a significant incentive bonus to the auxiliaries and to a lesser extent, the dentists. This study did not measure the number of procedures or service minutes, but we used revenue in dollars as a measure of services. Since the revenue increased significantly, it seems reasonable to assume that services also increased with the incentive program.

There were several potential confounding variables that were not taken into account in this study. Even though we used the Oakland clinic as a control at the outset, there could have been specific local variations in that clinic that would not be accounted for in our study. Also, there could be increases in patient visits and revenues due to a specific dentist that was very productive, and worked in a certain clinic at a certain time. There are different managers in each clinic that exert different motivational skills, and this could affect revenues and patient visits. The staff could have performed at a higher level just because they were being studied, and there was a stated goal of increasing production. This would make management happier. Given that this is a pilot study and many variables were not controlled, further study would be appropriate in order to see if these results could be replicated.

Conclusion

Our dental incentive program helped increase the number of patients served per day, thereby increasing the revenue to the clinic. Motivating dentists and staff to see at least ten patients per day per dentist promotes buying into the program, teamwork, and cooperation.

The average number of patients seen prior to the dental incentive program was 946 per quarter at the San Francisco site and 984 at Oakland site. Under the incentive program, the average number of patient visits increased at the Oakland site by about 40% and revenue collected increased by 59% over a

period of nine months. At the San Francisco site, the revenue generated increases by 49% and patients served by 39% over the 9-month period. This study suggests that an incentive program can be an effective method of increasing clinic revenues and seeing more patients while maintaining patient satisfaction.

Acknowledgements

We would like to give special thanks to Eraina Persson, San Francisco NAHC Director, Evaluation and Projects, and Jenny Lam, Oakland NAHC Dental Office Manager, for their assistance in compiling data and graphs.

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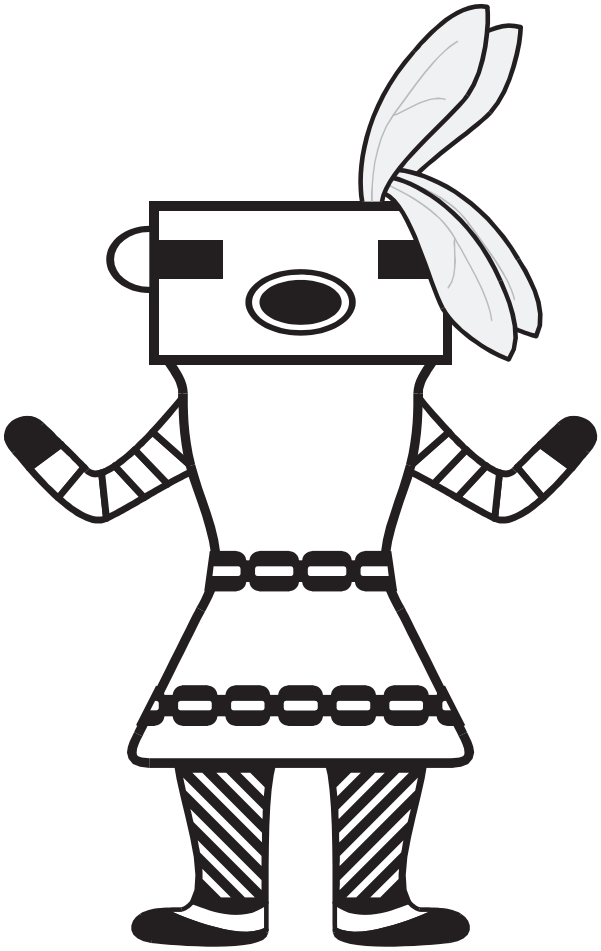


Ninth IHS Open Door Forum to be Held July 24

The Indian Health Service (IHS) quarterly Open Door Forum will be held on July 24, 2008. This 9th Forum will focus on innovative efforts to use telehealth tools in support of Behavioral Health, Chronic Care, and Health Promotion/Disease Prevention. Presenters from a range of disciplines and expertise within the Indian health system will highlight their experience with new models of service delivery. Presentations will be broadcast live via a real-time Internet webcast. A Forum agenda and details regarding how to participate from computers and desktops across the country will be available by early July.

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

"*Anger is contagious*."

Sandra Cisneros

Articles of Interest

Identification and evaluation of children with autism spectrum disorders. *Pediatrics*. November 2007;120(5):1183-1213.

Management of children with autism spectrum disorders. *Pediatrics*. November 2007;120:5;1161-1182.

These two clinical reports published in *Pediatrics* in November 2007 provide a complete summary for the clinician on autism spectrum disorders (ASDs). The review last month highlighted the identification and evaluation of children with autism spectrum disorders. The review this month will describe management strategies.

Autism Spectrum Disorders (ASDs) are not rare, with an estimated frequency in Europe and North America of 1/150 births. Given this frequency, most primary care providers will care for several patients with this disorder. ASDs, like other neurodevelopmental disorders, are generally not curable, but can benefit from management like other chronic diseases. The goal is to minimize the deficits associated with ASD, such as speech impairment and social interactivity, while maximizing the potential of patients to function independently.

There are a variety of modalities used to treat ASDs. Relatively few of these have been rigorously evaluated. The most work has been done with applied behavior analysis, a form of behavior modification. Studies have shown improvement in IQ measurements, academic performance, and social adaptiveness. For interventions to be effective, they need to be intensive and sustained, which is defined as one-on-one teaching for a minimum of 25 hours/week.

Medical management is also discussed. Seizures occur in 20 - 40% of children with autism, and treatment is based on the same principles used to treat other children with epilepsy. Challenging behavior, especially behaviors that include aggression or self-injury, may benefit from a trial of medications. SSRIs have been used for the past decade. Recently risperidone has been licensed by the FDA for use for symptoms of irritability and aggression in children with ASDs.

Lastly, a large number of biological and non-biological treatments have been offered for treatment of ASDs. Appropriately designed trials have show no benefit for treatment with the following; dimethlyglycine, vitamin B6, magnesium, secretin, auditory integrative training, and facilitated communication. Many other treatments have not been rigorously evaluated but are offered to patients; these include immunotherapy, chelation, anti-fungals, various elimination diets, and complementary and alternative medicine. The physician's job is to help families use the best evidence to choose therapies with proven benefit and avoid therapies with potential risks.

Editorial Comment

There is no cure for ASDs. Medical therapies for ASDs are limited but may be of benefit for specific indications. Educational interventions have the most potential but require personnel who are familiar with ASDs and can devote intensive time treatment. There is good evidence that children need intervention as soon as the diagnosis of ASD is entertained and that the intervention needs to be intensive with a minimum of 25/hours a week. This kind of expertise and intensive treatment could be made available through Head Start or public schools. The reality in many rural settings is that these patients may struggle to get the services they need. The physician's job is to be an advocate at the school for needed services.

Infectious Disease Updates.

Rosalyn Singleton, MD, MPH

Michael L. Bartholomew, MD

In a moment of unconscious communication, Drs. Singleton and Bartholomew both submitted reviews of the same article. This study demonstrates that the persistence of substandard housing and plumbing accounts for at least some of the continuing disparity in infectious disease burden for AI/AN children. As physicians, we often focus on medical determinants, such as vaccines and antibiotics, and may overlook many of the other important factors in health.

Hennessy TW, Ritter T, Holman RC, et al. The Relationship between in-home water service and the risk of respiratory tract, skin, and gastrointestinal tract infections among rural Alaska Natives. *American Journal of Public Health*. May 2008 Vol 98 No. 5.
http://www.ncbi.nlm.nih.gov/pubmed/18382002?ordinalpos=

2&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_RVDocSum

Modern water and sanitation services have long been known to be important in improving health and reducing the transmission of infectious diseases. During the first half of the 20th century, multiple surveys attempting to assess the health status of American Indians and Alaska Natives (AI/AN) cited a lack of water and waste disposal services as significant causal factors to the high rates of infectious diseases among AIs and ANs.[1] In 1959, The Indian Sanitation Facilities Act (P.L. 86-121) authorized the Indian Health Service to provide water and sanitation services to homes and communities. Since its inception, the impact on Native health has been dramatic, with reductions in morbidity and mortality from infectious diseases among AI/ANs.

This study investigates the relationship between modern sanitation services (in-home water services and wastewater disposal services) and hospitalization rates for respiratory, skin, and gastrointestinal tract infections in rural Alaska villages. Between 2000 and 2004, in-home water and waste disposal services were surveyed and analyzed in rural villages within defined regions in Alaska. Water service data for one region (Region A) was further examined on a village level. Additionally, regional and village level (Region A) hospitalization rates for infectious gastroenteritis, pneumonia or influenza, RSV among children less than 5 years, skin or soft tissue infection, and methicillin resistant *Staphylococcus aureus* (MRSA) infections were obtained and compared.

Overall, in-home water service was present in 73% (range 57% - 100%) of homes, while 71 % (range 55% - 100%) of homes had wastewater services. This is in comparison to the 99.4% of homes in the US with modern sanitation services. Unevenly distributed, 61% of homes had in-home water service within Region A (designated a low service area). Thirty percent of the population (less than 10% of homes) within Region A lived in homes that lacked modern sanitation. The largest town had 99.5% of homes with in-home water service, accounting for 23% of the Region A's population.

Regional hospitalization rates differed by water service level. Children less than 5 years of age living in low service regions were 3.4 times more likely to be hospitalized for RSV than children living in high service regions (95%CI=3.0,3.8). This trend can also be seen in all ages with pneumonia or influenza (RR=2.5; 95% CI= 2.4, 2.7)), skin or soft tissue infections (RR=1.9; 95% CI=1.8, 2.1)), and MRSA infections (RR=4.5; 95% CI=3.6, 5.7)). Hospitalization rates between high and low service regions for infectious gastroenteritis showed no difference. This may be related to the adequate availability of safe drinking water to all homes, low temperature of the water, and nutritional status of the population. Within Region A, hospitalization rates for lower respiratory tract infections (LRTI), pneumonia, and RSV among infants were the highest in villages where less 10% of homes had in-home water service. Significant trends of decreasing rates of hospitalizations of infants with LRTI and LRTI with pneumonia, skin and soft tissue infections, *Staphylococcus aureus* infections and MRSA infections were seen with increase proportions of homes with in-home water service.

Despite the inability to draw causal conclusions, the results strongly suggest an association between water service and infectious disease. In-home water service is an important public health intervention. The authors conclude from the results of this study that the simple intervention of providing modern water and sanitation to all homes in rural Alaska villages would significantly improve health of Alaska native children. The same can be said for all homes on tribal lands.

Reference:

1. Galloway JM, Goldberg BW, Alpert JS. 1999. *Primary Care of Native American Patients: Diagnosis, Therapy, and Epidemiology*. Boston: Butterworth-Heinemann

Editorial Comment by Dr Singleton:

The study, published in *The American Journal of Public Health*, demonstrated that RSV hospitalization rates (Relative Rate [RR] = 3.4 in children <5 years), pneumonia and influenza hospitalization rates (RR=2.5), and skin or soft tissue infection rates (RR=1.9) were higher in Alaska regions with low levels of water service than those with high levels of service. Diarrheal disease hospitalizations were uncommon and rates were similar throughout Alaska; each village has a supply of potable water.

Lack of clean water and wastewater disposal may contribute to respiratory and skin infections by making hand washing and body hygiene more difficult because families are conserving water for cooking and drinking. In many other parts of Indian Country, the lack of in-home water service is similar to rural Alaska. This study highlights the importance of addressing non-medical household determinants of health through construction of in-home sanitation services. Providing these basic services has the potential to reduce respiratory, skin and diarrheal diseases, through availability of adequate amounts of potable water for consumption and hygiene.

The Chief Clinical Consultant's Newsletter (Volume 6, No. 3, March 2008) is available on the Internet at http://www.ihs.gov/MedicalPrograms/MCH/M/OBGYN01.cfm. *We wanted to make our readers aware of this resource, and encourage those who are interested to use it on a regular basis. You may also subscribe to a listserv to receive reminders about this service. If you have any questions, please contact Dr. Neil Murphy, Chief Clinical Consultant in Obstetrics and Gynecology, at nmurphy@scf.cc.*

OB/GYN Chief Clinical Consultant's Corner Digest

Abstract of the month

Metformin versus insulin for the treatment of gestational diabetes

Background: Metformin is a logical treatment for women with gestational diabetes mellitus, but randomized trials to assess the efficacy and safety of its use for this condition are lacking.

Methods: We randomly assigned 751 women with gestational diabetes mellitus at 20 to 33 weeks of gestation to open treatment with metformin (with supplemental insulin if required) or insulin. The primary outcome was a composite of neonatal hypoglycemia, respiratory distress, need for phototherapy, birth trauma, 5-minute Apgar score less than 7, or prematurity. The trial was designed to rule out a 33% increase (from 30% to 40%) in this composite outcome in infants of women treated with metformin as compared with those treated with insulin. Secondary outcomes included neonatal anthropometric measurements, maternal glycemic control, maternal hypertensive complications, postpartum glucose tolerance, and acceptability of treatment.

Results: Of the 363 women assigned to metformin, 92.6% continued to receive metformin until delivery and 46.3% received supplemental insulin. The rate of the primary composite outcome was 32.0% in the group assigned to metformin and 32.2% in the insulin group (relative risk, 1.00; 95% confidence interval, 0.90 to 1.10). More women in the metformin group than in the insulin group stated that they would choose to receive their assigned treatment again (76.6% vs. 27.2%, P<0.001). The rates of other secondary outcomes did not differ significantly between the groups. There were no serious adverse events associated with the use of metformin.

Conclusions: In women with gestational diabetes mellitus, metformin (alone or with supplemental insulin) is not associated with increased perinatal complications as compared with insulin. The women preferred metformin to insulin treatment.

Rowan JA, et al. Metformin versus insulin for the treatment of gestational diabetes. *N Engl J Med*. 2008 May 8;358(19):2003-15.

OB/GYN CCC Editorial Comment

We have been waiting a long time for this study

Metformin is a much better physiologic fit for GDM than glyburide because metformin essentially sensitizes the muscles to what is an already relatively elevated insulin level. Though metformin is a Pregnancy Class B agent, we have been reluctant to use it widely because it can cross the placenta, and randomized trials to assess the efficacy and safety of its use for this condition are lacking. Please see the Ecker and Greene NEJM Editorial for more comments.

Ecker JL, Greene MF. Gestational diabetes -- setting limits, exploring treatments. *N Engl J Med*. 2008 May 8;358(19):2061-3.

From your colleagues

Chuck North, HQE

Effect of lower targets for blood pressure and LDL cholesterol on atherosclerosis in diabetes: the SANDS randomized trial in Native Americans

Context: Individuals with diabetes are at increased risk for cardiovascular disease (CVD), but more aggressive targets for risk factor control have not been tested.

Objective: To compare progression of subclinical atherosclerosis in adults with type 2 diabetes treated to reach aggressive targets of low-density lipoprotein cholesterol (LDL-C) of 70 mg/dL or lower and systolic blood pressure (SBP) of 115 mm Hg or lower vs standard targets of LDL-C of 100 mg/dL or lower and SBP of 130 mm Hg or lower.

Design, Setting, and Participants: A randomized, open-label, blinded-to-end point, 3-year trial from April 2003 - July 2007 at four clinical centers in Oklahoma, Arizona, and South Dakota. Participants were 499 American Indian men and women aged 40 years or older with type 2 diabetes and no prior CVD events.

Results: Mean target LDL-C and SBP levels for both groups were reached and maintained. Mean (95% confidence interval) levels for LDL-C in the last 12 months were 72 (69 - 75) and 104 (101 - 106) mg/dL and SBP levels were 117 (115 - 118) and 129 (128 - 130) mm Hg in the aggressive vs standard groups, respectively. Compared with baseline, IMT

regressed in the aggressive group and progressed in the standard group (-0.012 mm vs 0.038 mm; P < .001); carotid arterial cross-sectional area also regressed (-0.02 mm(2) vs 1.05 mm(2); P < .001); and there was greater decrease in left ventricular mass index (-2.4 g/m(2.7) vs -1.2 g/m(2.7); P = .03) in the aggressive group. Rates of adverse events (38.5% and 26.7%; P = .005) and serious adverse events (n = 4 vs 1; P = .18) related to blood pressure medications were higher in the aggressive group. Clinical CVD events (1.6/100 and 1.5/100 person-years; P = .87) did not differ significantly between groups.

Conclusions: Reducing LDL-C and SBP to lower targets resulted in regression of carotid IMT and greater decrease in left ventricular mass in individuals with type 2 diabetes. Clinical events were lower than expected and did not differ significantly between groups. Further follow-up is needed to determine whether these improvements will result in lower long-term CVD event rates and costs and favorable risk-benefit outcomes.

Howard BV, et al. Effect of lower targets for blood pressure and LDL cholesterol on atherosclerosis in diabetes: the SANDS randomized trial. *JAMA*. 2008 Apr 9;299(14):1678-89.

Comment in: Peterson ED, Wang TY. The great debate of 2008 -- how low to go in preventive cardiology? *JAMA*. 2008 Apr 9;299(14):1718-20.

Comments from Dr. North

This important study is worth reading and considering when setting goals. Congratulations to the patients, communities, and authors for making this contribution to improve care.

Hot topics

Obstetrics

HAPO Study Cooperative Research Group: Hyperglycemia and adverse pregnancy outcomes

Background: It is controversial whether maternal hyperglycemia less severe than that in diabetes mellitus is associated with increased risks of adverse pregnancy outcomes.

Methods: A total of 25,505 pregnant women at 15 centers in nine countries underwent 75-g oral glucose-tolerance testing at 24 to 32 weeks of gestation. Data remained blinded if the fasting plasma glucose level was 105 mg per deciliter (5.8 mmol per liter) or less and the 2-hour plasma glucose level was 200 mg per deciliter (11.1 mmol per liter) or less. Primary outcomes were birth weight above the 90th percentile for gestational age, primary cesarean delivery, clinically diagnosed neonatal hypoglycemia, and cord-blood serum C-peptide level above the 90th percentile. Secondary outcomes were delivery before 37 weeks of gestation, shoulder dystocia or birth injury, need for intensive neonatal care, hyperbilirubinemia, and preeclampsia.

Results: For the 23,316 participants with blinded data, we calculated adjusted odds ratios for adverse pregnancy outcomes associated with an increase in the fasting plasma glucose level of 1 SD (6.9 mg per deciliter [0.4 mmol per liter]), an increase in the 1-hour plasma glucose level of 1 SD (30.9 mg per deciliter [1.7 mmol per liter]), and an increase in the 2-hour plasma glucose level of 1 SD (23.5 mg per deciliter [1.3 mmol per liter]). For birth weight above the 90th percentile, the odds ratios were 1.38 (95% confidence interval [CI], 1.32 to 1.44), 1.46 (1.39 to 1.53), and 1.38 (1.32 to 1.44), respectively; for cord-blood serum C-peptide level above the 90th percentile, 1.55 (95% CI, 1.47 to 1.64), 1.46 (1.38 to 1.54), and 1.37 (1.30 to 1.44); for primary cesarean delivery, 1.11 (95% CI, 1.06 to 1.15), 1.10 (1.06 to 1.15), and 1.08 (1.03 to 1.12); and for neonatal hypoglycemia, 1.08 (95% CI, 0.98 to 1.19), 1.13 (1.03 to 1.26), and 1.10 (1.00 to 1.12). There were no obvious thresholds at which risks increased. Significant associations were also observed for secondary outcomes, although these tended to be weaker.

Conclusions: Our results indicate strong, continuous associations of maternal glucose levels below those diagnostic of diabetes with increased birth weight and increased cord-blood serum C-peptide levels.

HAPO Study Cooperative Research Group Hyperglycemia and adverse pregnancy outcomes. *N Engl J Med*. 2008 May 8;358(19):1991-2002.

OB/GYN CCC Editorial Comment

We have been waiting an even longer time for this study

Dr. Donald Coustan explained the HAPO process to the assembled group at the American Indian Women's Health and MCH Conference in August 2007. The HAPO group will now discuss whether these findings can help delineate a new set of GDM criteria. The discussion will take place at the International Association of the Diabetes and Pregnancy Study Group. Please see the Ecker and Greene *NEJM* Editorial for further comments.

Ecker JL, Greene MF. Gestational diabetes -- setting limits, exploring treatments. *N Engl J Med*. 2008 May 8;358(19):2061-3.

Gynecology

Management of Trichomonas vaginalis in women with suspected metronidazole hypersensitivity

Background: Standard treatment for Trichomonas vaginalis is metronidazole or tinidazole. Hypersensitivity to these drugs has been documented but is poorly understood. Desensitization is an option described in limited reports of women with hypersensitivity to nitroimidazoles. The purpose of this analysis is to improve documentation of management for trichomonas infections among women with metronidazole hypersensitivity.

Design: Clinicians who consulted Centers for Disease Control and Prevention concerning patients with suspected hypersensitivity to metronidazole were provided with

treatment options and asked to report outcomes.

Results: From September 2003 - September 2006, complete information was obtained for 59 women. The most common reactions were urticaria (47%) and facial edema (11%). Fifteen of these women (25.4%) were treated with metronidazole desensitization and all had eradication of their infection. Seventeen women (28.8%) were treated with alternative intravaginal drugs, which were less successful; 5 of 17 infections (29.4%) were eradicated.

Conclusion: Metronidazole desensitization was effective in the management of women with nitroimidazole hypersensitivity.

Helms DJ, Mosure DJ, Secor WE, et al. Management of *Trichomonas vaginalis* in women with suspected metronidazole hypersensitivity. *Am J Obstet Gynecol*. 2008;198:370.e1-370.e7.

Child Health

Breastfeeding Promotion: A Rational and Achievable Target for a Type 2 Diabetes Prevention Intervention in Native American Communities

Abstract: Type 2 diabetes is a serious, costly, and increasingly common disease among Native American communities. Increasing evidence suggests that early infant nutrition, particularly breastfeeding, may have a significant impact on the development of diabetes in later life. In this report, the authors describe the scientific basis and development of an innovative program that targets promotion of breastfeeding among Native women as a type 2 diabetes prevention intervention. The program materials, evaluation methods, and outcomes are presented. By developing and sharing strategies that effectively support breastfeeding, the impact of diabetes in Native American communities will be reduced.

Murphy S, Wilson C. Breastfeeding promotion: a rational and achievable target for a type 2 diabetes prevention intervention in Native American communities. *J Hum Lact*. 24(2):193-198.

OB/GYN CCC Editorial Comment

Diabetes Prevention Intervention in Native American Communities

Breastfeeding represents a unique opportunity for diabetes prevention. This report comes from the front lines of Indian Health Service Breastfeeding Advocacy and Diabetes Care, Phoenix Indian Medical Center.

Chronic Illness and Disease

Awareness of Stroke Warning Symptoms

Early recognition of the signs and symptoms of stroke and the need for victims or bystanders to immediately call 911 at the onset of symptoms is a matter of life and death. The five signs and symptoms of stroke include:

- Sudden numbness or weakness of the face, arms, or legs
- Sudden confusion or trouble speaking or understanding others
- Sudden trouble seeing in one or both eyes
- Sudden trouble walking, dizziness, or loss of balance or coordination
- Sudden severe headache with no known cause

Although the number of deaths from stroke have declined since the 1960s, more than half (54 percent) of US stroke deaths occur outside a hospital. A new CDC study revealed that less than half (44 percent) of people when asked about their awareness of the signs and symptoms of a stroke knew all five symptoms of a stroke, and only 38 percent of respondents knew to call 911 if they thought someone was having a stroke. This study, Disparities in Adult Awareness of Stroke Warning Signs and Symptoms, analyzed 2005 Behavior Risk Factor Surveillance Study data from 13 states and the District of Columbia and found there was no improvement in the publics′ awareness of stroke symptoms since a similar study conducted in 2001.

Awareness of Stroke Warning Symptoms -- 13 States and the District of Columbia, 2005 *MMWR*, May 9, 2008 / 57(18);481-485.

Breastfeeding

Suzan Murphy, PIMC

Supporting breastfeeding without money or a lot of time

Since obesity and its complications, including type 2 diabetes, have reached epidemic rates, health care planners are very eager for ways to reduce risk. At the moment, there are no promises of cure, but there are many different ways to reduce risk. Breastfeeding is one way.

But making breastfeeding work is not always easy. There are many distractions and barriers. Extra use of plastic nipples, pacifiers, and formula can slow down the lactation start up process. Painful latch, ineffective suck, jaundice, poor infant weight gain, engorgement, cracked and bleeding nipples, and well-meant-but-inaccurate information can end the best intentions to breastfeed. Reassuring anxious dads, friends, and relatives that "Yes, the baby is getting enough and yes, the milk is good" can be overwhelming for new moms and challenging for providers. Managing breastfeeding, childcare, and work/school can be exhausting for new families. Keeping track of how breastfeeding support interventions are working can be time consuming and frustrating for health care planners and providers.

But – there is hope. Thanks to technology and the Internet, there are more resources and reliable answers available than ever before. There are free materials available via Indian Health Service on-line resources like the MCH breastfeeding page at *www.ihs.gov/MedicalPrograms/MCH/M/bf.cfm*. There are downloadable patient education materials (under Staff

Resources), and a direct link to the amazing IHS Diabetes Education on-line catalog (click on the Indian Health Service link by the picture of the pink/salmon Easy Guide to Breastfeeding). This includes a lot of free, helpful, culturally appropriate materials, including the Easy Guide (under pregnancy). The materials can be ordered on line and are shipped promptly and for free. A free NIH/IHSvideo, "Close to the Heart: Breastfeeding our Children Honoring our Values" can be requested at 1-877-868-9473. The video is also part of a DVD that has other diabetes wellness/prevention stories; the DVD is 45 minutes long and looped so it can play over and over in the waiting room. Examples of other web pages that are especially helpful are the Centers for Disease Control (*www.cdc.gov*) – great for the latest on diseases/issues that impact lactation; American Academy of Pediatrics (*www.aap.org*) – helpful policies; DHHS/Office of Women's Health (*www.4women.gov*) – excellent resources for new moms; WIC (*www.fns.usda.gov/wic/benefitsandservices/*) – wonderful family friendly resources for breastfeeding; and NIH Lactation and Medication search engine (*http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT*) – quick, reliable, current research on maternal medication and breast milk.

Getting data? Electronic Health Records (EHR) can make it easy. When a baby is seen, click on visit data (visit element tab), at Personal Health click on "To add, select," then from the pull down menu, select infant feeding, push "add," and the big work is done. Feeding choice can be done at each visit. RPMS will track feeding choice by visit date. If it looks like last month's info disappeared, don't worry, it really didn't. The other variables, such as birth order, birth weight, mother's name, age of introduction of solids, and age of starting formula/stopping breastfeeding can be added by using the pull down menu and picking birth measurement. It is a short learning curve.

Need a report? CRS can report your progress for exclusively and mostly breastfeeding at predetermined ages. You can also do customized progress checks by using a vgen or qman searches. For more details, please check with your IT or EHR Department, or call us at 1-877-868-9473.

Reference: Online

STD Corner

Lori de Ravello, National IHS STD Program

Adolescent Sexual Risk: Factors Predicting Condom Use Across the Stages of Change

This study examined factors associated with high-risk adolescents' movement toward or away from adopting consistent condom use behavior using the Transtheoretical Model Stages of Change. Participants drawn from the inactive comparison condition of a randomized HIV prevention trial (Project SHIELD) responded to items assessing pros and cons of condom use, peer norms, condom communication, and perceived invulnerability to HIV. Participants were categorized based on their condom use behavior using the Transtheoretical Model. Multiple logistic regressions found that progression to consistent condom use was predicted by continuing to perceive more advantages to condom use, reporting greater condom use communication with partners, and less perceived invulnerability to HIV. Movement away from adopting consistent condom use was predicted by a decrease in perceived advantages to condom use, increased perceived condom disadvantages, and fewer condom discussions. Future interventions may be tailored to enhance these factors that were found to change over time.

Grossman C, et al. Adolescent sexual risk: Factors predicting condom use across the stages of change, *AIDS Behav*. 2008 Apr 22.

Barbara Stillwater
Alaska State Diabetes Program

Trends in the prevalence of preexisting diabetes and gestational diabetes mellitus among a racially/ethnically diverse population of pregnant women, 1999-2005

Objective: The purpose of this study was to assess changes in the prevalence of preexisting diabetes (diabetes antedating pregnancy) and gestational diabetes mellitus (GDM) from 1999 through 2005.

Results: Preexisting diabetes was identified in 2,784 (1.3%) of all pregnancies, rising from an age- and race/ethnicity-adjusted prevalence of 0.81 per 100 in 1999 to 1.82 per 100 in 2005 (P(trend) < 0.001). Significant increases were observed in all age groups and all racial/ethnic groups. After women with preexisting diabetes were excluded, GDM was identified in 15,121 (7.6%) of 199,298 screened pregnancies. The age- and race/ethnicity-adjusted GDM prevalence remained constant at 7.5 per 100 in 1999 to 7.4 per 100 in 2005 (P(trend) = 0.07). Among all deliveries to women with either form of diabetes, 10% were due to preexisting diabetes in 1999, rising to 21% in 2005, with GDM accounting for the remainder.

Conclusions: The stable prevalence of GDM and increase in the prevalence of preexisting diabetes were independent of changes in the age and race/ethnicity of the population. The increase in preexisting diabetes, particularly among younger women early in their reproductive years, is of concern.

Lawrence JM, Contreras R, Chen W, Sacks DA. Trends in the prevalence of preexisting diabetes and gestational diabetes mellitus among a racially/ethnically diverse population of pregnant women, 1999-2005. *Diabetes Care*. 2008 May;31(5):899-904.

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.

The Pharmacy Practice Training Program (PPTP): A Program in Patient-Oriented Practice
July 14 - 17 and August 4 - 7, 2008; Scottsdale, Arizona

The goal of this four-day training program for pharmacists employed by the Indian Health Service or Indian health programs is to improve the participant's ability to deliver direct patient care. This program encompasses the management of patient care functions in the areas of consultation, communication, interviewing techniques, laboratory test interpretation, conflict resolution, physical assessment, and disease state management. The course is made up of case studies that include role playing and discussion, and provides 27 hours of pharmacy continuing education. For more information, contact CDR Ed Stein at the IHS Clinical Support Center; e-mail ed.stein@ihs.gov or look for "Seminars & Training" at http://www.ihs.gov/MedicalPrograms/ClinicalSupportCenter/. The meeting will be held at the Chaparral Suites Hotel, 5001 North Scottsdale Road, Scottsdale, Arizona 85258.

Sexual Assault Nurse Examiner (SANE) Training Program
July 21 - 25, 2008; Aberdeen Area Office
August 18 - 22, 2008; Oklahoma Area Office

The Sexual Assault Nurse Examiner (SANE) workshop is an intensive five-day course to familiarize health care providers with all aspects of the forensic and health care processes for sexual assault victims. This course emphasizes victim advocacy and the overall importance of being a member of the interdisciplinary Sexual Assault Response Team (SART) in the investigative, health care, and prosecution processes. Lead faculty for this course will be Linda Ledray, PhD, RN, a certified SANE trainer and Director of the Sexual Assault Resource Service (SARS) of Hennepin County Medical Center in Minneapolis, MN. Dr. Ledray is a nationally recognized expert and pioneer in the area of forensic nursing. These courses are open to Indian Health Service health care professionals, including nurses, advanced practice nurses, physician assistants, and physicians. For more information about the event, contact LCDR Lisa Palucci at the IHS Clinical Support Center, (602) 364-7777, e-mail lisa.palucci@ihs.gov, or visit the CSC website at http://www.ihs.gov/MedicalPrograms/ClinicalSupportCenter/.

Tenth Annual American Indian Elders Conference
September 3 - 5, 2008; Oklahoma City, Oklahoma

The Indian Health Service is once again sponsoring the Annual American Indian Elders Conference; this year's conference on better health and wellness will look to recognize the wisdom and contributions of "Our Teachers, Our Protectors, Our Elders." Participants will explore pathways for better health and provide positive examples for generations to follow.

The conference will be held September 3 - 5 2008 at the Clarion Meridian Hotel and Convention Center, Oklahoma City, Oklahoma. Onsite registration will begin in the afternoon on Tuesday, September 2.

The American Indian Elders Conference provides information on health education and wellness and recognizes the need to keep traditions and traditional values alive. Each year the planning committee selects issues affecting elders and invites participation from American Indian communities across the nation. Presentations will focus on various health-related issues including fitness, cancer, heart disease, diabetes, and mental health. Social issues such as domestic violence in Indian country and grandparenting will also be addressed.

For more information visit www.katcommunications.net/conferences. Register for this conference and subscribe to receive conference updates by e-mail, or call KAT Communications at (888) 571-5967.

ACOG/IHS "Denver" Course (Now in Salt Lake City, Utah)
Obstetric, Neonatal and Gynecologic Care
September 14 - 18, 2008; Salt Lake City, Utah

This annual women's health update for nurses, advanced practice clinicians, and physicians provides a four-day schedule of lectures, workshops, hands-on sessions, and team building. The large interdisciplinary faculty collaborates to teach clinical and practical topics as they apply in Indian health settings. Many faculty members are your colleagues in IHS and tribal facilities; private sector faculty also bring a wide range of experience providing Indian health care.

Learn the latest evidence-based approaches to maternal and child health services, and share problems and solutions with your colleagues from across Indian country. The course can also serve as a good foundation for professionals who are new to women's health care or new to the Indian health system.

In addition to the basic course, you may sign up for the Neonatal Resuscitation Program, and come away with your certificate from this convenient pre-course program. The opportunity to fulfill continuing education requirements in a concentrated format is significant: with the optional NRP, we can document your participation in seven half-days of education.

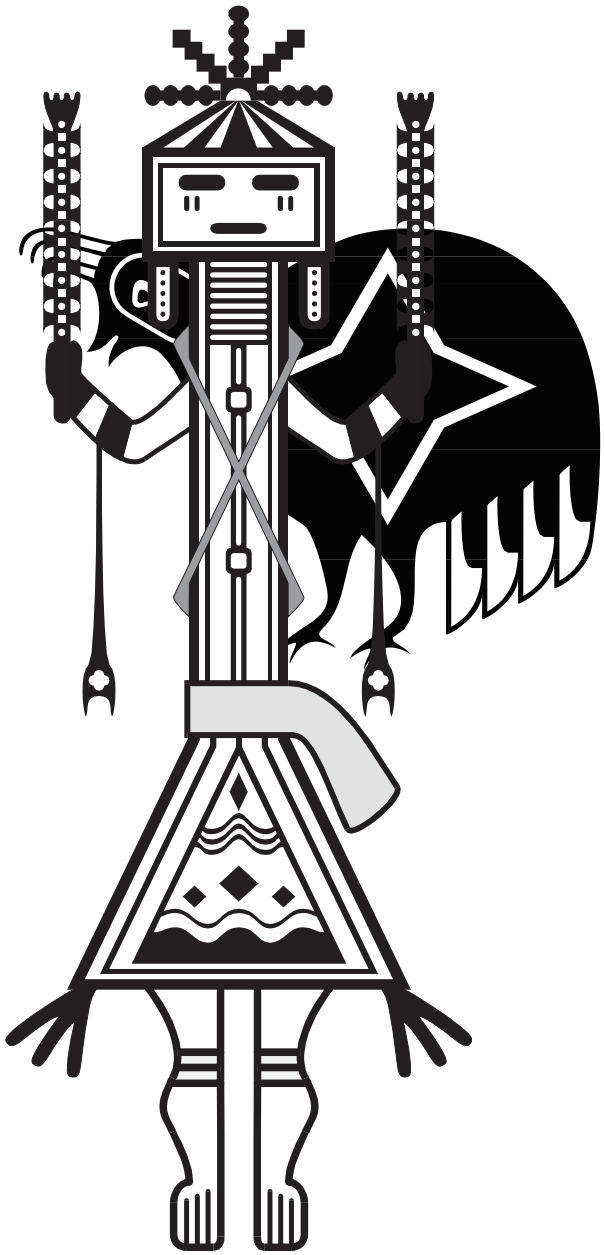
Sign up early! You'll have first chance for support from your facility and coverage for your time in Salt Lake City. Getting these benefits lined up takes time, so don't delay and miss out! In addition, early registration holds your place, and puts you in line for possible availability of scholarship funds.

Watch your mail for the course brochure and registration form. For more information, contact Yvonne Malloy at ymalloy@acog.org.

Childhood Obesity/Diabetes Prevention in Indian Country: Making Physical Activity Count!
December 2 - 4, 2008; San Diego, California

The target audience for this national conference includes health care providers, diabetes educators, school nurses, nutritionists, coaches, physical education teachers, fitness program directors, and other individuals involved in community or school based physical activity for Indian children and youth. Faculty for the conference includes a cross section of experts who will address successful physical activity interventions, technology in measuring physical activity outcomes, and selected programs that are successfully addressing childhood obesity and diabetes in Indian country. CME/CEUs will be available. Those interested in proposing a presentation or a poster on their success in addressing physical activity with American Indian children and youth are especially encouraged to apply.

The conference will be held at the Town and Country Resort and Convention Center. Sponsors of this conference include the Indian Health Service, Bureau of Indian Education (BIA), Active Living Research Center at San Diego State University, LIFESCAN, and the University of Arizona. To learn more about the conference, to register for the conference and/or to propose a paper or poster, visit http://nartc.fcm.arizona.edu/conference. Alternatively you can also call Ms. Pandora Hughes at the Native American Research and Training Center at (520) 621-5075 for additional information.



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 on an organizational letterhead to: Editor, THE IHS PROVIDER, The IHS Clinical Support Center, Two Renaissance Square, Suite 780, 40 North Central Avenue, Phoenix, Arizona 85004. Submissions will be run for two months, 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. The Indian Health Service assumes no responsibility for the accuracy of the information in such announcements.

Dentist
Staff 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 opportunities 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 several positions.

Dentist: Requires DDS/DMD degree from an American Dental Association accredited dental school, with two years of experience, preferably in general practice. Must have state licensure in good standing, valid driver's license with insurable record, and pass a background check. Salary DOE; part-time or full-time in Lapwai. Open until filled.

Staff Physician: Requires one to three years experience in family medicine/ambulatory care/prenatal care. Must be board certified or board eligible. Must have Idaho MD or DO license or obtain 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. Salary DOE; part-time or full-time in Lapwai. Open until filled.

Mid-Level Provider: 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. Must have valid driver's license with insurable record, and will be required to pass extensive background check. Salary DOE; full-time in Kamiah. Open until filled.

A complete application packet includes a NMPH job application, copy of current credentials, two references, resume or CV, a copy of your tribal identification or Certification of Indian Blood (CIB), if applicable, to Nimiipuu Health, 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. Indian preference applies.

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*.

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.

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.

Primary Care Physicians (Family Medicine/Internal Medicine)
Santa Fe Indian Hospital; Santa Fe, New Mexico

The Santa Fe Indian Hospital is expanding its primary care department and is currently seeking three to four board certified family physicians and general internists to join its outstanding medical staff. We provide care to a diverse population of nine Pueblo communities in north central New Mexico, as well as an urban population in and around Santa Fe, New Mexico. The current primary care staff of five family physicians, three pediatricians, one internist, and three PA/CNP providers work closely with one another to give full spectrum ambulatory and inpatient services. Three nurse midwives, one OB-Gyn, one general surgeon, one podiatrist, one psychiatrist, and one psychologist are also on site.

Family physicians and general internists at the Santa Fe Indian Hospital all have continuity clinics, and are collectively responsible for covering a moderately busy urgent care and same day clinic seven days a week. They also participate in a rotating hospitalist schedule. When fully staffed, these providers will take one in eight night call and will work approximately two federal holidays per year. In our "work hard, play hard" approach to scheduling, hospitalist weeks are followed by scheduled long weekends off, with scheduled days off during the week in compensation for other weekend shifts.

This is an opportunity for experienced primary care physicians to have the best of two worlds: providing care to a fantastic community of patients *and* living in one of the country's most spectacular settings. Santa Fe has long been recognized as a world-class destination for the arts and southwestern culture, with nearly unlimited outdoor activities in the immediate area. As a consequence, our staff tends to be very stable, with very little turnover. Ideal candidates are those with previous experience in IHS or tribal programs who are looking for a long-term commitment. For more information, please contact Dr. Bret Smoker, Clinical Director, at (505) 946-9279 (*e-mail at bret.smoker@ihs.gov*), or Dr. Lucy Boulanger, Chief of Staff, at (505) 946-9273 (*e-mail at lucy.boulanger@ihs.gov*).

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.

Nurse Executive
Santa Fe Indian Health Hospital; Santa Fe, New Mexico

The Santa Fe Indian Hospital is recruiting for a quality, experienced nurse executive. The 39-bed Santa Fe Indian Hospital is part of the Santa Fe Service Unit providing services in the clinical areas of general medical and surgical care, operating room, urgent care, progressive care, and preventive health. The purpose of this position is to serve as the top level nurse executive for all aspects of the nursing care delivery. As Director of Nursing (DON) services, manages costs, productivity, responsibility of subordinate staff, and programs, as well as providing leadership and vision for nursing development and advancement within the organizational goals and Agency mission.

The Nurse Executive is a key member of the SFSU Executive Leadership Team and has the opportunity to coordinate clinical services with an outstanding, stable, and experienced Clinical Director and Medical Staff. The SFSU includes the hospital and four ambulatory field clinics primarily serving nine tribes. The SFSU earned 2006 Roadrunner Recognition from Quality New Mexico. The hospital is located in beautiful Santa Fe, New Mexico, filled with cultural and artistic opportunities.

Contact CAPT Jim Lyon, CEO at (505) 946-9204 for additional information.

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.

Internist
Northern Navajo Medical Center; Shiprock, New Mexico

The Department of Internal Medicine at Northern Navajo Medical Center (NNMC) invites board-certified or board-eligible internists to interview for an opening in our eight-member department. NNMC is a 75-bed hospital in Shiprock, New Mexico serving Native American patients from the northeastern part of the Navajo Nation and the greater Four Corners area. Clinical services include anesthesia, dentistry, emergency medicine, family practice, general surgery, internal medicine, neurology, OB/Gyn, optometry, orthopedics, ENT, pediatrics, physical therapy, and psychiatry. Vigorous programs in health promotion and disease prevention, as well as public health nursing, complement the inpatient services.

The staff here is very collegial and unusually well trained. A vigorous CME program, interdepartmental rounds, and journal clubs lend a decidedly academic atmosphere to NNMC. Every six weeks, the departments of internal medicine and pediatrics host two medical students from Columbia University's College of Physicians and Surgeons on a primary care rotation. In addition, we have occasional rotating residents to provide further opportunities for teaching.

There are currently eight internists on staff, with call being about one in every seven weeknights and one in every seven weekends. We typically work four 10-hour days each week. The daily schedule is divided into half-days of continuity clinic, walk-in clinic for established patients, exercise treadmill testing, float for our patients on the ward or new admissions, and administrative time. On call, there are typically between 1 and 4 admissions per night. We also run a very active five-bed intensive care unit, where there is the capability for managing patients in need of mechanical ventilation, invasive cardiopulmonary monitoring, and transvenous pacing. The radiology department provides 24-hour plain film and CT radiography, with MRI available weekly.

The Navajo people suffer a large amount of diabetes, hypertension, and coronary artery disease. There is also a high incidence of rheumatologic disease, tuberculosis, restrictive lung disease from uranium mining, and biliary tract and gastric disorders. There is very little smoking or IVDU among the Navajo population, and HIV is quite rare.

Permanent staff usually live next to the hospital in government-subsidized housing or in the nearby communities of Farmington, New Mexico or Cortez, Coloado, each about 40 minutes from the hospital. Major airlines service airports in Farmington, Cortez, or nearby Durango, Colorado. Albuquerque is approximately 3½ hours away by car.

The great Four Corners area encompasses an unparalleled variety of landscapes and unlimited outdoor recreational activities, including mountain biking, hiking, downhill and cross-country skiing, whitewater rafting, rock climbing, and fly fishing. Mesa Verde, Arches, and Canyonlands National Parks are within a 2 - 3 hour drive of Shiprock, as are Telluride, Durango, and Moab. The Grand Canyon, Capitol Reef National Park, Flagstaff, Taos, and Santa Fe are 4 - 5 hours away.

If interested, please contact Thomas Kelly, MD, by e-mail at *Thomas.Kelly@ihs.gov* or call (505) 368-7037.

Physician Assistant
Native American Community Health Center, Inc.; Phoenix, Arizona

The Native American Community Health Center, Inc. (dba Native Health) is a non-profit, community focused health care center centrally located in the heart of Phoenix, Arizona. Native Health has been providing health care services to the urban Indian community in metro Phoenix, since it was incorporated in 1978. Native Health is currently seeking a physician assistant (PA). The PA is a key element in providing quality health care services to patients of all ages. Native Health offers competitive and excellent benefits. For more information, contact the HR Coordinator, Matilda Duran, at (602) 279-5262 or *mduran@nachci.com*.

Family Practice Physicians
Medical Clinic Manager
North Olympic Peninsula, Washington State

The Jamestown Family Health Clinic is seeking two BC/BE full spectrum family practice physicians with or without obstetrical skills. The clinic group consists of five FP physicians, two OB/GYN physicians, and five mid-level providers. The clinic is owned by the Jamestown S'Klallam

Tribe and serves tribal members and approximately 9,000 residents of the north Olympic Peninsula. The practice includes four days per week in the clinic and inpatient care at Olympic Medical Center. OMC is family medicine friendly with hospitalists who cover nighttime call and are available to assist with most hospital rounding. Our practice fully utilizes an electronic medical record system (Practice Partner) and participates in the PPRI net research affiliated with Medical University of South Carolina. The clinic serves as a rural training site for the University of Washington Family Medicine residency.

The Jamestown S'Klallam Tribe provides a competitive salary and unbeatable benefit package including fully paid medical, dental, and vision coverage of the physician and family. The north Olympic Peninsula provides boating opportunities on the Strait of San Juan de Fuca, and hiking, fishing, and skiing opportunities in the Olympic Mountains and Olympic National Park. Our communities are a short distance from Pacific Ocean beaches, a short ferry ride away from Victoria, BC, and two hours from Seattle.

Send CV to Bill Riley, Jamestown S'Klallam Tribe, 1033 Old Blyn Highway, Sequim, Washington 98382, or e-mail *briley@jamestowntribe.org*.

The Medical Clinic Manager is responsible for management and staff supervision of the multiple provider clinic in Sequim, Washington. Clinic services include primary care and OB/GYN. Send cover letter and resume to Jamestown S'Klallam Tribe, 1033 Old Blyn Highway; Sequim Washington 98382, Attn: Bill Riley; or fax to (360) 681-3402; or e-mail *briley@jamestowntribe.org*. Job description available at (360) 681-4627.

Chief Pharmacist
Deputy Chief Pharmacist
Staff Pharmacists (2)
Hopi Health Center; Polacca, Arizona

The Hopi Health Care Center, PHS Indian Health Service, is located on the Hopi Indian Reservation in beautiful northeastern Arizona. HHCC is a critical access hospital with an inpatient unit consisting of four patient beds plus two labor and delivery suites, emergency room, and a large outpatient clinic. The HHCC serves the Hopi, Navajo and Kiabab/Paiute Tribes. Housing, sign-on bonus and/or moving expenses are available for eligible applicants. The Hopi people are rich in culture, customs, and traditions and live atop the peaceful mesas. Applications are available on-line at *www.ihs.gov*, or contact Ms. April Tree at the Phoenix Area Office at (602) 364-5227.

Nurse Practitioners
Physician Assistant
Aleutian Pribilof Islands Association (APIA); St. Paul and Unalaska, Alaska

Renown bird watcher's paradise! Provide health care services to whole generations of families. We are recruiting for mid-level providers for both sites, and a Medical Director for St. Paul and a Clinical Director for Unalaska, Alaska.

Duties include primary care, walk-in urgent care, and emergency services; treatment and management of diabetes a plus. Must have the ability to make independent clinical decisions and work in a team setting in collaboration with referral physicians and onsite Community Health Aide/Practitioners. Sub-regional travel to other APIA clinics based on need or request. Graduate of an accredited ANP or FNP, or PA-C program. Requires a registration/license to practice in the State of Alaska. Credentialing process to practice required. Knowledge of related accreditation and certification requirements. Minimum experience 2 - 3 years in a remote clinical setting to include emergency care services and supervisory experience. Indian Health Service experience a plus. Will be credentialed through Alaska Native Tribal health Consortium. Positions available immediately. Work 37.5 hours per week.

Salary DOE + benefits. Contractual two year commitment with relocation and housing allowance. Job description available upon request. Please send resumes with at least three professional references to Nancy Bonin, Personnel Director, via email at *nancyb@apiai.org*.

Family Practice Physician
Dentist
Northeastern Tribal Health Center; Miami, Oklahoma

The Northeastern Tribal Health Center is seeking a full-time Family Practice Dentist and a Family Practice Physician to provide ambulatory health care to eligible Native American beneficiaries. The Health Care Center is located in close proximity to the Grand Lake area, also with thirty minute interstate access to Joplin, Missouri. The facility offers expanded salaries, excellent benefits, loan repayment options, no weekends, and no call. To apply please submit a current resume, certifications, and current state license. Applicants claiming Indian preference must submit proof with their resume. Applicants will be required to pass a pre-employment drug screen and complete a background check. To apply, send requested documents to Northeastern Tribal Health Center, P.O. Box 1498, Miami, Oklahoma 74355, attention: Personnel. The phone number is (918) 542-1655; or fax (918) 540-1685.

Internal Medicine and Family Practice Physicians
Yakama Indian Health Center; Toppenish, Washington

Yakama Indian Health Center in Toppenish, WA will soon have openings for internal medicine and family practice physicians. The current staff includes four family physicians, two pediatricians, one internist, five nurse practitioners, and a physician assistant. The clinic serves the 14,000 American Indians living in the Yakima Valley of south central Washington. Night call is taken at a local private hospital with

24/7 ER coverage. The on-call frequency is about 1 out of 7 nights/weekends. The area is a rural, agricultural one with close proximity to mountains, lakes, and streams that provide an abundance of recreational opportunities. The weather offers considerable sunshine, resulting in the nearest city, Yakima, being dubbed the "Palm Springs of Washington." Yakima is about 16 miles from Toppenish, with a population of 80,000 people. There you can find cultural activities and a college. For further information, please call or clinical director, Danial Hocson, at (509) 865-2102, ext. 240.

Family Practice Physician
Ilanka Community Health Center; Cordova, Alaska

The Ilanka Community Health Center has an immediate opening for a board certified/eligible family practice physician. Position is full-time or part-time with flexible hours.

Ilanka is a tribally-owned clinic that also receives federal Community Health Center funding. We serve all members of the community. Cordova also has a 10-bed Critical Access Hospital with on-site long-term care beds. Physicians and physician assistants provide services in the clinic and in the hospital emergency department, as well as inpatient and long-term care.

This is a very satisfying practice with a nice mix of outpatient, ER, and inpatient medicine. Sicker patients tend to be transferred to Anchorage. The clinic provides prenatal care to about 20 patients a year, but the hospital is currently not doing deliveries.

Cordova is a small, beautiful community situated in southeast Prince William Sound. It is a very friendly town. The population of Cordova is 2,500 in the winter and around 5,000 in the summer. The population is 70% Caucasion, 15% Alaska Native, and 10% Filipino, with an influx of Hispanic patients in the summer.

Most of the town is within easy walking distance to the clinic/hospital. The community is off the road system, but connects to roads by ferry and has daily flights to Anchorage and Juneau. This offers the advantages of remoteness with the benefits of connectivity.

We have tremendous access to outdoor sports and activities including excellent hiking, cross country skiing, alpine skiing, ice skating, boating, world class kayaking, heli-skiing, fishing, and hunting. This is the source of Copper River Salmon!

We offer flexible schedules, competitive salary and benefits, and loan repayment options. We would like to hear from you if you are excited about being an old style, small-town, family doctor.

Get more information about Cordova at *www.cordovaalaska.com*, *www.cordovachamber.com*, and *www.cordovaalaska.net/cordovarealty/*. For more information, please contact Gale Taylor, at (907) 424-3622; or *gale@ilanka.org*.

Emergency Department Physician/Director
Kayenta Health Center; Kayenta, Arizona

Kayenta is unique in many ways. We are located in the Four Corners area on the Navajo Indian Reservation as part of the Indian Health Service/DHHS. We have challenging assignments, beautiful rock formations, movie nostalgia, ancient ruins, and wonderful clientele to care for. We are within one hundred and fifty miles from the Grand Canyon and one hundred miles from Lake Powell, which offers boating, fishing, water skiing, and camping. World class skiing resorts and winter sports are just a few hours away in Colorado and Utah. Kayenta is a great place to raise a family with stress free living in a small hometown setting.

Working for Kayenta Health Center provides a unique opportunity. Because of our remote location and underserved population, you may be eligible for loan repayment and can be making a real difference in the world.

We are currently recruiting for a BC/BE emergency department physician and director to work in our 24-hour, eight bed facility. This is a great opportunity to join our multi-specialty ten member medical staff and nursing team. This position will be supported by dynamic outpatient clinical services, including dental, optometry, mental health, public heath nursing, pharmacy, radiology, environmental health services, and nutrition.

If interested in this exciting employment opportunity, please contact Stellar Anonye Achampong, MD, Clinical Director, at (928) 697-4001; e-mail *stellar.anonye@ihs.gov*; or send CV to Human Resources/Melissa Stanley, PO Box 368, Kayenta, Arizona 86033; telephone (928) 697-4236.

Multiple Professions
Pit River Health Service, Inc.; Burney, California

Pit River Health Service is an IHS funded rural health clinic under P.L.93-638 in northern California that provides medical, dental, outreach, and behavioral health. We are seeking several professional positions to be filled. We are looking for a Health Director to administer and direct the program to fulfill the Pit River Health Service, Inc.'s primary mission of delivering the highest possible quality of preventative, curative and rehabilitative health care to the Indian people served; a Dental Director to plan and implement the dental program and supervise dental staff; a Public Health Nurse or Registered nurse seeking a PHN license to provide public health nursing and to coordinate and supervise Community Health Services program; a Behavioral Health Director/LCSW as an active member of an interdisciplinary team providing prevention, intervention, and mental health treatment services to clients; and a Registered Dental Assistant.

Burney is located about 50 miles northeast of Redding, California in the Intermountain Area. The Intermountain Area offers plenty of recreational opportunities such as fishing, hiking, camping, boating, and hunting, with a beautiful landscape. Snow skiing is within an hour's drive away. The

Intermountain Area is a buyers market for homes, as well. All available positions require a California license and/or certification. To apply for employment opportunities and for more information, please contact John Cunningham; e-mail *johnc@pitriverhealthservice.org*; or telephone (530) 335-5090, ext. 132.

Family Practice Physician
Internal Medicine Physician
Psychiatrist
Winslow Indian Health Care Center; Winslow, Arizona

The Winslow Indian Health Care Center (WIHCC) in northern Arizona is currently looking for primary care physicians in family practice, internal medicine, and psychiatry. We have a staff of 12 physicians, including a surgeon, and nine family nurse practitioners and physician assistants. We offer comprehensive ambulatory and urgent/emergent care to patients at our health center in Winslow, which includes a state-of-the-art, seven-bed Urgent Care Center completed in 2006. WIHCC also operates two field clinics five days a week on the Navajo Reservation, at Leupp and Dilkon. Our FPs and internist also provide inpatient care at the local community hospital, the Little Colorado Medical Center, where the FPs provide obstetrical deliveries with excellent back-up from the local OB-Gyn group. The psychiatrist works as part of a team consisting of one full-time psychiatric nurse practitioner, another (part-time) psychiatrist, and five Navajo counselors, providing primarily outpatient services with occasional hospital consults.

WIHCC offers an awesome mix of professional, cultural, and recreational opportunities. It is located just seven miles from the breathtaking beauty of Navajoland and its people, and 50 miles from Flagstaff – a university town with extensive downhill and cross-country skiing, where several of our employees choose to live. Attractive salary and benefits, as well as a team oriented, supportive work environment are key to our mission to recruit and retain high quality professional staff.

WIHCC became an ISDA 638 contracted site in 2002, and has experienced steady growth and enhancement of programs and opportunities since the transition from a direct IHS program. Please contact Frank Armao, MD, Clinical Director, if you are interested in pursuing an opportunity here, at *frank.armao@wihcc.org*; telephone (928) 289-6233.

Family Practice Physician
Peter Christensen Health Center; Lac du Flambeau, Wisconsin

The Peter Christensen Health Center has an immediate opening for a board certified family practice physician; obstetrics is optional, and call will be 1/6. The facility offers competitive salaries, excellent benefits, and loan repayment options; all within a family oriented work atmosphere.

The Lac du Flambeau Indian Reservation is located in the heart of beautiful northern Wisconsin. The area's lakes, rivers, and woodlands teem with abundant wildlife, making it one of the most popular recreational areas in northern Wisconsin. The area boasts fabulous fishing, excellent snowmobiling, skiing, hunting, golf, and much more. Four seasons of family fun will attract you; a great practice will keep you.

For specific questions pertaining to the job description, call Randy Samuelson, Clinic Director, at (715) 588-4272. Applications can be obtained by writing to William Wildcat Community Center, Human Resource Department, P.O. Box 67, Lac du Flambeau, Wisconsin 54538, Attn: Tara La Barge, or by calling (715) 588-3303. Applications may also be obtained at *www.lacduflambeautribe.com*.

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

The Zuni Comprehensive Community Health Center (Zuni-Ramah Service Unit) has an opening for a full-time primary care physician starting in January 2008. This is a family medicine model hospital and clinic providing the full range of primary care -- including outpatient continuity clinics, urgent care, emergency care, inpatient (pediatrics and adults) and obstetrics -- with community outreach, in a highly collaborative atmosphere. For a small community hospital, we care for a surprisingly broad range of medical issues. Our professional staff includes 14 physicians, one PA, one CNM, a podiatrist, dentists, a psychiatrist, a psychologist, optometrists, physical therapists, and pharmacists. Our patient population consists of Zunis, Navajos, and others living in the surrounding area.

Zuni Pueblo is one of the oldest continuously inhabited Native American villages in the US, estimated to be at least 800 - 900 years old. It is located in the northwestern region of New Mexico, along the Arizona border. It is high desert, ranging from 6000 - 7000 feet elevation and surrounded by beautiful sandstone mesas, canyons, and scattered sage, juniper, and pinon pine trees. Half of our medical staff has been with us for more than seven years, reflecting the high job and lifestyle satisfaction we enjoy in this community.

For more information, contact John Bettler, MD at (505) 782-7453 (voice mail), (505) 782-4431 (to page), or by e-mail at *john.bettler@ihs.gov*. CVs can be faxed to (505) 782-4502, attn: John Bettler.

Primary Care Physicians (Family Practice, Internal Medicine, Med-Peds, Peds)
Psychiatrists
Pharmacists
Nurses
Chinle Service Unit; Chinle, Arizona

Got Hózhó? That's the Navajo word for joy. Here on the Navajo Reservation, there's a great mix of challenging work and quality of life. No rush hour traffic, no long commutes, no stressors of urban life. We walk to work (naanish) and enjoy living in our small, collegial community. Our 60-bed acute

care hospital is located in Chinle, Arizona, the heart of the Navajo Nation. At work we see unique pathology, practice evidence-based medicine, and are able to utilize the full scope of our medical training. Together, we enjoy learning in an atmosphere of interdepartmental collaboration, supported by an established network of consulting specialists across the southwest. A comprehensive system of preventive programs and ancillary services allows us to provide the best possible care for our patients. During our time off, many of us explore the beautiful southwest, bike on amazing slick rock, and ski the slopes of the Rocky Mountains. It's a great life – combining challenging and interesting work with the peaceful culture of the Navajo people and the beautiful land of the southwest.

We're looking for highly qualified health care professionals to join our team. If you're interested in learning more about a place where "naanish baa hózhó" (work is joyful), contact Heidi Arnholm, Medical Staff Recruiter, Chinle Service Unit, telephone (970) 882-1550 or (928) 674-7607; e-mail *heidi.arnholm@ihs.gov*.

Family Practice Physician
Family Practice Medical Director
Tanana Chiefs Conference, Chief Andrew Isaac Health Center; Fairbanks, Alaska

We are seeking a board certified family practice physician, preferably with obstetrics skills for a full-time position. We will have openings in the summers of 2007 and 2008.

The facility is a multispecialty clinic providing services in obstetric/gynecology, internal medicine, and family practice. It also includes dental, optometry, pharmacy, behavioral health, community health aides, and other services. Our referral region includes 43 villages in interior Alaska covering an area the size of Texas. Fairbanks has an outstanding school system and university. We offer a very competitive salary with a great benefits package and a loan repayment plan. Commissioned Corps positions are also available. Contact Jim Kohler at (907) 459-3806 or *james.kohler@tananachiefs.org*.

Family Practice Physician
Seattle Indian Health Board; Seattle, Washington

Full Time, Fantastic Benefits! We are recruiting for a family practice physician to join our team at the Seattle Indian Health Board in Seattle, Washington. We are a multiservice community health center for medical, dental, mental health, substance abuse, and community education services. We are looking for a physician who is familiar with health and social issues facing American Indians/Alaska Natives and a desire to promote the delivery of appropriate health services to this population.

Seattle Indian Health Board (SIHB) physicians are responsible for the delivery of quality, culturally sensitive primary medical care to the SIHB's patient population. This position provides general medical care (including diagnosis, treatment, management, and referral) to SIHB patients with acute, chronic, and maintenance health care needs. The physician chosen will also participate in the medical on-call rotation schedule and other responsibilities such as consulting and coordinating care with other practitioners, nursing, pharmacy, laboratory, and outside referral sites. He or she will provide clinic preceptorship of mid-level practitioners and patient care instruction to nurses, pharmacists, and other SIHB clinical staff. The incumbent will precept for residents for the outpatient continuity family practice clinics. In addition to supervising patient care, preceptors engage in didactic activity to enhance resident learning. The physician will also participate in quality assurance, program development, community health education/screening, and related activities. He or she will document all patient care information/treatment in problem-oriented format in the patient's medical records, as well as complete and submit encounter forms and related materials according to established procedure. Finally, the person selected will comply with SIHB policies and procedures, and the AAAHC Standards of Care.

Qualifications include board certification in family medicine and a Washington State medical license. All applicants will be required to complete a background check. Please visit our website at *www.sihb.org* for more information, or you can call Human Resources at (206) 324-9360, ext. 1123.

Primary Care Physicians
USPHS Claremore Comprehensive Indian Health Facility; Claremore, Oklahoma

The USPHS Claremore Comprehensive Indian Health Facility has openings for full-time positions for an emergency medicine physician, a surgeon, an anesthesiologist (or nurse anesthetist), an OB/GYN physician, and an internal medicine physician.

The Claremore hospital is a 50-bed specialty based comprehensive care facility, providing care through nine organized clinical services: community health, dentistry, optometry, emergency medical services, general surgery, internal medicine, obstetrics and gynecology, pediatrics, and radiology. In addition, the hospital has a six-bed intensive and coronary care unit and CAT scan equipment with 24 hour teleradiology support. The facility maintains several academic affiliations, and has a professional staff consisting of 36 staff physicians, approximately 60 contract physicians, five dentists, three nurse practitioners, a physician assistant, an optometrist, and an audiologist.

Claremore is a town of 18,000 just 21 miles northeast of the very metropolitan city of Tulsa, with a US Census county population of 560,431. Tulsa has a major airport with international flights and destinations in most major US cities, and was ranked in the top 10 southern cities in Southern Living magazine and Fodor's Travel Publications as one of its outstanding travel destinations. Tulsa's cost of living is 8 percent below the national average and has a county per capita income 11 percent above the national average. If you prefer

rural living, there are many opportunities nearby. The facility is located 10 minutes from a major lake, and only one hour from a lake with over 1,100 miles of shoreline.

For more information, contact Paul Mobley, DO at (918)342-6433, or by e-mail at *paul.mobley@ihs.hhs.gov*. CVs may be faxed to (918) 342-6517, Attn: Paul Mobley, DO.

Family Practice Physician
Hopi Health Care Center; Polacca, Arizona

The Hopi Health Care Center currently has openings for family practice physicians and family nurse practitioner or physician assistants. The Hopi Health Care Center is a small, rural IHS hospital providing full spectrum family practice medical services including ambulatory care, adult/peds inpatient care, low risk obstetrics, and ER care. We currently staff for 12 full time physicians, and four full time FNP/PA positions. Our facility is located in northern Arizona, 90 miles northeast of Flagstaff and 70 miles north of Winslow, on the Hopi Indian Reservation. Services are provided to both Hopi and Navajo reservation communities. The reservation is located in the heart of the southwest; within a 90 mile radius are abundant mountain areas, lakes, forests, and archeological sites. The Hopi Health Care Center is a new facility established in 2000 with a full ambulatory care center environment including a dental clinic, physical therapy, optometry, and behavioral health services. We are a designated NHSC site, and qualify for the IHS Loan Repayment Program.

For more information, please contact Darren Vicenti, MD, Clinical Director at (928) 737-6141 or *darren.vicenti@ihs.gov*. CVs can be faxed to (928) 737-6001.

Family Practice Physician
Chief Redstone Health Clinic, Fort Peck Service Unit; Wolf Point, Montana

We are announcing a job opportunity for a family practice physician at the Chief Redstone Clinic, Indian Health Service, Fort Peck Service Unit in Wolf Point, Montana. This is a unique opportunity for a physician 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 northeast 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 a 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. Tribal Health 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 to 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. Northeast 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*. Alternatively, you can contact Dr. Craig Levy at (406) 768-3491, or e-mail *craig.levy@ihs.gov*, or the Billings Area Physician Recruiter, Audrey Jones, at (406) 247-7126 or e-mail *audrey.jones@ihs.gov*. We look forward to communicating with you.

Pediatrician
Family Practice Physician
Obstetrician/Gynecologist
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, 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, an active diabetes program, 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 offers 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 medical team, contact Dr. Peter Reuman at *peter.reuman@ihs.gov* or telephone (406) 338-6150; or contact the 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
Pharmacists
PHS Indian Hospital; Harlem, Montana

The Fort Belknap Service Unit is seeking family practice physician and pharmacist candidates 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 a 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. Robert Andrews at *robert.andrews@ihs.gov* or telephone (406) 353-3195; or contact the Physician Recruiter, Audrey Jones, at *audrev.jones@.gov*; telephone (406) 247-7126.

Family Nurse Practitioner or Physician Assistant
Fort Peck Service Unit; Poplar, Montana

We are announcing a job opportunity for a family nurse practitioner and/or physician assistant at the Verne E Gibbs Health Center in Poplar, Montana and the Chief Redstone Health Clinic, Indian Health Service, Fort Peck Service Unit in Wolf Point, Montana. The Fort Peck Service Unit is located in the northeast 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. The 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 a very active Diabetes Department that includes one nurse educator, one FNP, and one nutritionist. We strive to provide quality care through a strong multidisciplinary team approach; we believe in being involved in the community 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 to the website at *http://www.ihs.gov/FacilitiesServices/AreaOffices/Billings/FtPeck/index.asp*. We are looking for an applicant with well rounded clinical skills. Two years experience is preferred but new graduates are welcome to apply. Northeast 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*.

Family Practice Physicians
Dentists
Pharmacists
Crownpoint Comprehensive Healthcare Facility; Crownpoint, New Mexico

The Crownpoint IHS facility has openings for two family practitioners with low risk obstetric skills (we will consider candidates without OB skills), two pharmacists, and two general dentists. Our service unit follows a family medicine model for providing full-spectrum care to our patients, with a dynamic medical staff that finds the work here quite rewarding. With a high HPSA rating, we are a NHSC-eligible site for payback and loan repayment.

Crownpoint is a town of about 2,500 people in the Four Corners region of New Mexico. We serve a traditional community of 25,000 Navajo people, many of whom speak only Navajo and live in traditional homes with no running water, electricity, or phone service. Our hospital has a six bed ER, a 17 bed med/peds unit, a labor and delivery/post-partum unit, and a large outpatient clinic. We have a total of 16 dental chairs, optometry, and mental health services, as well as on-site pharmacy, laboratory, radiology, and ultrasonography. Our medical/dental staff is a collegial and supportive group including ten family physicians, two pediatricians, an obstetrician/gynecologist, a psychiatrist, three PAs, three FNPs, four dentists, and a podiatrist. We have a very exciting, full-spectrum medical practice that includes high-risk prenatal care, low-risk labor and delivery, emergency room care with management of trauma and orthopedics, and an interesting inpatient medicine and pediatric service.

As primary care physicians in a rural setting, we manage a wide variety of medical problems. We care for many patients

with diabetes and hypertension, but we also see some unusual illnesses such as plague, Hantavirus, and snake bites. There are many opportunities for outpatient and ER procedures including suturing, therapeutic injections, closed reductions of fractures and dislocations, para/thoracentesis, chest tubes, LPs, colposcopy, sigmoidoscopy, and OB ultrasound.

While Crownpoint is small, there is a lot to do in the surrounding area. There are two junior colleges in town where many of us have taken Navajo language, weaving, and history classes. Some have gotten involved with local churches and children's activities. Outdoor activities are plentiful, with downhill and cross-country skiing, camping, and fishing all nearby. There are several excellent mountain biking and hiking trails, as well as Anasazi ruins that are right in Crownpoint. Albuquerque is two hours away and is our nearest large city with an international airport. Other destinations that are within an afternoon's drive include Santa Fe (three hours), Durango and the Rocky Mountains (two hours), Taos (four hours), Southern Utah's Moab and Arches/Canyonlands National Parks (four hours), Flagstaff (three hours) and the Grand Canyon (five hours).

For more information, contact Harry Goldenberg, MD, Clinical Director, at (505)786-5291, ext.46354; e-mail *harry.goldenberg@ihs.gov*; or Lex Vujan at (505) 786-6241; e-mail *Alexander.vujan@ihs.gov*.

Family Practice Physician
Pediatrician
Bristol Bay Area Health Corporation; Dillingham, Alaska

Bristol Bay Area Health Corporation (BBAHC) is a mature tribal compact located in scenic southwestern Alaska. The Bristol Bay Area Service Unit encompasses 44,000 square miles of Alaska country bordering the Bristol Bay region of the state. Over 400 employees provide primary care to 28 villages including two sub-regional villages, and a primary care hospital, Kanakanak, located in Dillingham, Alaska. The Medical Staff consists of nine family physicians, a pediatrician, a nurse midwife, four dentists, a physical therapist and an optometrist, all providing primary care. The patient population consists of Yupik Eskimo, Aleut, and Athabascans who have been residents of the area for hundreds of years. Family physicians provide a broad spectrum of practice including obstetrics, inpatient medicine, emergency care and procedures such as colonoscopy, EGD, flexible sigmoidoscopy, colposcopy, and treadmill services in a very collegial and supportive atmosphere. Our solo pediatrician is allowed to practice full spectrum pediatrics with an extremely interesting patient mix and some very high risk and rare genetic disorders unique to this area. The pediatrician works in a collegial manner with family physicians and is not required to perform any adult medicine or obstetrics, but solely pediatrics.

BBAHC was the first hospital in the country to establish a 638 contract and has an extremely good working relationship with their Board of Directors. Of note, the practice here in Alaska is unique, and air travel to outlying villages is required, since continuity care to the villages is very important to our care here and is uniquely rewarding. BBAHC has an extremely competitive salary and benefits package.

If interested, please contact Arnie Loera, MD, Corporate Medical Director, at (907) 842-9218, Kanakanak Hospital/Bristol Bay Area Health Corporation, PO Box 130, Dillingham, Alaska 99576. You may also contact him by e-mail at *aloera@bbahc.org*. CVs can be faxed to (907) 842-9250, attn: Arnie Loera, MD. You may also view our website for information about our corporation at *www.bbahc.orq*.

Medical Technologist
Tuba City Regional Health Care Corporation; Tuba City, Arizona

The Tuba City Regional Health Care Corporation, a 73-bed hospital with outpatient clinics serving 70,000 residents of northern Arizona, is recruiting for full-time generalist medical technologists. The laboratory has state-of-the-art equipment. We offer competitive salary, based on experience. Relocation benefits are available. New graduates are encouraged to apply for this position. Tuba City is located on the western part of the Navajo reservation approximately 75 miles north of Flagstaff, Arizona, with opportunities for outdoor recreation and cultural experiences with interesting and adventurous people.

For more information, please contact Minnie Tsingine, Laboratory Supervisor, at (928) 283-2716 or *minnie.tsingine@tcimc.ihs.gov*. For an application, please contact Human Resources at (928) 283-2041/2432 or *michelle.francis@tchealth.org*.

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*.

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THE IHS PRIMARY CARE PROVIDER

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

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