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Innovations in Planned Care and iCare

Is iCare Right for You?

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Do you have something you have to do for a group of patients? Do you have to identify problem areas in a particular subset of patients? Well, iCare may be your solution.

iCare is the IHS's population management IT tool that was first released two years ago. It is a Windows-based, graphical user interface (GUI) that displays RPMS data such as Patient Registration; PCC V files (lab, medications, radiology, health factors, measurements, etc.); Health Summary Reminders; Best Practice prompts; HIV Register data; and Performance Measure data in an easy to use format. iCare is easily used to identify groups of patients with similar characteristics, such as gender, age, diagnosis, appointment, provider, etc., and create panels of these patients. It is intended to be used by all sorts of providers, including physicians, nurses, mid-level providers, dieticians, public health personnel, dentists, pharmacists -- anyone who cares for patients.

The Office of Information Technology (OIT) has been busy promoting the use of this useful tool through presentations at national and regional conferences, web-based training sessions, on-site trainings, and through simple word of mouth. In spite of OIT's efforts, we are continually amazed to hear that there are sites that are still not fully engaged and sites that have still never even heard of it!

So, we've cast our nets a bit wider and bring to you a "real user" perspective on how iCare might help you at your facility.

Alana Smith, RN, MSN, Diabetes Program Nurse Manager, Will Rogers Health Center, Cherokee Nation Health Systems, Tahlequah, Oklahoma

Aldous Huxley stated "There's only one corner of the universe you can be certain of improving, and that's your own self." I am partial to this statement because I believe it encompasses the role that iCare has in facilitating improvement in patient care and outcomes; in addition it sets the stage for planned care. Change is never easy. Especially when it is seen as an unnecessary change; such is how it was in the beginning when the phrases iCare and planned care started to float through the interoffice jabber like bad cousins, in for the weekend.

The three northern health centers of Cherokee Nation Health Services, with headquarters in Tahlequah Oklahoma, encompass the Will Rogers Health Center, the Vinita Clinic, and the Bartlesville clinic. These health centers are still at the stages where the nurses know the patients on a first name basis, can tell you about their medical history without pulling their charts and medical records, and know chart numbers without

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looking up the patients. The relationship is still very personal.

From the onset, the principal complaints from the staff on the subject of iCare were the reports; the reports being generated were not accurate. "Why should we waste our time?" Additional chart reviews were required due to the inaccuracies of iCare. The team knew they were performing tests and procedures that were set forth in the performance measures, but it was not getting transferred into the iCare system. Or was it?

With the question in mind of whether the information was getting entered into the system appropriately, utilization of systems theory management was initiated to distinguish the source of the communication breakdown between the documentation on the PCC Form in the chart and the information being generated by iCare report systems and the performance measures. Instead of working on several issues at once, one area was chosen, immunizations. Specifically, the influenza vaccine and Pneumovax, administered to persons with an age over 65, were targeted.

This population was targeted due to its relatively small size and the proven need for immunization. The iCare report would be generated to be compared to the patient encounter form to verify the immunization status. The first problem that was noted was that the patient would have the immunizations administered or would have a history of having received the immunization documented, these data then having been processed through data entry, but then it would still show up on the iCare generated report as due or past due. The immunizations would show up as having been administered in RPMS, so what is the deal? Is it a programming question? Is it a conspiracy? How can we fix it?

What is the fix? It is always easy to lay the blame, to find fault in someone other than yourself or in other departments. When searching for a solution, this was not the approach that was taken throughout this endeavor. With a positive approach to the task, engaging each individual not by trying to find somewhere to place blame for "what is wrong," but how best to showcase the hard work each individual team member performs on a daily basis, the solution to our dilemma began to reveal itself.

I compare it to playing the game without knowing all the rules; it didn't work well until we took time to learn the rules. Once we did, huge improvements were seen in the iCare reports being generated. These reports validated what the staff did on a daily basis. It is amazing to see the difference that it has made to the staff's attitude toward iCare and its use on a daily basis in the clinics.

"Garbage in Garbage out" is as simple as it gets. The information that was being entered into the system did not always match what the taxonomy was looking for. Knowledge of the definitions of what the program was looking for answered many of the questions. Armed with the knowledge of the taxonomies, we were then able to figure out that many of the immunizations that had been entered were entered as NOS, which the taxonomy for the Pneumovax or influenza did not recognize. The patient had the immunization documented correctly but not entered using the specific definition that is required by the taxonomy.

Now the focus is on using this knowledge to incorporate the goals of Planned Care. iCare and Planned Care are not so reviled by the staff, but are now looked upon as a better way to serve the growing needs of the population base. Recently, thin clients, computers armed with access to RPMS and iCare, have been installed in the exam rooms at the Will Rogers Health Center so that LPNs can review and address any items that have been flagged by the system. The provider's allotted time can now be better utilized addressing the disease processes that initiated the patient's need for the visit.

The health centers are growing and new charts are being made daily. As the health centers grow and evolve, the unique ability to know the patients so intimately will slowly fade. Obtaining and entering the appropriate data are becoming of greater importance as we move toward EHR. iCare allows for the health care provider to have the most current information available to review. iCare is a gateway for Planned Care. It allows for case managers to improve the use of their time, as they no longer have to do manual chart reviews. iCare is significantly more user friendly than RPMS; it is easier to perform queries of patients who are needing labs, depression screens, foot exams, and tests, instead of having to run a Q-man report.

Personally, I find iCare an invaluable tool. I rotate between the three health centers, and iCare allows for easier access for pulling patient data in specific patient panels or a diabetic registry. Many times I require information that is not available at the site where I am located, but with iCare, it is fast and easy.

Getting back to what Mr. Huxley stated about the only corner of the universe that you can be certain of improving, that is, your own self, iCare allows for that self improvement. The universe that I work in is my immediate locale of the health care system. I can improve my outcomes by providing quality care that leads to quality data. Quality data being entered leads to accurate reports from iCare and measurements of performance goals. Accurate reports will allow for development of programs to meet the needs of specific patient populations and reflect the positive outcomes resulting from the interventions contributed by all team members.

The Division of Epidemiology and Disease Prevention
and
The IHS Clinical Support Center (Accredited Sponsor)
Present:

Updated HIV Screening Guidelines WebEx Presentation

Brigg Reilley, MPH
CDR Kara Levri, MD, MPH
Angela Fallon, RN

Target Audience:	Healthcare Providers
Date:	July 10, 2009
Time:	12:00 PM Noon (MST)
Method:	WebEx
Contact:	Brigg Reilley at *brigg.reilley@ihs.gov*
Objectives:	Become familiar with CDC HIV screening guidelines and understand best practices

To obtain a certificate of continuing education, you must submit a completed evaluation form (via email) and document your attendance.

Accreditation:

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

The IHS Clinical Support Center designates this educational activity for a maximum of **1 contact hour** AMA PRA Category 1 Credit(s)™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

This Category 1 credit is accepted by the American Academy of Physician Assistants and the American College of Nurse Midwives.

The Indian Health Service Clinical Support Center is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity is designated **as 1 contact hour** for nurses.

Faculty Disclosure Statement:

As a provider accredited by ACCME, ANCC, and ACPE, the IHS Clinical Support Center must ensure balance, independence, objectivity, and scientific rigor in its educational activities. Course directors/coordinators, planning committee members, faculty, and all others who are in a position to control the content of this educational activity are required to disclose all relevant financial relationships with any commercial interest related to the subject matter of the educational activity. Safeguards against commercial bias have been put in place. Faculty will also disclose any off-label and/or investigational use of pharmaceuticals or instruments discussed in their presentation. The course directors/coordinators, planning committee members, and faculty for this activity have completed the disclosure process and have indicated that they do not have any significant financial relationships or affiliations with any manufacturers or commercial products to disclose.

Financing Adult Vaccines

Amy Groom, MPH, IHS Immunization Program Manager, IHS Division of Epidemiology and Disease Prevention, Albuquerque, New Mexico; Diana Hu, MD, Pediatrician, Acting MCH Consultant, Tuba City Regional Health Care Corporation, Tuba City, Arizona; Ronald Chapman, PharmD, Director of Pharmacy Services, Tuba City Regional Health Care Corporation, Tuba City; LT Joseph Bryant, PharmD, BCPS, Supervisor, Pharmacy Support Branch, IHS National Service Supply Center; Oklahoma City, Oklahoma; and CDR Robert Hayes, PharmD, Director, IHS National Service Supply Center, Oklahoma City

In the last few years, there have been several new vaccines licensed and recommended for use in the adult population. In addition to pneumococcal, influenza, and Td vaccines, we now have Tdap, zoster, human papillomavirus (HPV) and meningococcal vaccines for certain adult populations. In addition, measles, mumps, and rubella (MMR), varicella, and hepatitis A and B vaccines, which are routinely given to children, are recommended for certain adults. The CDC Adult Immunization schedule can be found at *http://www.cdc.gov /vaccines/recs/schedules/adult-schedule. htm#print*.

Finding the funding to cover these important vaccines can be challenging for many sites, particularly as some of the newer vaccines (e.g., zoster, HPV) can be quite costly. Below is some information on costs and potential funding sources for some of these vaccines.

Costs

Vaccines for American Indian/Alaska Native (AI/AN) children < 19 years of age are provided free of charge through the federally funded Vaccines for Children (VFC) program, which is managed by state immunization programs. For adult vaccines, however, funding for vaccines is often cobbled together from different sources. While some states offer some adult vaccines to certain adult populations, most facilities need to purchase their own vaccine, which may be done through a distributor, directly from the manufacturer, or through the IHS National Service Supply Center (NSSC). The NSSC works through the VA Prime Vendor contract and offers some of the lowest prices for vaccines. IHS, tribal, and urban (I/T/U) facilities are eligible to purchase vaccines through the NSSC for AI/AN beneficiaries. More information on the NSSC can be found at *http://www.ihs.gov/NonMedicalPrograms/NSSC/ index.asp?module=about*.

Below is a table that offers the range of current prices for adult vaccines from NSSC compared to the private sector cost.

Table 1. Vaccine Costs: National Service Supply Center vs. Private Sector

	NSSC Price/Dose	Private Sector Price/Dose*
Pneumococcal polysaccharide (PPV23)	$20.57	$32 - $37
Influenza (inactivated)	$6.57	$11 - $16
Influenza (LAIV)	$13.66	$19
Td	$12.90-$13.63	$18
Tdap	$26.36	$37
Zoster	$107.64	$153-$161
HPV (quadrivalent)	$87.13	$130
Meningococcal conjugate	$62.34	$98
MMR	$32.72	$46
Varicella	$53.80	$80
Hepatitis A	$18.44	$59 - $63
Hepatitis B	$22.79	$52 - $61
Hep A/B (Twinrix)	$38.47	$86

*Source: CDC Vaccine Price list at *http://www.cdc.gov/ vaccines/programs/vfc/cdc-vac-price-list.htm*

While all I/T/U facilities will likely need to purchase at least some vaccine for their adult population, there are potential sources for vaccine and strategies that can be used to help recoup some of the costs, some of which are described below.

State Immunization Programs. In addition to funding for the VFC program, states receive a limited amount of discretionary funding from CDC for immunizations, called "317" funding. Currently there are 13 states that use these and state funds to purchase adult vaccines for use in their public sector clinics, including I/T/U facilities. For example, some states currently provide Hepatitis B or Hepatitis A/B vaccines for use in high risk adults, and some states provide pneumococcal, influenza, and Tdap vaccines for certain groups. As part of the economic stimulus package, states will be receiving a substantial increase in 317 funding, with the

majority of the funding dedicated for the purchase of vaccines. There is an emphasis on increasing coverage with adult vaccines, particularly influenza and zoster. Check with your state immunization program to see if they provide adult vaccines and if you are eligible to receive these vaccines. A list of state immunization program contacts can be found at *http://www.immunize.org/coordinators/*.

Merck Vaccine Assistance program. The pharmaceutical company Merck has a vaccine patient assistance program which provides certain Merck vaccines free of charge to uninsured, low income patients through a dose replacement program. The vaccines available include:

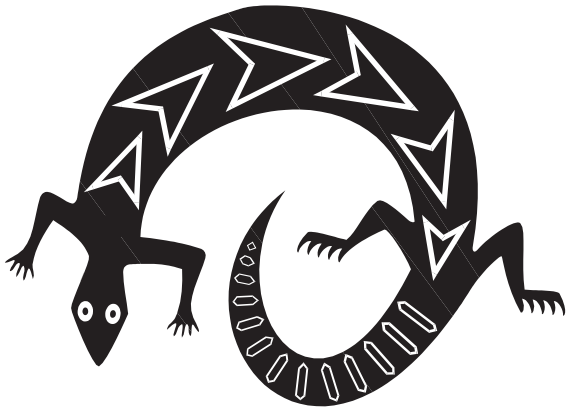
- GARDASIL® [Human Papillomavirus Quadrivalent (Types 6, 11, 16, and 18) Vaccine, Recombinant]
- M-M-R® II (Measles, Mumps, and Rubella Virus Vaccine Live)
- PNEUMOVAX® 23 (Pneumococcal Vaccine Polyvalent)
- RECOMBIVAX HB® [Hepatitis B Vaccine (Recombinant)]
- VAQTA® (Hepatitis A Vaccine, Inactivated)
- VARIVAX® [Varicella Virus Vaccine Live]
- ZOSTAVAX® [Zoster Vaccine Live]

This program was recently expanded, and now both tribal and direct service IHS sites are eligible to participate. Patients whose only source of health care is IHS-funded care are considered to be "uninsured," and if they meet certain income criteria and are approved by Merck, the company will replace the vaccine used for that patient. Facilities need to purchase the vaccine up front and on a quarterly basis Merck will ship replacement doses of vaccine to the facility for each patient who qualified for the program. More information on the program can be found at *http://www.merck.com/merckhelps/vaccines/home.htm*l. In addition, Alaska Native Medical Center staff who have implemented this program in their facility hosted a WebEx training session entitled "Merck Vaccine Patient Assistance Program" on how to enroll your facility and participate in this program. The recording of that session as well as the PowerPoint slides can be found by going to *https://ihs-hhs.webex.com/mw0305l/mywebex/default.do?siteurl=ihs-hhs&service=7*, and clicking on "Recorded Sessions."

Third Party Billing Strategies: Medicaid reimbursement. Several IHS and tribal sites have developed an innovative way to help their facility recoup some of the costs of purchasing adult vaccine. Because many sites receive a flat fee from Medicaid for any Medicaid patient visit, if a patient comes in and is seen by a provider and receives an immunization, the fee that is billed to Medicaid for that visit more than covers the cost of the vaccine for that patient. These additional monies can then be used to offset the cost of vaccine purchase for non-Medicaid eligible patients. Tuba City Regional Health Care Corporation (TCRHCC) has used this strategy to help expand the availability of flu vaccine by hiring a provider just to give flu shots during flu season. They have also used this model to provide HPV vaccine to women 19 - 26 years of age, and Tdap and zoster vaccines to eligible patients. They have created a weekly "adult immunization clinic" for the non-flu season where the routine vaccines are available to patients on an appointment and walk in basis. It is critical for the service units to understand that these are billable visits only if the patient is seen by a health care provider and the provider orders the vaccine (it cannot be a "nursing only" visit). The patient does have to be seen separately for this service to recoup the full visit reimbursement. For those patients covered by Medicaid, the flat fee rate is billed; for those covered by Medicare, Medicare Part D is billed for the Medications and Dispensing fee. This strategy has resulted in a profit for the facility, which is used to cover the cost of vaccines for patients who are not otherwise covered. For more information, contact Ronald Chapman, Director of Pharmacy Services at TCRHCC, at *ronald.chapman@tchealth.org*.

Conclusion

While the increasing the number of vaccines available to prevent disease will significantly reduce morbidity and mortality and improve the overall health of individuals and their communities, there are real challenges in providing all recommended vaccines in I/T/U facilities. With many competing health priorities, the cost for some of the newer vaccines can seem prohibitive, but from a prevention and public health perspective, it is incumbent upon I/T/U facilities to explore ways to incorporate these vaccines into their practice.



Health Promotion/Disease Prevention Initiative: Showcasing Promising Strategies for Healthier Families and Communities.

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Health Promotion/Disease Prevention: Using Multiple Strategies

In Native communities, traditional views of health include the concept of balance; a consideration of mind, body, and spirit; and a sense of the well-being of all, rather than just a few. We are taught to consider the impact of decisions for seven generations into the future. This wisdom emphasizes prevention and maintaining wellness, rather than simply treating illnesses or problems. These teachings have led Native communities well through hundreds of years to survive many challenges, and form the foundation for effective current and future efforts.

Heart disease, cancer, and unintentional injuries are the leading causes of morbidity and mortality among American Indian/Alaska Native (AI/AN).[1] Many of these diseases and injuries are impacted by modifiable behavioral risk factors such as unhealthy diet, commercial tobacco use, physical inactivity, and excessive and underage alcohol use. The Health Promotion and Disease Prevention (HP/DP) program focuses on culturally tailored efforts to increase effective public health, prevention, and intervention strategies that are necessary to reduce these risk factors among AI/AN communities.

To address these health challenges, the HP/DP program is utilizing multiple strategies that include directly funding tribal and urban programs to promote wellness in their community through competitive grants; directly promoting healthy behaviors through developing and disseminating culturally tailored tools (e.g., Physical Activity Kit); arming communities with public health and wellness tools and resources on the IHS website; and increasing community capacity through the Healthy Native Fellowship program and Youth Leadership training. The HP/DP program completes this work through National IHS program staff, Area HP/DP Coordinators, the Healthy Native Communities Partnership (HNCP), and countless other partners at the National, Area, and AI/AN community level. A sample of each prevention strategy will be described in this article.

Since 2005, the HP/DP program has provided 33 competitive grants to tribal and urban Indian organizations and programs to develop innovative approaches to address obesity, cancer, underage drinking, and cardiovascular disease. The purpose of the competitive grants is to encourage tribal and urban programs to enhance and expand health promotion and reduce chronic disease by preventing and controlling obesity by developing and implementing science-based nutrition and physical activity interventions; preventing the consumption of alcohol and tobacco use among youth; increasing accessibility to tobacco cessation programs; and reducing exposure to second-hand smoke. Prevention and intervention strategies include public education and information, media campaigns to support healthier behaviors, policy and environmental changes, community capacity building and training, school classroom curricula, and health care provider education. Two grantees are highlighted below.

The Southeast Alaska Regional Health Corporation in Sitka, Alaska implemented WISEFAMILIES through traditional knowledge to strengthen healthy lifestyles. SEARHC has partnered with the Jilkaat Kwann Cultural Heritage Center to support the tribe's social and economic development plan and to improve chronic disease risks for all Klukwan residents. This pilot program supports a series of traditional knowledge camps that focus on learning about and experiencing subsistence lifestyle skills and Tlingit culture. The program hosts a subsistence skills camp to teach residents about processing and storing of healthy foods such as salmon, hooligan, and moose. The camp participants and their families received an annual physical exam, received education on physical activity, tobacco, and nutrition. Over 90 health screenings have been conducted; more than 50% of the participants returned for subsequent annual health screenings. Tobacco cessation program were provided to help individuals quit smoking, and over 119 people received health education focusing on physical activity.

The Round Valley Indian Health Center is located in Covelo, California. Round Valley hired a coordinator to work with the Round Valley Unified School District to implement the Fit Teen curriculum focusing on physical activity and

nutrition. The curriculum is integrated into the local community schools' physical education classes. Health screenings, including total cholesterol (high density lipoprotein, low density lipoprotein) and a fitness evaluation that included stretches, sit-ups, blood pressure, and 3-minute step test were provided. To support Indian youth to lead healthier lifestyles, there is a weekly parent meeting to share recipes and exchange healthier food ideas. A garden project was created at the local substance abuse counseling facility. Youth and adults assist with the gardening and learn about many aspects of food production. Each of the participants received college credit from Mendocino Community College. The Fit Teen curriculum is being reviewed and will be modified to meet state education standards. An average of 25 adults met for the Healthy Lifestyle each month.

Physical Activity Kit (PAK)

Despite the well known benefits of physical activity, many adults and children remain sedentary. Daily physical activity and exercise are extremely important for the health and well being of all people. According to the IHS Clinical Reporting System data, more than 80% of adults are either overweight or obese, and 49% of the children (ages 6 to 11) are overweight or obese.

In an attempt to increase physical activity in communities, the IHS HP/DP program partnered with the University of New Mexico, Prevention Research Center to develop a Physical Activity Kit (PAK): Staying on the Active Path in Native Communities . . . a Lifespan Approach. The goal of the PAK is to promote age and culturally appropriate physical activities across the life span in AI/AN communities and to increase time spent in moderate to vigorous physical activity. The PAK contains modified American Indian games, exercise breaks, Native American dance aerobics, healthy body awareness, and powwow dances to encourage people of all ages to engage or be involved in physical activity in the school, Head Start program, elderly centers, youth organizations, and communities.

A workgroup consisting of IHS HQ HP/DP representatives, IHS nutritionists, Community Health Representatives, Head Start personnel, Area HP/DP Coordinators (Albuquerque, Portland, Oklahoma), and UNM staff was convened to plan, develop, and fieldtest PAK. Much of the work was built on the Pathways Physical Activity Intervention program and the Healthy Body Awareness program. Communities and schools may have limited resources to purchase equipment, so the workgroup took this into consideration when games and dances were developed or contributed. The PAK was developed in accordance with the Centers for Disease Control and Prevention (CDC) Physical Activity Guidelines and *Guide to Community Prevention Services Systematic Reviews and Evidence Based Recommendations*.

Eleven teams consisting of two to three individuals from across the country attended a two-and-a-half day training held in Albuquerque, New Mexico in April 2007. Follow up teleconferences were scheduled for the teams to share outcomes, ideas, challenges, and successes. Team feedback and ideas were taken into consideration in the revision of the PAK and development of the training manual. Teams reported that the PAK is easy to use, kids and adults had fun engaging in the exercise breaks and American Indian games and dances, and could be used in any setting. The project was realized through partnership with the University of New Mexico, Prevention Research Center, and the many partners representing eleven American Indian communities who made significant contributions by implementing and providing recommendations to the workgroup. Their enthusiasm and energy has made it possible for the development and rollout of the PAK to encourage people of all ages to participate in physical activity. A National Physical Activity Kit Rollout event was held May 14, 2009 in Rockville, Maryland. The PAK and a list of trainers who might be available in your area may be found on the IHS HP/DP website at *http://www.ihs.gov/hpdp/*.

New Web Tools on HP/DP Web Site

To increase access to tools, resources, and information, the HP/DP website (*http://www.ihs.gov/hpdp*) was updated in May 2009. Most of the new content has been added to the "Tools and Resources" section of the main menu. First, the interim "*Community Health Assessment*" page lists American Indian and Alaskan Native (AI/AN) and other community assessment materials. Resources include community assessment tools, data resources, and information on how to collect and analyze community assessment data. Second, the "*Wellness Data*" link leads to Behavioral Risk Factor Surveillance System (BRFSS) data analyzed by HP/DP staff for AI/AN and the US General Population; this content is hosted on the Agency's Initiatives pages. Data were analyzed among the six IHS statistical regions and available in table and PowerPoint slide formats (*Example: East Region*).

Third, the "*Physical Activity Kit*," (PAK), as described above, promotes the kit that contains AI/AN traditional forms of physical activity that are modifiable at any age; this was a product of the collaboration between the HP/DP program and the University of New Mexico. Links to the PAK Books are available as well as a link to the "Workstation" (created to facilitate development and pilot testing of the PAK) on the "*Resources*" link on the PAK web site; the Workstation was developed using Microsoft SharePoint Services 3.0 and might not be available on Mac OS X platforms. Similarly, the "*Restoring Balance*" displays information on resources developed to increase community mobilization efforts and an increase in community owned wellness. The Restoring Balance manual was originally developed in the 1970s and is being updated to incorporate tools that communities use today. The "*Fact Sheets*" link displays fact pertinent to HP/DP as well

as links to social marketing (e.g., active promotion of health programs) resources available. Lastly the "old" version of the "*Best and Promising Practices and Local efforts*" is still available on the website.

While there are a number of updates available on the website, the HP/DP program is working to provide communities with more tools to promote health and wellness. First, in collaboration with the other Agency Initiatives (i.e., Behavioral Health and Chronic Care), HP/DP is helping to develop the IHS Best and Promising Practices, Local Efforts, Resources, and Polices Online Submission, Consultation, and Reporting (OSCAR) system. OSCAR will assist communities with getting the information and health services they need, form a database of programs that can be easily accessed on the IHS website, be a resource of external and internal collaboration and communication, and highlight the great work that occurs in the field. Second, the program will be incorporating an online adult Community Health Assessment survey and focus group generator; the survey tool is currently in testing phases and is expected to go live by the end of 2009, with other portions to follow.

Additional tools for 2009 include the schools and worksites policy assessment tool. This tool is being developed to assist schools in assessing their health and wellness policies as well as identify additional policies that they might want to implement in their facility. The HP/DP program is also working with at least one tribal epidemiology center to develop community health profiles based on RPMS and secondary data (e.g., Mortality and Behavioral Risk Factor Surveillance data). The last key improvement will be the incorporation of new media (e.g., RSS feeds) so that tribal leaders, health directors, and community advocates can keep up to date with the most recent information posted on the HP/DP website. To provide any feedback regarding the site updates, please contact Dwayne Jarman at *dwayne.jarman@ihs.gov*.

Healthy Native Communities Partnership, Inc. Seeks to Sustain Health Promotion Efforts at the Community Level

In order to sustain community-based prevention efforts and to provide a focus for partnerships, the Healthy Native Communities Partnership, Inc (HNCP) was incorporated in December 2007. As a non-profit organization that supports Native communities in realizing their own vision of wellness, HNCP serves and is guided by Native communities; facilitates the establishment of local, regional, and national partnerships for wellness; provides training and ongoing technical assistance for public health, leadership, and community development; and supports forums and networks for linking Native community priorities to learning opportunities and available resources.

The Healthy Natives Community Fellowship (HNCF) program, one of the HNCP programs, develops and supports teams of change agents to lead creative wellness strategies in Native communities. The Fellowship program is designed to build the capacity for effective health promotion practices at the local level by increasing the knowledge, skills, and capacities of tribal, IHS, and urban Indian health workers and leaders. The program is an intense year-long opportunity that develops leaders who are catalysts for positive change and who have the skills needed to work with tribal communities to advance a new vision of population health. Native teams from across the country gather four times a year for intensive learning that is hands-on, collaborative, and grounded in Native cultural and spiritual teachings. To date more than 200 fellows from 70 community teams have participated in this powerful, transformational leadership experience.

Fellows have the opportunity to experience and try new tools, practice new skills, and nurture new leadership actions at multiple levels. The Fellowship is seeking teams of 2 to 3 people who represent different sectors of the community, and are part of an on-going group working towards community change and wellness. Application for the 2010 Fellowship class begins with submitting a letter of intent. Instructions are available at *hncpartners.org*.

Find out more about Healthy Native Communities Partnership, Inc. at their website at *hncpartners.org*, where you can hear the stories of Healthy Native Communities Fellows, Community Wellness Champions and Just Move It Partners.

Youth Leadership Training

Youth can play a significant role in planning interventions for their peers and their community. Youth have the capacity to become positive influences and leaders to implement ongoing prevention efforts to reduce tobacco and alcohol use, and use of other drugs among their peers. To effectively address unhealthy behaviors among youth, it is critical to involve youth to identify and implement strategies that will deter their peers from using alcohol and tobacco, and engaging in other risky behaviors. It is critical to reach youth before they begin abusing substances and engage them in meaningful positive activities to enhance their communication and problem-solving skills, and foster leadership and team building skills.

In recognizing that youth are valued partners to plan, coordinate, and implement effective interventions, HPDP called upon the Youth Leadership Institute to develop a customized leadership training for youth and their adult mentors. Two trainings were held in two Area Offices for more than 60 youths and adults. Some of the youth project highlights included organizing a community town hall meeting to discuss and address underage drinking with more than 100 participants, and establishing a youth council recognized by the tribe. The youth council was also successful in obtaining funds to support their prevention efforts. These are two examples of how youth and their adult mentors transformed their new skills and knowledge into action by recruiting and engaging youth in on-going prevention plans.

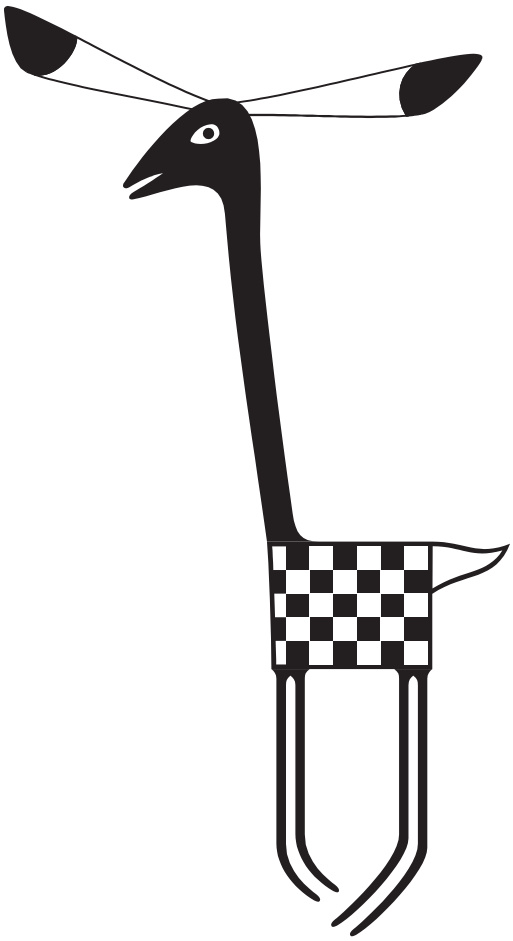
To expand local capacities, HP/DP and Youth Leadership Institute will be developing a customized train-the-trainer activity for AI/AN communities. The training is scheduled to be held in Phoenix, Arizona in August 2009. For information contact Alberta Becenti at (505) 248-4238 or e-mail at *alberta.becenti@ihs.gov*.

In addition to developing culturally tailored tools for communities, the HP/DP Program is working with other IHS Agency Initiatives to promote heath and wellness in the community. To support this integrated plan, four of the twelve IHS Areas have developed an action plan to drive the initiatives. Some of the efforts to integrate the three initiatives included a coordinated plan to bridge the gaps by fully engaging key community leaders and members, utilizing multi-disciplinary approaches, and prioritizing and addressing local health issues.

In summary, HP/DP is working to provide customizable and accessible tools that can be downloaded, printed, and implemented in the local communities. Depending on the users' level of confidence and skill, some of the tools may require training prior to implementation. Please contact your IHS Area HP/DP Coordinators for additional information. If you have any questions about the HP/DP Initiative, please contact Alberta Becenti at (505) 248-4238 or Dwayne Jarman at (240) 328-4923.

References

1. Indian Health Service, Regional Differences in Indian Health 2000 – 2001. U.S. Department of Health and Human Services. May 2003.



Agency Health Initiatives: Spring 2009 Behavioral Health Initiative Update

Peter Stuart, MD, National Psychiatry Consultant, Chinle Comprehensive Health Care Clinic, Chinle, Arizona

The year 2009 promises to be one of change for the Behavioral Health Initiative (BHI). To start, thanks is owed to Gary Quinn, MSW and his leadership of the BHI in 2007 and 2008; his work proved vital to establishing tighter links with Indian Country tribal and program behavioral health leadership through the development of the National Tribal Advisory Council (NTAC) and the national Behavioral Health Workgroup (BHWG). The NTAC brings direct tribal leader input to the IHS Headquarters Division of Behavioral Health (DBH) helping develop strategic direction for behavioral health in Indian Country. The BHWG provides clinical, subject matter expert input to the DBH and assists in refining approaches to and strategies for the clinical, program, and community behavioral health challenges that continue to be sources of significant suffering in our communities. The result has been higher visibility for behavioral health concerns in health care leadership circles throughout IHS and improving relationships and support to the largest segment of our service – the clinical programs. Jon Perez, PhD and Tammy Clay, MSW have taken over, providing support to the NTAC and BHWG.

For 2009 the BHI moves forward with Dr. Peter Stuart, MD, the IHS National Psychiatry Program Consultant, at the lead, assisted by Amina Bashir, MD. The focus of the BHI is shifting from global, cross-agency leadership efforts such as the development and support of the NTAC and BHWG, as these now have become incorporated into DBH functioning, to more focused, applied efforts to support the redesign of health care services and improve access to primary care behavioral health interventions for a broad range of both psychiatric and non-psychiatric acute and chronic conditions.

As a result, the emphasis for 2009 and 2010 has changed to:

1. Getting behavioral health perspectives to the table wherever and whenever health care planning is taking place, and
2. Helping clinical systems of care integrate behavioral health services into primary care.

The following sections provide a glimpse of some of the many activities happening throughout Indian Country that symbolize the increasing engagement of behavioral health in health care system development – both directly sponsored by the BHI and also those occurring as part of individual site efforts to improve the access to and acceptability of behavioral health support. Many sites, providers, and leaders are already actively engaged in discussions that will determine the face of health care in our communities over the next decade and the role behavioral health will play.

Bringing Behavioral Health to the Management and Planning Table

DBH continues to look for opportunities to get involved in the planning and execution of health care activities. This has included participating in discussions with the IHS planning department on updates of the Resource Requirements Methodology (RRM) staffing standards and facilities planning resource documents in order to accommodate the new and changing integrated primary care activities. DBH has increased contacts with the Area Behavioral Health Consultants and will be supporting attendance for the consultants at the annual National Councils meeting. Area Behavioral Health Consultant leadership and coordination provide a critical link between clinical programs and national activities. DBH has also deployed more resources supporting relations with cross-disciplinary activities such as the development of national policy on the use of chronic opioid therapy, developing approaches to managing alcohol and substance abuse regulation conflicts (42 CFR Part 2) arising from work in integrated settings, collaborating with traditional healers in the treatment and management of HIV, and engaging with primary care providers at conferences such as the annual Advances in Indian Health conference.

Nashville Area Develops Behavioral Health Leadership

Nashville Area, under the direction of Palmeda Taylor, PhD, promotes the active involvement of behavioral health directors in disseminating best practice approaches. Using the primary principle from the Chronic Care Initiative Innovations in Planned Care collaborative – *we all teach and we all learn* – the Area established a learning community for its health care providers in part through a series of scheduled continuing education conference calls. While these calls are primarily aimed at behavioral health providers, Area providers of all disciplines are encouraged to participate.

The goal of the calls is to provide information and tools necessary to implement new ideas and best practices in integrated care, and to accelerate improved and sustainable outcomes in the management of patients with chronic conditions.

Nashville Area plans four all-Area calls for FY'09. The

topics include: Telehealth for Behavioral Health; Co-occurring Disorders in Treatment: Evidence-Based Strategies; Screening and Assessing Substance Abuse in Adolescents; and Motivational Interviewing Techniques in Counseling. Session facilitators are recognized experts in the fields of mental health and substance abuse, and come from within and without the Indian Health Service (IHS). The first call in the series on telebehavioral health was held in March. The third call scheduled for May will be facilitated by staff from the Unity Healing Center at Cherokee, NC.

The Area plans frequent communication with its established learning community via videoconferencing, web-based presentations, email, and listservs, with a particular focus on supporting providers managing difficult cases. For more information, contact Palmeda Taylor, PhD at *palmeda.taylor@ihs.gov*.

Merging Data Systems: Bringing the Behavioral Health Record into the Electronic Health Record

Another area benefiting from ongoing and active behavioral health involvement in planning is the IHS Electronic Health Record. Denise Grenier, MSW and BJ Bruning, MSW continue to coordinate and oversee the ongoing integration of RPMS behavioral data functions into the larger Electronic Health Record package. Health information technology plays a critical role in the integration of primary care and behavioral health. A comprehensive, integrated health information system can offer the care team the ability to provide services in a manner that promotes coordinated and holistic care, enhanced patient safety, and improved patient outcomes. The Resource and Patient Management System Electronic Health Record (RPMS EHR) is now deployed at approximately 200 tribal, urban, and federal health care facilities. Behavioral health (BH) providers at these facilities can now enter individual patient services into the EHR, including individual visit encounters, phone calls, and chart reviews. Prescribing providers can utilize electronic order/prescription entry for medications, lab tests, and radiographs. Medical Social Workers can have access to complete medical information, including Immunization, Prenatal, and Well Child history. EHR clinical application coordinators (CAC) work with BH providers to develop BH-specific ICD9, CPT, and Patient Education pick lists, as well as clinical note templates. National recommendations for business rules to limit access to BH clinical notes have been developed. The EHR user interface can even be customized to support the unique work flow and business processes of BH providers.

Future enhancements to the EHR to support the provision and documentation of BH services include group encounter entry and the ability to enter diagnosis and Problem List entries using either ICD9 or Diagnostic Standards Manual (DSM-IV-TR) codes.

Behavioral health visits entered into RPMS via the EHR also populate the RPMS Behavioral Health System database. Information from this database, in addition to that from the Patient Care Component (PCC)/National Data Warehouse (NDW), is mined routinely by the Division of Behavioral Health to support workload reporting and program planning.

For more information on the use of the RPMS EHR by behavioral health providers, please visit the Office of Information Technology EHR and Integrated Behavioral Health websites at *http://www.ihs.gov/cio/bh/* or *http://www.ihs.gov/cio/ehr/* or contact Denise Grenier at *denise.grenier@ihs.gov*.

Integrating Behavioral Health Services into Primary Care

Primary care behavioral health, integrated primary care, behavioral health integration – whatever you prefer to call delivering real and effective behavioral care in primary care – are all coming to a Medical Home near you. If you are serious about patient centered care, this approach needs to be on your planning list. Fortunately, Indian Country has programs at the forefront of this movement and is trying out several different models of integration. The Innovations in Primary Care (IPC-II) collaborative sites are building a base from which to successfully incorporate behavioral health expertise in the day-to-day primary care practice. Here are some thoughts from two of our home-grown expert systems – Southcentral Foundation in Anchorage and Wind River Service Unit – on integrating behavioral health services.

Behavioral Health Integration at Southcentral Foundation in Anchorage Alaska

Type of Collaboration: In keeping with the Southcentral Foundation (SCF) vision of wellness for the whole person, a team of behavioral health consultants, or BHCs, was started in the Primary Care Center five years ago. Customers can receive comprehensive and immediate treatment in the exam room while visiting their primary care provider. Overall, the goal is to meet customers right where they are and to provide immediate services for a wide range of physical, mental, and emotional needs. BHCs share offices with the providers and case managers, creating seamless communication and collaboration for patient care.

Staffing, Funding, and Infrastructure: BHCs are part of primary care and are located in family medicine, women's health, and pediatrics. There are currently 11 BHCs to serve about 40 provider teams. BHCs are Licensed Professional Counselors and Licensed Clinical Social Workers. Southcentral Foundation is funded by a mix of private insurance, IHS funds, and grants.

Resources and Toolkits: We use a variety of resources, such as the Prime MD for depression, the P-3 and SCL-90 for chronic pain, the Cognistat for dementia, the ASQ for child development, and the Audit for substance abuse. We have also developed clinical guidelines for mood disorders, grief, anxiety, chronic pain, ADD/ODD, and sleep disorders. In

addition, a combination of handouts and workbooks are utilized.

What Works: For integration to be successful, shared offices are a must. Information is easily shared and it reminds providers to utilize BHCs. Remember: out of sight, out of mind. Also, when customers are seen in the exam room and introduced by their providers, it makes for a seamless transition. Stick to short, solution focused visits.

What Doesn't: Having too many scheduled visits makes the BHC unavailable for consults. Trying to be too rigid in therapeutic approaches also will not work. Flexibility is key. Hiring clinicians who have a lot of experience can pose adaption issues, as it can be difficult for them to change the way they work.

Next Steps: Implementing a chronic pain program, developing collaboration with university systems to expose and train students to the integration model, developing prenatal support and early family intervention, implementing a data tracking system to assess and monitor program improvements, and working at the state level to develop billing systems for Brief Intervention.

For more information, contact Wendy Bradley at *wdbradley@southcentralfoundation.com*.

Behavioral Health Integration at Wind River Service Unit

Wind River Service Unit is a pilot site for the Indian health system Chronic Care Initiative. I have been the key contact and team leader through the first phase (Innovations in Planned Care, or IPC-I) and continue in that role now that IPC-II is in full swing. Integration of motivational techniques into the primary care clinic has been a focus and a goal of mine since my arrival in Fort Washakie in February 2006. Integration of behavioral health is also a secondary goal of IPC-II, so I have been able to focus on some of my goals over the past two years while giving much of my attention to IPC-I.

To begin integrating my services directly into the medical clinic, my PC was taken away and replaced with a laptop. Without an office in the medical clinic, I began wandering and accepting "warm hand-offs" from the providers in the exam room, borrowing some rapport in order to establish a quick connection with our customers/patients. A good connection happens about 75% of the time and the other 25% are just not interested in talking.

Contacts with patients are kept to about 15 minutes (coded Preventive Medicine or Risk Factor Reduction CPT #99401) (30, 45 and 60 minutes are coded 99402, 03, and 04 respectively). If more time is needed in more complex cases, the patient is taken from the exam room to my office or an appointment is made for the patient to return. They often do not return, so quick motivational work is the way to operate.

Often the patient is gone and the provider is off in another exam room before I get an opportunity to huddle with the provider about my findings. Using the Electronic Health Record's "Identify Additional Signers" feature (under the Action menu in Progress Note) is a good way to communicate recommendations to the provider regarding medications as well as findings or plans. The note will not go away until the provider signs it, and our providers know they are only asked to sign notes that contain important information for them.

At this writing, we have no outcome measures on this work. The providers say they find it helpful. The patients say they find it helpful (and they often reveal information prefaced by, "Please don't tell the doctor, but . . .." as if they don't wish to disappoint her/him.) Revelations like this offer great opportunities for growth.

I cannot take up exam rooms needed by providers, so with a shortage of rooms we have logistical problems. I cannot see as many patients as I should. The other difficulty is that IPC-II work is very demanding, taking me out of the medical clinic. If the providers don't see me, they don't think to use my services. Additionally, though I've provided inservice training, some providers still don't seem to understand the difference between what I do and what the Behavioral Health Department professionals do. In other words, I continue to get called in for adults in the midst of depressive episodes unrelated to any chronic illness or condition.

For more information, contact Sandra Delehanty at *sandra.delehanty@ihs.gov*.

Innovations in Planned Care Collaborative – Phase 2

As part of the integration journey, DBH is coordinating closely with IPC leadership to develop and maintain alignment of behavior health related outcomes and indicators. This has included work on broadening available measures of depression management in order to more effectively track the introduction of care management for depression and patient response in the primary care setting. IPC-2 work sessions have included integration presentations by national experts such as Brenda Reiss-Brennan from Intermountain Healthcare's Integration Learning Community and Steven Cole from the HRSA Depression Collaboratives. Work is underway on expanding the alcohol screening indicator and tracking trauma-related presentations to primary care settings, where interventions like the Alcohol Screening and Brief Intervention can be effectively applied. As part of IPC-2, sites comfortable with basic population care management processes are beginning discussions on introducing more formal primary care level behavioral health services into the primary care setting using the cycles of change testing model (Model for Improvement).

For more information, contact Ty Reidhead at *charles.reidhead@ihs.gov*.

Plans for 2009/10

1. Incorporating presentations and tracks into the Indian Health Summit to be held on July 7 - 9 in Denver, Colorado and the National IHS/SAMHSA Behavioral Health Conference on behavioral health integration, best practice cross-disciplinary programs and basic

integration technology.

2. Promoting development of expertise in primary care-based behavioral health services by supporting participation in the University of Massachusetts' Department of Family Medicine and Community Health Certificate Program in Primary Care Behavioral Health (contact Peter Stuart at *peter.stuart@ihs.gov* for details).
3. Developing the Behavioral Health Initiative Core Leaders group with representation from Women's Health, IPC-II and the Chronic Care Initiative, the Health Promotion/Disease Prevention Initiative, Area Behavioral Health Consultants, and Indian Country Behavioral Health subject matter experts.
4. Participating in the joint development of the three Health Initiatives' communication plan to assist in more effective dissemination of information, technical resources, and community sharing among I/T/U sites and throughout the Indian health system.
5. Supporting the development of the current and next generation of Indian Country behavioral health leaders in collaboration with the Center for Mental Health Services. Two face-to-face meetings are planned in late summer and early fall. Contact your Area Behavioral Health Consultant in early summer if interested.
6. Looking for opportunities to develop a primary care behavioral health-specific learning community – likely in collaboration with existing national learning communities and tied closely into the IPC-II activities.
7. Continuing support to cross-disciplinary efforts such as IPC-II and the Chronic Care Initiative; the Obesity Workgroup under the Health Promotion and Disease Prevention Initiative; the Alcohol Screening and Brief Intervention program arising from the IHS Trauma program under the leadership of David Boyd, MD; and the pilot integrated women's health care grant program and soon to be expanding Domestic Violence funding initiative under the leadership of Carolyn Aoyama, CNM, MPH.
8. Developing outcome indicators that accurately reflect the changing care delivery approaches, and assist sites in assessing their progress on the integration continuum while helping identify positive patient outcomes.

In summary, the Behavioral Health Initiative remains focused on the integration of a behavioral health perspective into health care delivery throughout our systems of care. Practically, this means both the medical and behavioral health systems collaborating more closely with each other and planning services together, and working to develop systems of care that bring behavioral health supports and interventions to our patients, families, and communities when and where they need it.

The BHI contacts are Peter Stuart, MD at *peter.stuart@ihs.gov* and Amina Bashir, MD at *amina.bashir@ihs.gov*.

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

""Any idiot can face a crisis; it is this day-to-day living that wears you out.""

Anton Chekov

Editorial Comment

The article below is reprinted from *The New York Times* of April 24, 2009. Dr. Reinhardt is a health economist, born in Germany, who now works at Princeton University. He suggests that the way we, as a nation, provide health care for children is a reflection of how we value them. Are children "pets" or "precious resources"? Read on.

Article of Interest

Seriously, What Is a Child?

Dr. Uwe Reinhardt

An intriguing question to which I have sought the answer ever since coming to these shores is what Americans think of children. Do they view children as the human analogs of pets? Or do they view them, as do most Europeans and Asians, as precious national treasures? Perhaps a mixture of both?

This is not meant to be a frivolous question. Its answer informs the nation's health policy. If one views children primarily as the human analog of their parents' pets, then it follows that children's health care is primarily the parents' financial responsibility, although one might extend public subsidies to very poor parents to help them care for their children adequately. On this view it is just and proper that, of two households with identical incomes, the one with children will have substantially less discretionary income after necessities than does the childless household.

On the other hand, if one views children as national treasures -- and the nation's economic future -- then it makes sense to make the health care of children the financial responsibility of society as a whole, just as is the financing of public elementary and secondary education. Why treat children's education as a social good, but their health care as a private consumption good?

I developed renewed interest in this question after observing the tortuous debate in Congress during the last two years over S-chip, the State Children's Health Insurance Program. The debate was over how high up the income scale the public subsidies inherent in S-chip should be extended to American families.

At the time, about *nine million* American children remained uninsured, most of them in low-income or poor households. Of these, however, close to seven million children actually were entitled to S-chip, but not enrolled. Parental ignorance about this program and the often vexing bureaucratic hurdles that must be scaled to enter S-chip have been the main barriers of entry.

Worse still, unlike Canadians, Europeans, Taiwanese, and Japanese, Americans seem to impute different social values to the health care of children, depending on their socioeconomic status, even if they have insurance. In New Jersey, for example, Medicaid pays a pediatrician about $30 or so for a pediatric office visit. The comparable fee for commercially insured children is somewhere between $100 to $120 a visit. Evidently, through their legislative representatives, the good burghers of New Jersey tell pediatricians that their professional work has only about a third or a quarter of the social value that New Jersey citizens impute to an office visit by a child from a middle- or upper-income family. This differential valuation is uncommon in other industrialized nations, where physicians typically are paid the same fee for a given service, regardless of the patient's socioeconomic status.

Physicians in New Jersey, and in analogous situations in other sates, have perceived this differential-value signal only too clearly. So informed by the citizenry, many of them refuse to treat children on Medicaid altogether. Blame not the physicians, however. The Hippocratic Oath does not mandate ignoring such powerful economic signals. If Americans want to blame anyone for this circumstance, they'll find the culprit in the mirror.

As an American who grew up in Europe and lived for years in Canada, I still have the habit of regarding children as national treasures. In that frame of mind, I recommend to the president and to Congress an alternative approach to health insurance for children. Just as merely being born on American soil entitles even the child of illegal immigrants to American citizenship and with it a whole battery of publicly financed services -- notably elementary and secondary education -- so should any child in this country be entitled to tax-financed public health insurance until age 22. Parents who wish to opt out of this public program would receive a risk-adjusted, actuarially equivalent voucher to procure at least equally good coverage from a private insurer. But coverage of children would be mandatory.

The purchasing function under this public program, that is organizing and managing care, could be delegated to private for-profit or nonprofit insurers, as in Medicaid Managed Care. Private insurers would then compete over the quality of their disease-management programs, not through judicious risk selection. Finally, the fees paid providers under the public program would be set equal to the average of fees paid by the largest two or three private insurers in the state, lest the professional work of physicians caring for poor children continue to be relatively undervalued.

Gone would be the presence of uninsured children in our midst. Gone would be the haggling over how high up the income scale S-chip eligibility should go. Gone would be the relative undervaluation of professional work for poor children. School-based programs for primary health care, staffed by local, self-employed physicians and nurses under contract, would be financially feasible. And American health-services researchers would no longer have to blush over this country's spotty health insurance for children when attending health care conferences abroad.

We have about 3.3 working-age Americans per elderly American in this country now. According to the Social Security Trustees, that ratio will decline to close to about 2 by the 2030. In light of this trend alone, can anyone doubt that children really are precious? We should give medals to parents who have them, not penalize them financially.

Infectious Disease Updates.
Rosalyn Singleton, MD
H1N1 "Swine-origin Flu and You"

Novel influenza A (H1N1) is a new flu virus of swine origin that was first detected in April, 2009. As of May 11 there are 2618 H1N1 cases in 43 states and Washington DC, with three deaths and 94 hospitalizations in the US. The novel H1N1 flu spreads in the same manner as regular seasonal flu. Although regular seasonal flu (H1N1, H3N2, and B) viruses are still circulating, the H1N1 "unsubtypeable" virus now accounts for a significant number of viruses detected in the US.

Testing. The CDC has developed a PCR diagnostic test to detect this novel H1N1 virus and has distributed test kits to all states, to allow states to confirm this virus.

Clinical Guidance. CDC has issued interim guidance for clinicians on identifying and caring for patients (*http://www.cdc.gov/h1n1flu/identifyingpatients.htm*) and on the use of antiviral drugs (*http://www.cdc.gov/h1n1flu/recommendations.htm*). For antiviral treatment of novel influenza (H1N1) virus infection, either oseltamivir or zanamivir are recommended. The FDA has issued an emergency use authorization allowing use of oseltamavir in children <1 year of age. All 62 states or project areas have received shipments from the Strategic National Stockpile, which includes antivirals. Tribal nations need to work with their states to receive these assets. Go to *http://www.cdc.gov/h1n1flu/pdf/preparing_tribal_national_stockpile.pdf*.

Vaccine. The regular seasonal 2008 - 9 Flu vaccine is not expected to have efficacy against this novel strain of flu. Development of a vaccine specific to this virus is in progress, but the vaccine will not be available until September at the soonest, and will not be available in mass quantities until later.

For more information on H1N1, visit the CDC website at *http://www.cdc.gov/H1N1flu/*.

Impact of Immunizations on Disease Burden of American Indian/Alaska Native Children

FYI, a new article summarizing the "Impact of Immunizations on Disease Burden of American Indian and Alaska Native Children" was just published in the May edition of *Archives of Pediatrics*. Go to *http://archpedi.ama-assn.org/cgi/content/full/163/5/446*.

Recent literature on American Indian/Alaskan Native Health
Michael L. Bartholomew, MD

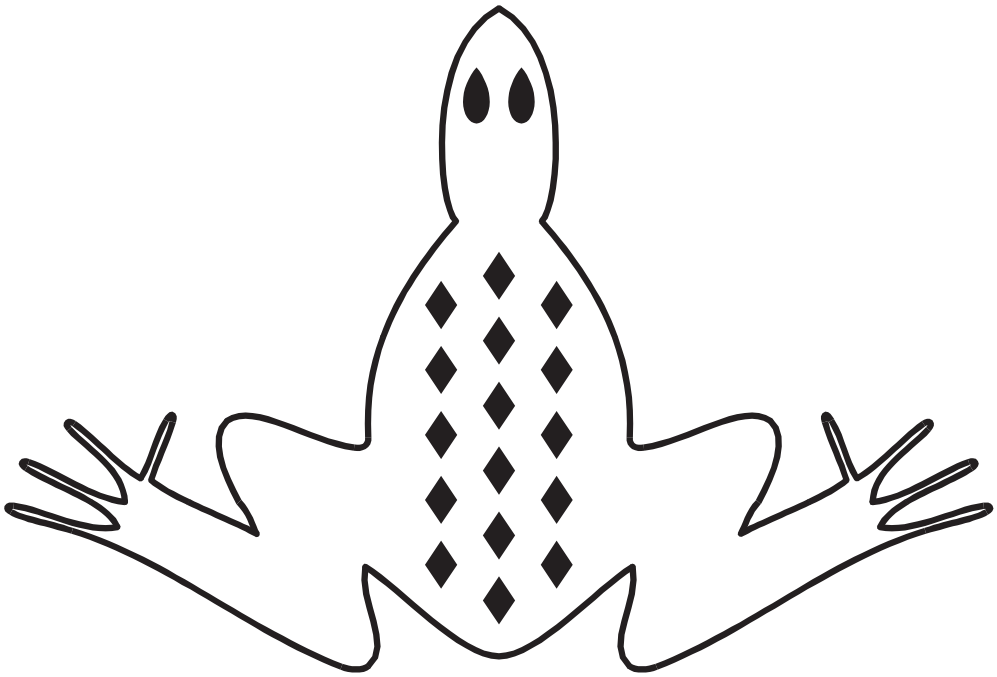
Reynolds MG, Holman RC, Christensen KLY, et al. (2009). The incidence of Molluscum contagiosum among American Indians and Alaska Natives. PLos ONE 4(4): e5255. doi:10.1371/journal.pone.0005255.

Molluscum contagiosum (MC) is a superficial, viral dermal infection. It is often a benign self-limiting skin condition of distinctive persistence that slowly evolves over the course of several weeks to several months. Due to the distinct characteristics of the lesions, diagnosis is often clinically based and laboratory testing is not required. Treatment (mechanical removal or topical therapies) for Molluscum contagiosum is often variable and dependent upon location, the number of lesions, and patient preference. Despite the highly communicable characteristics of this disease, the epidemiology of MC is largely unknown. The authors of this analysis sought to describe the epidemiology of Molluscum contagiosum among American Indian and Alaska Native persons.

The authors analyzed IHS direct and contract molluscum contagiosum-associated outpatient data from the IHS National Patient Information Reporting System (NIPRS) between 2001 - 2005. The average annual AI/AN MC-associated outpatient visit rate between 2001 - 2005 was 20.15 per 10,000 persons, similar to the general US population MC-associated outpatient visit rate of 22.0 per 10,000 persons. The number of visits and rate were similar by gender in both AI/AN population and in comparison to the general US population. AI/AN children aged 1 - 4 years had the highest MC-associated outpatient visit rate of 102.98 per 10,000 (general US population 82.6/10,000). Among IHS regions, the west region had the highest annual MC-associated outpatient visit rate (35.4/10,000) while the southern Plains had the lowest at 12.1/10,000. The mean annual incidence of MC-associated clinic visits among AI/AN was 15.3 cases per 10,000. Regionally, the west, east, and

Alaska had the highest incidence, while the southwest and southern Plains had the lowest.

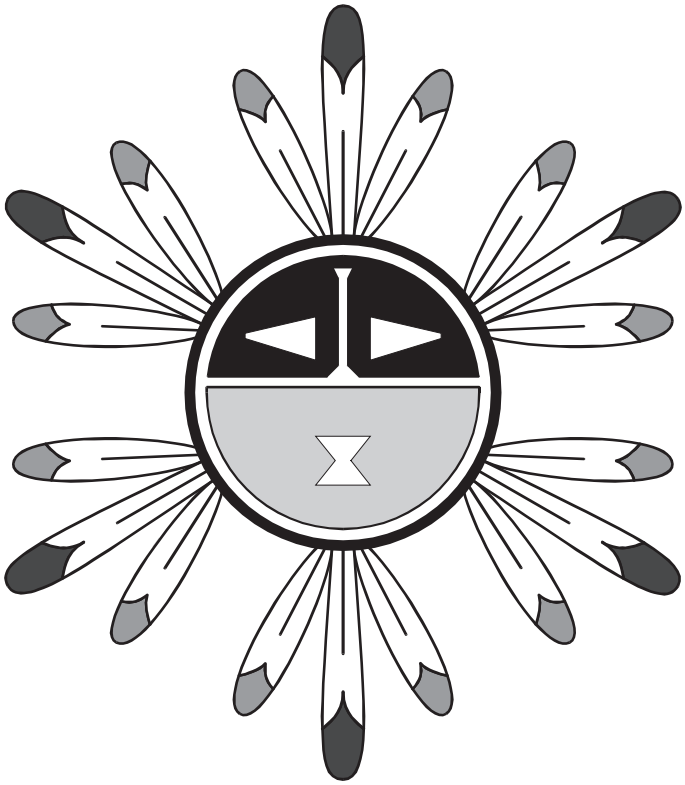
This study illustrates a comprehensive epidemiologic evaluation of Molluscum contagiosum in the AI/AN population. However there are a number of limitations, including that the derived rate is dependant upon patient visitation for MC, incomplete miscoded diagnosis, the fact that the AI/AN user population is an estimate of AI/AN population, and because health care seeking behavior is regionally variable. The authors conclude that the AI/AN population "should benefit from community outreach regarding MC prevention, particularly in very young children."



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

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

Data generated from iCare reports may suggest areas of desirable performance improvement that may respond to both educational and system-based interventions.



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*.

Indian Health Summit
July 7 - 9, 2009; Denver, Colorado

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

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

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

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

NANAINA Summit XV: Preventing Violence against American Indian/Alaska Native Women
August 6 - 9, 2009; Albuquerque, New Mexico

IHS, tribal, and urban nurses are encouraged to attend the NANAINA Summit XV to be held at the Embassy Suites Hotel, 1000 Woodward Place NE, Albuquerque, New Mexico, 87102. To reserve a room at the Embassy Suites Hotel call (505) 245-7100 or (800) EMBASSY. Please be sure to mention NANAINA. A block of rooms has been reserved for NANAINA at the rate of $129 per night/king or double, additional person $10.00. Reservations can also be made online at *www.embassysuites.com*. Insert the dates "August 6 - 9, 2009" and put Convention Code "ANA." Deadline for group room rate is July 7, 2009.

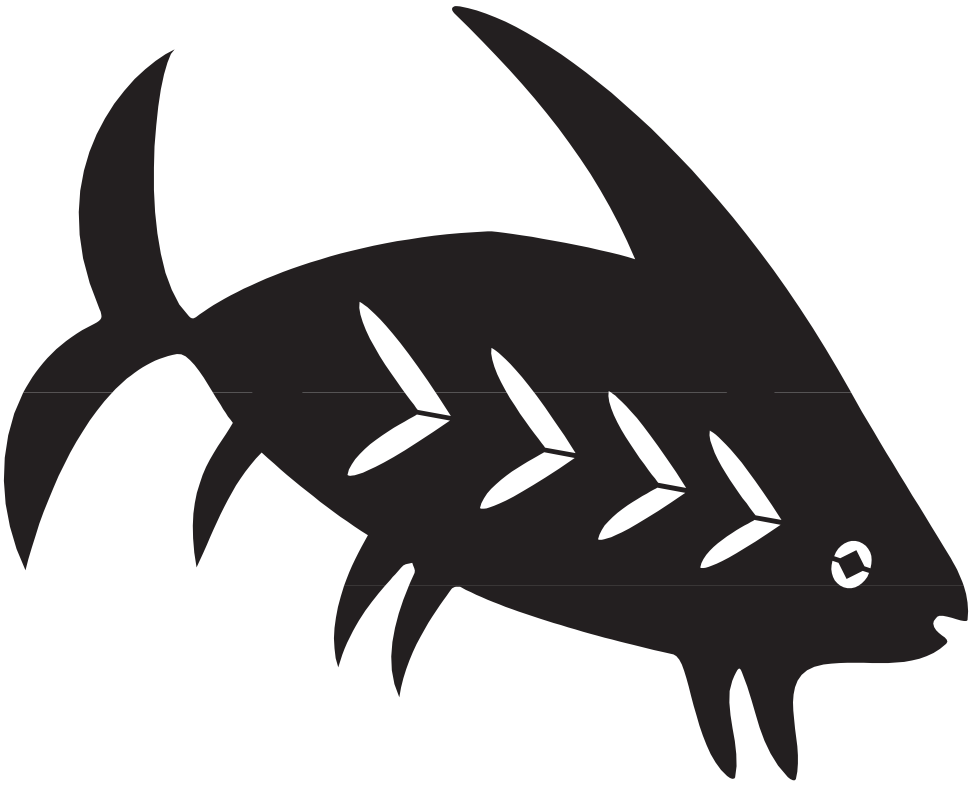
Abstracts for the poster session can be sent to Beverly Patchell at *Beverly-Patchell@ouhsc.edu*. Deadline for poster abstract submission is July 15, 2009. The IHS Clinical Support Center is the accredited sponsor of this meeting. For on-line registration and for more information about the conference, visit the NANAINA website at *www.nanainanurses.org*.

August 2009 Clinical Update on Substance Abuse and Dependency (Formerly known as the Primary Care Provider Training on Chemical Dependency)
August 25 - 27, 2009; Bemidji, Minnesota

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

Where Are My Back Issues?

Due to delayed payments to some vendors that have occurred with the transition to the UFMS system, there have been problems with distribution of the mailed issues of The Provider. These have been resolved, and back issues have been mailed. We will do everything in our power to keep things current from this point on. Readers are still encouraged to take advantage of the opportunity to sign up for the listserv that gives notification as soon as the electronic version is posted on our website – usually in the middle of the month. Issues may be read in their entirety as soon as they are posted, and so no time-sensitive information will be missed. To join the listserv, go to *http://www.ihs.gov/PublicInfo/Publications/HealthProvider/provform.asp* and subscribe. You may retain your paper subscription also, if you prefer to receive issues both ways.



POSITION VACANCIES

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

Family Practice Physician
Pharmacist
PHS Clinics; Wind River Service Unit, Wyoming

This is the primo IHS opportunity. Two family physicians will be retiring in January to split a position between them, leaving a hiring opportunity for this progressive and stable seven-physician group (six FP and one pediatrician). We admit patients to the Lander Regional Hospital on a 1/7 on-call basis and staff two clinics on the reservation, along with four nurse practitioners. The Wind River Reservation is home to the Northern Arapaho and Eastern Shoshone Tribes. Local cultural opportunities abound, and the medical practice is fascinating and challenging.

The physicians tend to live in Lander, which is located adjacent to the Wind River Indian Reservation. Lander was featured in Sunset Magazine as one of "The West's Twenty Best Small Towns" and has been featured in the book "Best Small Towns in America." It is located next to the Wind River Mountains, which offer a spectacular chance for world class climbing, hiking, outfitting, fishing, and hunting. Lander is progressive and is the world headquarters for the National Outdoor Leadership School. Next fall, Lander High School graduates will attend MIT, Duke, and Princeton. The IHS physicians enjoy a great relationship with the private physicians in town, and the hospital sports the latest generation MRI, CT, and nuclear medicine capabilities. This is the kind of IHS medical staff that physicians join and end up staying for ten to twenty years. Board eligible/certified applicants only, please. E-mail CV to Paul Ebbert, MD at *paul.ebbert@ihs.gov* or call him at work at (307) 856-9281 or at home at (307) 332-2721.

The Wind River Service Unit also has an opening for a pharmacist. Pharmacists at Wind River enjoy a close professional relationship with the medical staff. There is interest and opportunity for pharmacists to expand their skills into enhanced patient education and management. Interested candidates should contact Marilyn Scott at *marilyn.scott@ihs.gov* or call (307) 332-5948. (6/09)

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

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

We are seeking two providers:

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

Candidates must currently hold a California license. Qualified applicants, please fax resume, cover letter, and salary requirements to Human Resources at (707) 485-7837. For the right candidate, we offer a competitive salary, excellent benefits, and an opportunity for loan repayment. Native American preference in hiring; all qualified applicants will be considered. For more information, please contact Annie Kavanagh at (707) 467-5685, or by e-mail at *akavanagh@cthp.org*. (6/09)

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

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

Sixty miles east of the Sells Hospital by paved highway lies Tucson, Arizona's second largest metropolitan area, and

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

We offer competitive salary, relocation/recruitment/retention allowance, federal employment benefits package, CME leave and allowance, and loan repayment. Commuter van pool from Tucson is available for a monthly fee. For more information, please contact Peter Ziegler, MD, SSU Clinical Director at (520) 383-7211 or by e-mail at *Peter.Ziegler@ihs.gov*. (6/09)

Family Nurse Practitioners

San Simon Health Center, Sells Service Unit; Sells, Arizona

The Sells Service Unit (SSU) in southern Arizona is recruiting for a family nurse practitioner to provide ambulatory care in the recently opened San Simon Health Center and another family or pediatric nurse practitioner to provide ambulatory care in our school health program. The SSU is the primary source of health care for approximately 24,000 people of the Tohono O'odham Nation. The service unit consists of a Joint Commission accredited 34-bed hospital in Sells and three health centers: San Xavier Health Center, located in Tucson, the Santa Rosa Health Center, located in Santa Rosa, and the San Simon Health Center located in San Simon, with a combined caseload of approximately 100,000 outpatient visits annually. Clinical services include family medicine, pediatrics, internal medicine, prenatal and women's health care, dental, optometry, ophthalmology, podiatry, physical therapy, nutrition and dietetics, social work services, and diabetes self management education.

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We offer competitive salary, relocation/recruitment/retention allowance, federal employment benefits package, CME leave and allowance, and loan repayment. For more information, please contact Peter Ziegler, MD, SSU Clinical Director at (520) 383-7211 or by e-mail at *Peter.Ziegler@ihs.gov*. (6/09)

Internal Medicine/Hospitalist

Phoenix Indian Medical Center; Phoenix, Arizona

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

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

Psychiatrist

White Earth Health Center; White Earth, Minnesota

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

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

Family Practice Physician

Nurse Practitioner

Pawhuska IHS Health Center; Pawhuska, Oklahoma

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

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

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

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

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

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

Physicians
Belcourt Comprehensive Health Care Facility; Belcourt, North Dakota

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

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

Physicians
Eagle Butte IHS Hospital, Eagle Butte, South Dakota

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

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

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

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

Medical Director (Salary/DOE/Full-Time/Lapwai). MD or DO with current certification in family practice or internal medicine. Must have completed an internship, be board certified, with at least five years of clinical experience. Must be licensed to practice medicine in Idaho, or obtain state of

Idaho license within one year of appointment. Must have BLS and ACLS certification. Knowledge of history, culture, and health needs of Native American communities preferred. Must maintain current license and certification, have a valid driver's license with insurable record, and will be required to pass extensive background. Closes 1/09/09. Tribal preference applies.

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

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

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

Pharmacist
Juneau, Alaska

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

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

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

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

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

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

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

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

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

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

Anchorage is a city of 330,000, the largest city in Alaska. Lots of cultural activities including a performing arts center that hosts national and regional troops, the Anchorage Museum of Natural History, and the Alaska Native Heritage Center. Alaska is known as the land of the midnight sun, as we bask in

19.5 hours of daylight on summer solstice. Our summer temperatures reach into the upper 70s, and the landscape transforms into green trees and flower blossoms. On winter solstice, we enjoy beautiful sunrises and sunsets over snowcapped mountains, and darkness brings the possibility of breathtaking displays of the northern lights.

Hundreds of kilometers of groomed, interconnected cross country ski trails in town are lit at night by artificial light and the incredible moonlight reflecting off of the snow; these trails are perfect for running and biking in the summer. There are good public schools, good community, and incredible outdoor activity opportunities.

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

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

The Wind River Service Unit has an immediate opening for a family nurse practitioner/physician assistant and a pharmacist (PharmD), as well as a fall 2009 opening for a family practice physician to provide care across the life span and to manage panel of patients from the Shoshone and Arapahoe Tribes on the Wind River Reservation. Located in the central part of pristine Wyoming, climbing, hiking, hunting, fishing, and water sports are minutes away. Out patient care is provided at two sites, one located in Arapahoe and one located in Ft. Washakie. Dedicated, dynamic staff includes ten RNs, six family physicians, one pediatrician, four family nurse practitioners, psychologists, social workers, four dentists, a certified diabetic educator, a diabetes educator, a health educator, five public health nurses, three PharmDs, two pharmacists, and two optometrists. Specialty clinics include orthopedics, podiatry, nephrology, obstetrics, and audiology. An open access model is used. Inpatient care is provided by the physicians at an excellent 83-bed community hospital in nearby Lander, with a fully staffed inpatient psychiatric hospital and rehabilitation unit.

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

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

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

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

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

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

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

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

Our Medical Staff is composed of five family practice physicians, two internal medicine physicians, one pediatrician, one podiatrist, and four family nurse practitioners/physician assistants. We have a full complement of support services, which include dental, optometry, audiology, psychology, social

work, radiology, lab, public health nursing, and very active Diabetes Department. These are ambulatory clinics; however, our providers have privileges in the local community hospital. We have approximately 80,000 patient contacts per year. We work very closely with the private sector. IHS and the private hospital have a cardiac rehabilitation center. By cooperating with IHS, the hospital has been able to get a CT scanner and a mammography unit. The Tribal Health Program has a dialysis unit attached to the Poplar IHS clinic. Customer service is our priority. The IHS has excellent benefits for Civil Service and Commissioned Corps employees. There are loan repayment options, and we are a designated NHSC site. We strive to provide quality care through a strong multidisciplinary team approach; we believe in being closely involved in our population to encourage a healthier community.

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

Family Practice Physician
Pharmacists
PHS Indian Hospital, Harlem, Montana

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

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

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

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

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

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

The Northern Cheyenne Service Unit is seeking health practitioners to come work with their dedicated staff on the Northern Cheyenne Indian Reservation. The Northern

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

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

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

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

The Crow Service Unit is seeking health practitioners to come work with their dedicated staff on the Crow Indian Reservation. The Crow Service Unit consists of a small 24-bed hospital located in Crow Agency and two satellite clinics, Lodge Grass Health Center, located approximately 20 miles south of Crow Agency, and Pryor Health Station, located about 70 miles northwest of Crow Agency.

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

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

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

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

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

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

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

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

Nurse Specialist - Diabetes
Whiteriver Service Unit; Whiteriver, Arizona

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

The Whiteriver Service Unit is located on the White Mountain Apache Indian Reservation. The hospital is a multidisciplinary facility that includes emergency room, urgent care, inpatient, outpatient, dental, social services, physical therapy, optometry, obstetrics, podiatry, dietary, ambulatory surgery, and public health nursing. We are just a short distance from Sunrise Ski Resort which offers great snow skiing. We are surrounded by tall ponderosa pine trees and beautiful

mountains where you can experience the four seasons, and great outdoor activities such as mountain biking, hiking, hunting, fishing, camping, and boating. We are just three hours northeast of the Phoenix metropolitan area.

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

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

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

The Rosebud Comprehensive Health Care Facility in Rosebud, South Dakota is seeking board eligible/board certified family practice physicians, pediatricians, emergency medicine physicians, an internist, and an ob/gyn with at least five years post-residency experience. We are also in need of ER PA-Cs, family practice PA-Cs, and family nurse practitioners. Rosebud is located in rural south central South Dakota west of the Missouri River on the Rosebud Indian Reservation and is approximately 30 miles from the Nebraska boarder. We are a 35 bed facility that has a 24 hour emergency department, and a busy clinic that offers the following services: family practice, internal medicine, ob/gyn, pediatrics, general surgery, oral surgery, optometry, dentistry, physical therapy, dietary counseling, and behavioral health. Our staff is devoted to providing quality patient care and we have several medical staff members that have been employed here ten or more years.

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

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

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

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

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

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

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

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

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

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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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