THE IHS PRIMARY CARE PROVIDER

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

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This article is reprinted from the Alliance for Continuing Medical Education Almanac*, Volume 32, Number 9, pages 6 – 9, published in September 2010. The Alliance for Continuing Medical Education (ACME), as stated in their mission statement, "is a membership organization that provides professional development opportunities for CME professionals, advocates for CME and the profession, and strives to improve health care outcomes." They have graciously allowed us to reprint this article, which will explain to our readers the new, enhanced focus of the needs assessment process for continuing professional education. The list of resources that follows the article offers many sources to use in your assessment of learners' needs. Many more are available that apply more specifically to health care delivery in the Indian health system, your Area, and even your service unit. Most of us are affected by this process either as continuing education coordinators, presenters, or consumers, so we believe this information will be useful to all.*

Identifying and Analyzing Professional Practice Gaps

Kolette Massy, CCMEP, Alliance for Continuing Medical Education Almanac Editorial Board Member

A significant shift has occurred in the CME enterprise over the course of the past five years. The updated Accreditation Council for Continuing Medical Education (ACCME) criteria provide explicit guidance to assist CME providers to incorporate many of the same adult learning principles that are reflected in undergraduate and graduate medical education and adult learning theory. CME should be designed to engage learners in interventions designed to enhance physician competency and practice with the anticipated goal being the reduction of medical errors and patient harm.

The updated ACCME accreditation criteria are specifically intended to foster measurable change and improved patient care through the delivery of continuous learning aimed at improving physician knowledge, competence, performance, and patient care outcomes. At their core the updated criteria support the development of CME activities that contribute to improving physician practice. Using a specific educational planning methodology helps achieve this goal. CME providers and their planners can begin this process by identifying areas where improvement is needed.

This is referred to as a professional practice gap. The ACCME defines a professional practice gap as the difference between current health care processes or outcomes observed in practice and those potentially achievable on the basis of current professional knowledge and standards of care. Simply stated, a gap in practice is the difference between what your learner currently knows or has the ability to do, and where they should be in their knowledge, competence, and/or performance.

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Identifying Practice Gaps

1. You can begin this analysis by looking at practice areas that learners find challenging or areas for which local or national data suggest practitioners are having difficulty.
2. Determine what factors contribute to the gap.
3. Consider whether or not education can help improve practice in these areas.

Questions that will Help Identify Practice Gaps

1. What data sources are available that might identify areas where improvement is needed (e.g., local or national quality data, departmental data, departmental reports, clinical reports, quality improvement and performance improvement committees)?
2. What do the learners report are their learning gaps (e.g., surveys of learners in which they report key issues or obstacles to patient care)?
3. Are there institutional data that illuminate challenging clinical situations for learners (e.g., Joint Commission on Accreditation of Healthcare Organizations [Joint Commission] core measures or other quality measures)?
4. Are there patient cases that consistently present challenges in the learners' clinical practices (e.g., the difficult patient, the co-morbid patient)?
5. What are the most common cases seen in learners' practices, and are there opportunities for improvement or coordination of care?
6. What are the most prevalent and serious medical problems in your local region or state (e.g., obesity in North Carolina)?

Planning an Educational Intervention to Eliminate Practice Gaps

With the analysis and validation of these data sets and the synthesis of the information, the educational needs underlying the professional practice gaps emerge. If the gap analysis leads to a conclusion that an educational intervention may contribute to practice improvement, the planning process will then include:

- Identification of the target audience(s) and their scope of practice
- Specification of what a learner needs to change in order to improve his/her practice and the clinical outcomes for patients
- Selection of the most effective teaching format for the activity based on the desired results and the learning objectives (e.g., didactic lecture, interactive lecture with Q&A or audience response systems, online learning modules, group discussion, audio visual presentation, case-based presentations, hands-on demonstration, simulation or technical skills workshops)
- Identification of a method for assessing how the educational intervention contributed to improvement in competence, performance, or patient outcomes.

Also, it is important to consider how educational outcomes can be enhanced and supported by incorporating one or more noneducational strategies or additional educational approaches. Noneducational strategies might include a chart reminder or patient education materials.

The ACCME has defined compliance with Criterion 2 as documentation that the CME activity incorporated needs (knowledge, competence, or performance) that underlie a professional practice gap(s) of the provider's learners. The provider should document the sources used, evidence of analysis and interpretation of the data selected to support the educational need(s), and the subsequent identification of a knowledge, competence, or performance issue that underlies those gaps. Please refer to the ACCME resources at *http://education.accme.org/video/accme-video-faq/documenting-professional-practice-gaps*. Also, be sure to check out the accompanying list of practice gap resources that follows.

Professional Practice Gap Resources

A. Quality Measures

1. Ambulatory Care Quality Alliance
   Performance measures for ambulatory care, which align with agreed-upon parameters and address specific conditions and therapeutic areas.
   a. *www.ahrq.gov/qual/agastart.htm*
   b. *www.ahrq.gov/qual/qualix.htm*
   c. *http://hcupnet.ahrq.gov*
2. American Society of Clinical Oncology (ASCO) Quality Measures
   Quality measures developed for the ASCO's National Initiative on Cancer Care Quality (NICCQ) and recommendations of the National Comprehensive Cancer Network (NCCN) Breast Cancer, Colon Cancer, and Rectal Cancer Guidelines.
   www.asco.org/ASCO/Downloads/Cancer %2OPolicy 20and%20CIinical%20Affairs/ NCCN/ASCO%20NCCN%20Quality%2O Measures%20table%20web20posting%20 with%20CoC%200507.pdf
3. Hospital Quality Alliance
   Twenty-one quality measures on which hospitals voluntarily report.
   www.cms.gov/HospitalQualitylnits/33 Hospital QualityAlliance.asp
4. National Quality Forum
   Quality measures, indicators, events, practices, and other products to help assess quality across the health care continuum. Gold standard for the measurement of health care quality.
   www.qualityforum.org
5. National Quality Measures Clearinghouse
   Public repository for evidence-based quality measures sponsored by Agency for Healthcare Research and Quality (AHRQ) and the US Health and Human Services Department.
   www.qualitymeasures.ahrq.gov
6. National Committee for Quality Assurance
   National, regional and state averages and percentiles from all Healthcare Effectiveness Data and Information Set (HEDIS) measures.
   www.ncga.org

B. Performance Measures

1. American Medical Association (AMA) Physician Consortium for Performance Improvement (PCPI)
   a. Seventeen ambulatory care measurement sets and 151 ambulatory care measures.
   www.ama-assn.org/ama/pub/ physician-resources/clinical-practice-improvement/clinical-qualify/physician-consortium-performance-improvement.shtml
   b. Addressing the professional practice gap (online module)
   www.amaprimarycare.org
2. The Commonwealth Fund
   Results from 2006 National Scorecard on US Health System Performance.
   www.commonwealthfund.org/usr floc/site-flocs/ annualreports/2006/msg evp0l.htm
3. Joint Commission
   Core performance measures that support organizational process improvement.
   www.jointcommission.org
4. NCCN Clinical Practice Guidelines in Oncology
   www.nccn.org
5. National Guideline Clearinghouse
   Guidelines with associated measures available through AHRQ and National Quality Measures Clearinghouse (NQMC) websites.
   www.guideline.gov

C. Registries

1. Physician Quality Reporting Initiative (PQRI) Qualified Registries
   In 2008, 32 vendors became *qualified* registries for PQRI reporting. They were vetted for their ability to provide required PQRI data elements, measures calculated accurately and transmitted information in requested format.
   www.cms.gov/pgri
2. Comorbid Disease Management Database (COMMAND)
   Downloadable chronic disease patient registry allowing the entering and tracking of any disease, test/laboratory result, examination, immunization, patient education, medication, assessments, general counts and other self-defined items over time.
   www.igh.org/index.php?option=com content &view= article&id=97:command-patient-registry&catid=92:do-not use&Itemid=155

D. Additional Resources

1. Consumer Assessment of Healthcare Providers and Systems (CAHPS)

   Multi-year initiative of the AHRQ to support the assessment of consumer's experiences with health care.

   www.cahps.ahrq.gov/content/cahps Overview/Over Program.asp?p=101 &s=12

2. Practice Redesign

   The new model of care proposes transformational redesign of both the work and the workplaces of family and primary practices in order to better serve the changing needs of patients, physicians, and practice teams.

   www.transformed.com

3. Institute for Healthcare Improvement (IHI)

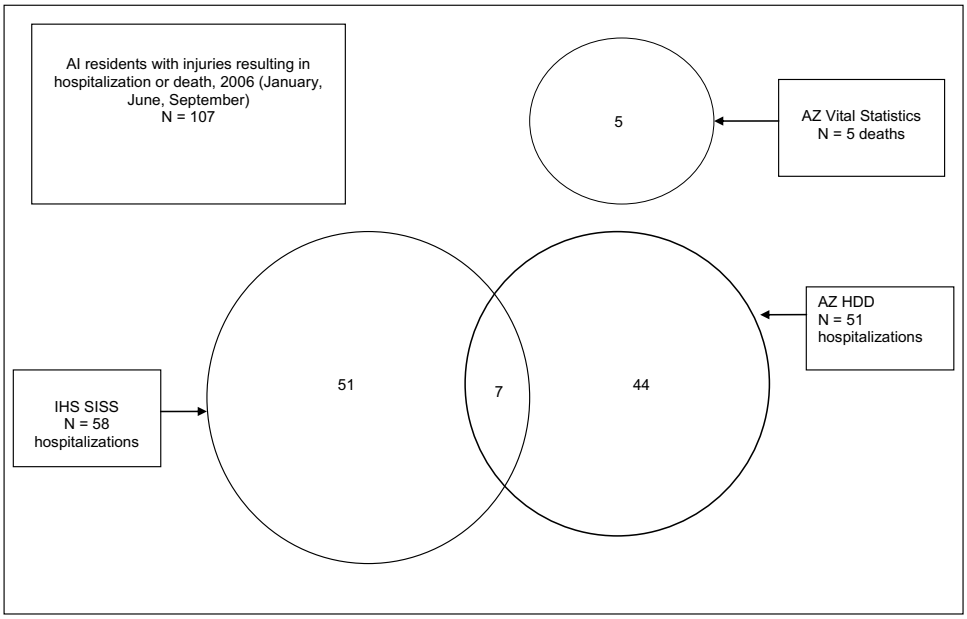
   The IHI is an independent, not-for-profit organization helping to lead the improvement of health care throughout the world. IHI works to accelerate improvement by building the will for change, cultivating promising concepts for improving patient care, and helping health care systems put those ideas into action.

   www.ihi.org

Erratum

In the February issue of *The Provider* (Volume 36, Number 2), on page 23, the venn diagram in Figure 1 was incorrect. Below is the corrected figure.

Figure 1. Venn diagram of the three injury surveillance sources. American Indian Arizona residents with injuries resulting in hospitalization or death, January, June, and September 2006



SISS = Severe injury surveillance system; HDD = Hospital Discharge Data.

MAYO CLINIC

The Mayo Clinic and the Indian Health Service proudly announce

Save the Date!

"Intensive Case-Based Training in Palliative Care"

October 17-20, 2011
Rochester, Minnesota

This evolving and innovative program will include hands-on training using palliative care scenarios with live actors in the state-of-the-art Mayo Clinic Simulation Center, clinical rounds with Mayo Clinic staff in palliative care, pain management, and other teams, real-life case studies, and the opportunity to tailor training in specific areas of palliative care to meet your team or individual needs. The course is designed for those who wish to further their skills in clinical practice and program development in palliative care for their communities.

Participants: We can accept a total of 24 participants in teams of 2-4 individuals from an IHS, Tribal or Urban Indian Health program. Send the team that that will be building or furthering your palliative care program. The most common teams include a physician, PA or NP, a nurse, and a social worker. Other members of a team could be a pharmacist, administrator, public health nurse, or CHR. More than one team may come from an Area.

Prerequisites: This is an intensive course, designed to build on existing knowledge and experience in providing palliative care. Applicants should have attended a previous EPEC-O for Indian Health training or have comparable experience in palliative care. EPEC-O for Indian Health training is available this year in a multiple-session palliative care track at the Advances in Indian Health conference in Albuquerque, NM, May 3-6, 2011. We will consider individuals or teams without those prerequisites on an individual basis.

Cost: The course itself is at no cost to the participant/team. Travel and per diem is the responsibility of the IHS, Tribal or Urban Indian health program. This remains an outstanding opportunity to receive world-class training in palliative care at relatively little cost. Travel dates will be Oct 16 & 21.

The deadline for applications is August 1, 2011. Applications will be accepted on a first-apply, first-approved basis. Register on line at http://www.csc.ihs.gov "Event Calendar."

For more information please contact: Bret Benally Thompson, MD at Bret.BenallyThompson@ihs.gov

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 is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

Community Transformation Grants Are Coming Soon . . .

The Affordable Care Act includes funding to support new Community Transformation Grants (CTGs) for purposes of implementation, evaluation, and dissemination of evidence-based community preventive health activities. This grant program is designed to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming.

Who is Eligible?

- Indian tribes or tribal organizations
- State and local governmental agencies
- Territories
- National networks of community based organizations
- State and local non-profit organizations

What Type of Activities Will Be Funded?

Applicants must devise a plan that lays out changes in policies, programs, environment, and infrastructure to promote healthy living and reduce disparities. Specific activities suggest providing sustained investments to:

- Reduce tobacco use
- Reduce obesity (BMI)
- Increase physical activity
- Increase healthy nutrition (such as consumption of fruits and vegetables, increases in low-fat milk consumption, and reductions in salt consumption)
- Reduce the severity and impact of chronic diseases and associated risk factors

Activities within the plan may focus on (but are not limited to):

1. Creating healthier school environments, including increasing healthy food options, physical activity opportunities, promotion of healthy lifestyle, emotional wellness, and prevention curricula, and activities to prevent chronic diseases
2. Creating the infrastructure to support active living and access to nutritious foods in a safe environment
3. Developing and promoting programs targeting a variety of age levels to increase access to nutrition, physical activity and smoking cessation, improve social and emotional wellness, enhance safety in a community, or address any other chronic disease priority area identified by the grantee
4. Assessing and implementing worksite wellness programming and incentives
5. Working to highlight healthy options at restaurants and other food venues
6. Prioritizing strategies to reduce racial and ethnic disparities, including social, economic, and geographic determinants of health
7. Addressing special populations needs, including all age groups and individuals with disabilities, and individuals in urban, rural, and frontier areas

How Will National Organizations Be Involved in CTGs Program?

National organizations will be funded to provide training and technical assistance to funded communities to effectively plan, develop, implement, and evaluate community-based interventions to reduce the risk factors that influence the burden of chronic disease and associated risk factors in communities.

How Much Money is Available?

The Centers for Disease Control and Prevention's (CDC) Fiscal Year 2012 request of $221,061,000 from the Affordable Care Act Prevention and Public Health Fund will support CTGs.

Who Oversees the CTGs?

The CDC will award the grants, help develop community transformation plans, and provide training on effective strategies for the prevention and control of chronic disease and the link between physical, emotional, and social well-being.

How Will CTGs be Evaluated?

In general, funded programs will conduct activities to measure changes in the prevalence of chronic disease risk factors among community members participating in preventive health activities. In addition, the CDC will help devise a structure for evaluating programs.

Why Are CTGs Important?

Awarding CTGs will allow communities to focus on advancing state, local, tribal, and territorial policies and systems to reduce the leading causes of death, associated risk factors, and health disparities.

Where Can I Obtain More Information?

During 2011, CDC will announce the Funding

Opportunity Announcement for the CTGs on *www.grants.gov*. For more details about CTGs, please see section 4201 of the Patient Protection and Affordable Care Act. For more information about the Affordable Care Act and Public Health Fund, visit *www.healthcare.gov*. Additional information will not be available until the Funding Opportunity Announcement is announced on *www.grants.gov*.

YOUR LIBRARY CORNER

Don't Be a "Loansome Doc" Doc

Diane Cooper MSLS, AHIP, NIH Library Services for IHS

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E-mail me at *cooperd@mail.nih.gov*, or call (301) 594-2449 if you need help.

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

I thought I'd use this opportunity to publicize the Reach out and Read Program for American Indian/Alaska Native children.

Reach Out and Read

Reach Out and Read prepares America's youngest children to succeed in school by partnering with doctors to prescribe books and encourage families to read together. At every well-child visit (ages of six months through five years) each child gets a new, age-appropriate book from their medical provider, and the parents receive advice from the doctor about reading the book with their child.

Reach Out and Read was developed to serve children in poverty, which includes many AI/AN children. As a group, AI/AN children have poor reading scores, low high school graduation rates, and low rates of matriculation to college. The single best predictor of future school success is reading ability in early grades. Reach Out and Read has a proven record in this regard, as demonstrated in peer-reviewed research.

Reach Out and Read has been serving AI/AN families for over ten years. Today, over 40,000 AI/AN families nationwide participate in the program. The Reach Out and Read American Indian/Alaskan Native (AI/AN) Coalition was developed in partnership with the American Academy of Pediatrics and serves four primary functions:

1. Providing Site-based training, technical assistance, and quality improvement visits to programs
2. Securing funding for each program's annual book budget.
3. Expanding the Reach Out and Read program to additional clinics across the country
4. Increasing the affordability of books with AI/AN themes and/or written in AI/AN languages.

Any hospital or clinic that provides well-child visits to families is eligible to participate. Many clinics are unfamiliar with Reach Out and Read. We will provide on-site training. Many clinics feel that starting a program is difficult. We will provide technical assistance. Lastly, many clinics lack discretionary funds to purchase books. We will supply books at no cost for new sites and help pay for costs in the future.

If you are interested in starting a Program at your clinic, please visit our website at *http://www.reachoutandread.org /providers/startingaprogram/*. You may also contact Stacie Fredriksson at *Stacie.fredriksson@reachoutandread.org* or call (617) 455-0658 for additional information.

Recent literature on American Indian/ Alaska Native Health
Jeff Powell, MD, MPH

Hoberman A, Paradise JL, et al. Treatment of acute otitis media in children under 2 years of age. *NEJM*. 2011;Vol364(2): pages 105–115

This month's entry focuses on an issue central to the work of all pediatricians – the initial treatment of acute otitis media (AOM). Hoberman, Paradise, and colleagues describe a prospective randomized controlled comparison of early antibiotic use for AOM versus placebo. This study is important because it offers distinctly different findings from other recent studies. These studies have moved the management of acute otitis media towards the strategy of "wait and see," based on evidence that the majority of acute otitis media cases resolve spontaneously. What this study offers that is *new* are the following: 1) strict diagnostic criteria were used to establish AOM diagnoses, and 2) treatment (antibiotic choice and per kilo dosing) was set up by protocol to be uniform amongst all study participants randomized to the treatment group. To jump ahead to the study conclusions, the authors showed that the early treatment group had better clinical outcomes in the first several weeks after AOM diagnosis. The findings raise valid questions about our initial management approach to AOM.

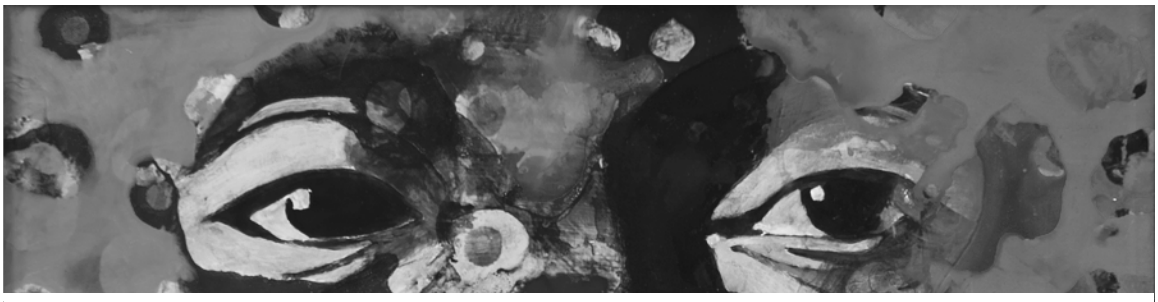
The study team prospectively enrolled and randomized 291 children ages 6 months to 24 months, diagnosed with acute otitis media. Participants were excluded if they had other diagnoses along with acute otitis media, if they had been sick longer than 48 hours, if they were allergic to penicillin, or if they had been pretreated with antibiotics. All children in the study were required to have already received 2 doses of pneumococcal vaccine (presumably 7-valent vaccine at the time). In all, 498 children were eligible to enroll in the study; 207 of these families declined to participate. About 70 percent

of the children had Medicaid insurance, 45 percent were white and 41 percent were black, and 55 percent were infants ages 6 to 11 months. The children all lived in Pennsylvania and were receiving care for acute illnesses at either a children's hospital or a private pediatric practice.

From the 291 participating children, 144 were assigned to receive amoxicillin-clavulanate (chosen to provide the best efficacy to initial therapeutic choice). All study participants were very closely followed for a period of 21 to 25 days. The study was powered to detect a difference in response to antibiotic versus placebo. Response was assessed in multiple ways: in-depth AOM symptom scales, clinical exam, and the development of complications related to AOM. The diagnosis of AOM was based on symptom rating scales, and on the use of specific clinical examination findings. Providers who participated in the study all took part in otoscopy training with formal validation of clinical diagnostic skills.

To summarize the study findings, the antibiotic group showed improved outcomes in both symptomatic relief and in rates of clinical failure. Symptomatic relief was assessed in several ways – the most compelling was the resolution of symptom scores on two consecutive scoring opportunities (assessed twice daily). The group treated with antibiotics showed the following response: 1 in 5 children were better by day 2, 40% by day 4, and two-thirds by day 7. Children receiving placebo improved less – by day seven just over half had resolution of symptoms. In addition, the placebo group had more frequent signs of clinical failure – one-fifth showed signs of treatment failure at a 4-5 day follow up visit, and more than half at a 10-12 day visit (versus 4% and 16 % of the antibiotic treated group). The treatment group also had significantly smaller rates of otitis media with effusion (OME) at a 21-25 day follow up visit: 50% of children in the treatment group had OME, versus 63% in the placebo group.

What I find interesting about this study is the emphasis on correct and consistent diagnosis. This study gives us solid information about the response of children who actually have AOM, and who have AOM alone. Many of the conclusions drawn from prior studies may be based on children who had other or additional conditions. Lastly, a note on the antibiotic choice of this study: the study authors chose amoxicillin-clavalunate to maximize the chances of showing a treatment effect. This should not be taken as an endorsement of this particular antibiotic for first line treatment of AOM. In the vast majority of situations, current AAP guidelines on antibiotic choice should be followed.



Aii
American Indian Institute
The University of Oklahoma

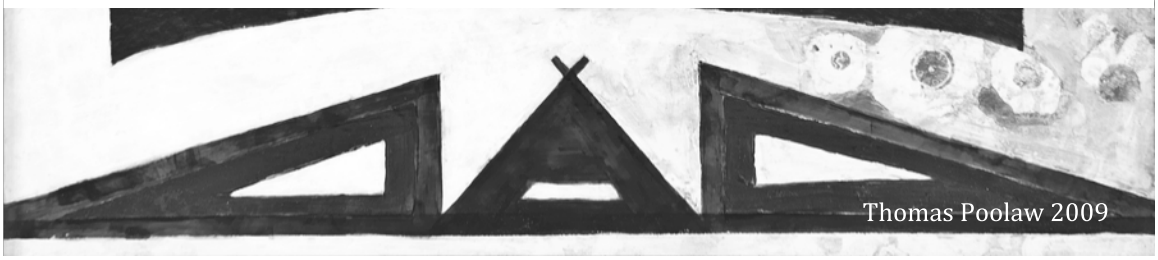
UPCOMING EVENTS

10th Annual Native Women & Men's Wellness Conference
March 27 - 31, 2011 - Albuquerque, NM

2011 Native Fitness Training
June 12 - 14, 2011 - Santa Fe, NM

14th Annual Native Diabetes Prevention Conference
June 14 - 17, 2011 - Santa Fe, NM

www.aii.ou.edu



Recent Publications on AI/AN Health Issues: A Selected Bibliography

Compiled by Diane Cooper, MSLS, AHIP, NIH Library Services for IHS

***PMID**s are included with each reference in this list. **PMID** is an acronym for **PubMed Identifier** which is a unique number assigned to citations of journal articles that are indexed by PubMed. You can use the number to find the article citation and abstract in PubMed instantly. Just enter the number in the PubMed search box. Click on the article title that is retrieved to go to the abstract of the article. On this page you will see a NIH Library Full-Text Plus green icon located in the upper right hand corner above the abstract. This is your link to full text. Note: Remember to use PubMed within the NIH Library website at* http://nihlibrary.nih.gov/IHS *to obtain full text of an article.*

Dentistry

The development and implementation of dental health aide therapists in Alaska. *J Calif Dent Assoc*. 2011 Jan; 39(1):31-5. (PMID: 21337960)

Dental therapist program in Alaska helps dentists provide needed dental care for those in remote villages.

Endocrinology and Metabolism

1. The prevalence of metabolic syndrome and associated risk factors in Northern Plains and southwest American Indians. *Diabetes Care.* 2011 Jan; 34(1):118-20. (PMID: 20864516)

This study confirms a high prevalence of the metabolic syndrome among Northern Plains and southwest American Indians of all ages.

2. Prevalence of diabetes and cardiovascular risk factors among California Native American adults compared to other ethnicities: the 2005 California Health Interview Survey. *Metab Syndr Relat Disord*. 2011 Feb;9(1):49-54. (PMID: 20958204)

Age-adjusted prevalence of metabolic syndrome was almost 50% among approximately 4,500 Native Americans in California who were 18-88 years of age.

Gastroenterology

1. Screening prevalence and incidence of colorectal cancer among American Indian/Alaskan Natives in the Indian Health Service. *Dig Dis* Sci. 2011 Jan 14. [Epub ahead of print] (PMID: 21234688)

Colorectal cancer was found to be common among AI/AN receiving IHS medical care. Screening for prevalence was lower than reported for the US population.

2. Azathioprine metabolite measurements are not useful in following treatment of autoimmune hepatitis in Alaska Native and other non-Caucasian people. *Can J Gastroenterol.* 2011 Jan;25(1):21-7. (PMID: 21258664)

The study confirmed the limited utility of monitoring levels of azathioprine metabolites in autoimmune hepatitis patients.

Information Technology

1. Developing the Native People for Cancer Control Telehealth Network. *Telemed J E- Health*. 2011 Jan-Feb; 17(1):30-4. (PMID: 21214371)

A cancer telehealth network exceeded expectations in the number of participating sites and the number of patients served.º The network was developed to deliver post-diagnosis cancer care clinical services and education to AI/AN patients, their families, and their providers.

2. Innovation in Indian healthcare: using health information technology to achieve health equity for American Indian and Alaska Native populations. *Perspect Health Inf Manag*. 2011 Jan 1;8:1d. (PMID: 21307987)

Dr. Mark Carroll and Dr. Terry Cullen's overview of health information technology tools used at IHS.

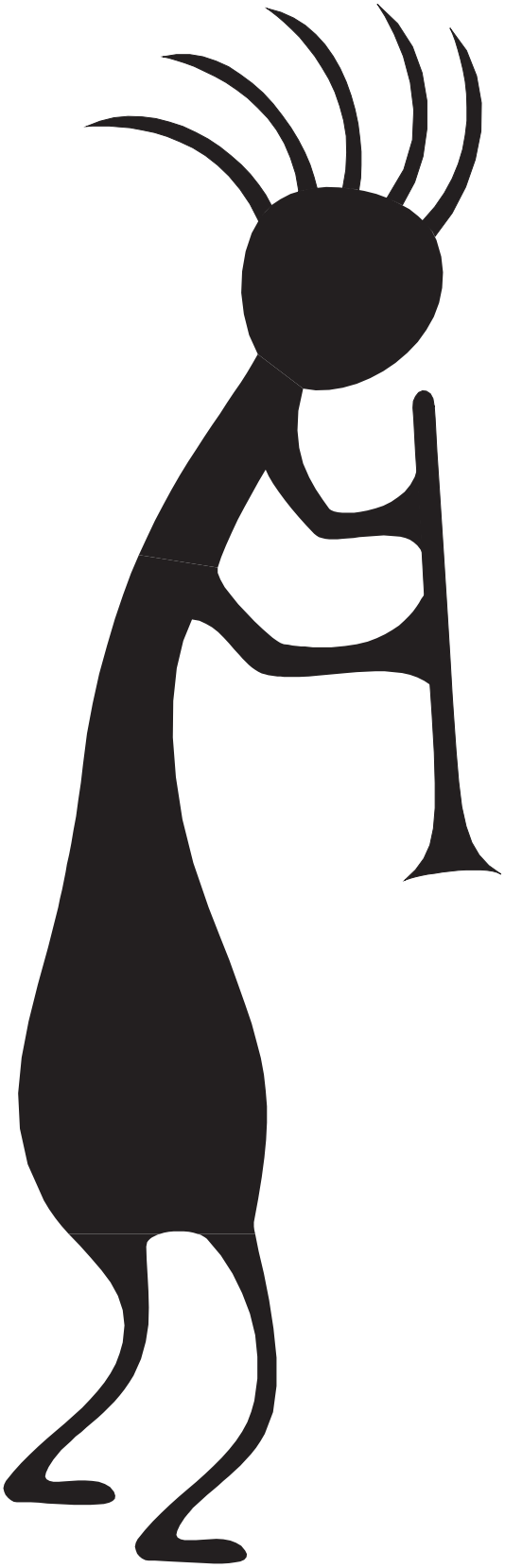
Nutrition

1. Formative assessment using social marketing principles to identify health and nutrition perspectives of Native American women living within the Chickasaw Nation boundaries in Oklahoma. *J Nutr Educ Behav*. 2011 Jan-Feb; 43(1):55-62. (PMID: 21216367)

This qualitative study used social marketing principles to assess Native American women's views of health and nutrition.

2. Behavioral symptoms of eating disorders in Native Americans: Results from the Add Health Survey Wave III. *Int J Eat Disord*. 2011 Jan 7. [Epub ahead of print]. (PMID: 21218419)

Native American women were significantly more likely than men to report loss of control and embarrassment due to overeating. In gender-stratified analyses, a significantly higher prevalence of Native American women reported disordered eating behaviors compared with white women.



Ophthalmology

1. Prevalence and risks factors of age-related macular degeneration in Oklahoma Indians -The Vision Keepers Study. *Ophthalmology*. 2011 Feb 8. [Epub ahead of print] (PMID: 21310490)

This study is the first to report detailed prevalence of age-related macular degeneration in Oklahoma Indians and its risk factors.

2. The impact of eyeglasses on vision-related quality of life in American Indian/Alaska Natives. *Am J Ophthalmol.* 2011 Jan;151(1):175-182. (PMID: 20951973)

Change in vision-related quality-of-life scores increased significantly after providing eyeglasses to American Indian/Alaska Natives with under-corrected refractive error.

Substance Abuse

1. Tobacco use among American Indian or Alaska Native middle- and high-school students in the United States. *Nicotine Tob Res*. 2011 Mar; 13(3):173-81. (PMID: 21183589)

Prevalence rates and predictors of different types of tobacco use were identified by conducting a national survey of AI/AN middle school and high school students. Over 50% of the respondents smoked cigarettes followed by 24% who smoked cigars.

2. Item response theory analysis of binge drinking and its relationship to lifetime alcohol use disorder symptom severity in an American Indian community sample. *Alcohol Clin Exp Res*. 2011 Feb 11. (PMID: 21314696)

Item response theory, used to examine alcohol use disorder (AUD) symptoms, is applied in the AI population.

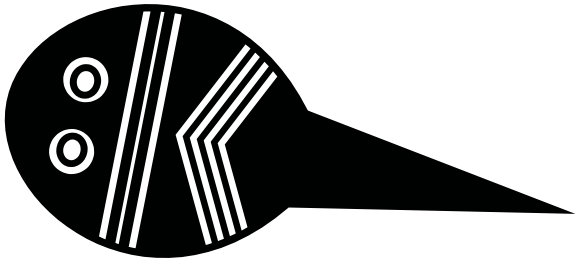
The AUD symptoms of "withdrawal" and "activities given up" were the most severe symptoms.

3. Age of onset of first alcohol intoxication and subsequent alcohol use among urban American Indian adolescents. *Psychol Addict Behav*. 2011 Jan 17. [Epub ahead of print] (PMID: 21244122)

An assessment of the effect of early onset intoxication on subsequent alcohol involvement among urban American Indian youth found that intoxication appears to be associated with a deleterious course of alcohol involvement during adolescence and into the transition to young adulthood.

The 16th Annual Elders Issue

The May 2011 issue of THE IHS PROVIDER, to be published on the occasion of National Older Americans Month, will be the sixteenth annual issue dedicated to our elders. Indian Health Service, tribal, and Urban Program professionals are encouraged to submit articles for this issue on elders and their health and health care. We are also interested in articles written by Indian elders themselves giving their perspective on health and health care issues. Inquiries or submissions can be addressed to the attention of the editor at the address on the back page of this issue.



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POSITION VACANCIES

Editor's note: As a service to our readers, THE IHS PROVIDER *will publish notices of clinical positions available. Indian health program employers should send brief announcements on an organizational letterhead to: Editor,* THE IHS PROVIDER, *The IHS Clinical Support Center, Two Renaissance Square, Suite 780, 40 North Central Avenue, Phoenix, Arizona 85004. Submissions will be run for two months, but may be renewed as many times as necessary. Tribal organizations that have taken their tribal "shares" of the CSC budget will need to reimburse CSC for the expense of this service. The Indian Health Service assumes no responsibility for the accuracy of the information in such announcements.*

Family Practice Physician
Social Worker
Consolidated Tribal Health Project;
Redwood Valley, California

The Consolidated Tribal Health Project in Redwood Valley, California is recruiting for a family practice physician and a social worker. These positions are full-time with benefits; salary DOE. All applicants will be considered; Native American preference applies. Visit *www.cthp.org* for an application and job description. Send application and resume to HR Department by fax at (707) 485-7837. ADA/EEO. (3/11)

Family Medicine, Internal Medicine,
Emergency Medicine Physicians
Family/Pediatric Nurse Practitioner for
School Health Program
Family Nurse Practitioner for Sells Indian Hospital
Sells Service Unit; Sells, Arizona

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

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

We offer competitive salary, relocation/recruitment/retention allowance, federal employment benefits package, CME leave and allowance, and loan repayment. For more information, please contact Peter Ziegler, MD, SSU Clinical Director at (520) 383-7211 or by e-mail at *Peter.Ziegler@ihs.gov*. (1/11)

Mid-Level Practitioner
Pediatrician
St. Regis Mohawk Health Service;
Akwesasne, New York

The St. Regis Mohawk Tribal Health Service is looking for a mid-level practitioner and a pediatrician to work in our general practice clinic. We are located in Akwesasne, New York, and we are uniquely situated in northeastern upstate New York. Split right down the middle by the Canadian border, we are in the northern foothills of the Adirondack Mountains and along the beautiful and historic St. Lawrence River. We are 90 miles from both Montreal, Quebec, and Ottawa, Ontario (about 5½ hours north of New York City).

Our Medical Clinic operates Monday to Friday, 8:00 am to 5:00 pm, and is staffed by a board certified internist, a board certified family practitioner, and an experienced family nurse practitioner. We have an Outreach Program staffed by a family nurse practitioner and two registered nurses and two licensed practical nurses. There are also mental health, alcohol and chemical dependency, nutrition/WIC; dental, pharmacy, ane certified laboratory services.

We are a congenial staff who work hard and like to laugh. We provide excellent medical care to our appreciative patients. If you are interested, please contact Debra Martin, Health Director, St. Regis Mohawk Health Service, 412 State Route 37, Akwesasne, New York 13655; telephone (518) 358-3141, Ext. 103. (12/10)

Family Practice Physician
Family Nurse Practitioner
Physician Assistant
Psychiatrist
Bay Mills Health Center/Bay Mills Indian Community; Brimley Michigan

The Bay Mills Health Center is seeking a family practice physician (MD or DO; board certified). Must have completed a residency program and have a Michigan license or be able to obtain one. New Graduates are welcome to apply!

We are seeking a full time psychiatrist who is board certified, able to obtain a Michigan license and has completed a residency program. The primary focus is on the adult population with some children in the patient case load.

We are in need of a certified mid-level practitioner, a FNP or a PA, with a background in Family Practice.

The health center is located in the beautiful eastern Upper Peninsula of Michigan on the Bay Mills Indian Reservation. We are located on the shores of Lake Superior, bordering Canada and we are rich in culture. The area is the outdoor enthusiast's dream.

We are an outpatient facility open 8 am to 4:30 pm, M-F. We have onsite lab, pharmacy, x-ray, behavioral health, dental, community health, and social service departments. Physicians carry a patient load averaging between 15 - 20 patients a day, with adequate time to be aclimated to the facility and procedures. There are no on call and weekend duties.

The Bay Mills Health Center was established in 1976 and is a Federally Qualified Health Center. The center is open to the general public and is Joint Commission accredited. Our patient focus is geared toward prevention. We are striving to become a patient-centered medical home, and plan to collaborate with Michigan State University to host residents during rotations.

We offer a competitive salary, student loan repayment options, CME leave and allowance, and benefits. If you are interested, please contact Audrey Breakie at (906) 248-8327 (day) or (906) 437-5557 (evenings); or e-mail *abreakie @baymills.org*. (12/10)

Medical Director
Emergency Room Physicians
Emergency Medicine PA-Cs/Nurse Practitioners
Family Practice PA-Cs/Family Nurse Practitioners
OB/GYN Physician
Nurse Mid-Wives
Family Practice Physicians
Rosebud Comprehensive Health Care Facility; Rosebud, South Dakota

The Rosebud Comprehensive Health Care Facility in Rosebud, South Dakota is seeking board eligible/board certified physicians and mid-levels with at least 2 - 3 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 border. 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, 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 who 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 cultural history, and the lands 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 Kevin Stiffarm, Chief Executive Officer, at (605) 747-3111, (605) 517-1283; or e-mail him at *kevin.stiffarm@ihs.gov*. (11/10)

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

The Warm Springs Health and Wellness Center has an opening for a board certified/eligible family physician. Located in the high desert of central Oregon, we have a clinic that we are very proud of and a local community that has much to offer in recreational opportunities and livability. Our facility has been known for innovation and providing high quality care and has received numerous awards over the past ten years. We have positions for five family physicians, one created by a physician who recently retired after 27 years of service. Our remaining four doctors have a combined 62 years of experience in Warm Springs. This makes us one of the most stable physician staffs in IHS. Our clinic primarily serves the Confederate Tribes of Warm Springs. We have a moderately busy outpatient practice with our doctors seeing about 15 - 18 patients per day under an open access appointment system. We were a pilot site for the IHS Innovations in Planned Care (IPC) project and continue to make advances in how we provide care to our patients. We fully utilize the IHS-Electronic Health Record, having been an alpha test site for the program when it was created. We provide hospital care, including obstetrics and a small nursing home practice, at Mountain View Hospital, a community hospital in Madras, Oregon. Our call averages 1 in 5 when fully staffed. For more information, please call our Clinical Director, Miles Rudd, MD, at (541) 553-1196, ext 4626, or e-mail *stephen.rudd@ihs.gov*. (10/10)

Family Practice Physician
Menominee Tribal Clinic; Keshena, Wisconsin

Join seven experienced primary care physicians in beautiful north central Wisconsin 45 miles from Green Bay. We provide comprehensive primary care for Wisconsin's longest residing residents at a large, established clinic on the banks of the Wolf River. Practice in an efficient setting with committed colleagues, your own nurse, and a robust electronic health record. Inpatient and obstetrical care are provided at a 25-bed community hospital nine miles away, where family doctors do C-sections, colonoscopies, and EGDs. Live in a safe town of 8000 with great schools and endless recreational opportunities. Competitive compensation available, along with loan repayment (NHSC and State of Wisconsin). Contact Kevin Culhane, MD at (715) 799-5786, or e-mail at *kevinc@mtclinic.net*. (10/10)

Community Dietitian
Southeast Alaska Regional Health Consortium (SEARHC); Juneau, Alaska

SEARHC invites registered dietitians to apply for a community dietitian opening on the SEARHC Health Promotion Team. The baseline qualifications are a BS in community nutrition/dietetics or a nutrition-related field. Two years clinical nutrition and/or community nutrition work experience are required, with specific experience in management and prevention of diabetes, heart disease, and other chronic diseases. Must be a registered dietitian and eligible for dietetic licensure in the State of Alaska.

The dietitian will assess, plan, implement, and evaluate community nutrition programming focused on diabetes prevention. Additionally, the community dietitian offers medical nutrition therapy to clients living with diabetes and pre-diabetes on an on-site, outpatient basis as well as using distance delivery via Polycom. These services are provided to individuals, small groups, and communities in Juneau and the northern SEARHC region. SEARHC is a non-profit tribal health consortium of 18 Native communities, which serves the health interests of the Tlingit, Haida, Tsimshian, and other Native people of southeast Alaska. Residents of southeast Alaska towns share a strong sense of community. Residents take full advantage of the excellent opportunities for fishing, boating, skiing, hiking, and other outdoor activities. Applications are available on-line at *www.searhc.org*, or please contact Human Resources at (907) 463-6693. (10/10)

Family Practice Physician
Western Oregon Service Unit (Chemawa); Salem, Oregon.

The Western Oregon Service Unit is a comprehensive ambulatory care facility located on the campus of the BIA's Chemawa Indian Boarding School. Chemawa serves not only the 420 high school teens who come to the boarding school every fall, but urban and regional beneficiaries as well.

Staffed with two family practice physicians and one family nurse practitioner, Chemawa is currently recruiting for a board certified/board eligible family medicine physician. If selected for the position, you would have a federal position, competitive salary, the absence of call, and have week-ends, holidays, and nights free to enjoy the urban lifestyle of Oregon's state capitol, Salem. Salem has moderate weather and easy access to the Pacific Ocean, the Cascade Mountains, the high desert, Portland, and the renowned viticulture of the Willamette Valley.

For more information, contact CAPT Les Dye at *leslie.dye@ihs.gov*. (9/10)

MEETINGS OF INTEREST

Advancements in Diabetes Seminars
Monthly; WebEx

Join us monthly for a series of one-hour WebEx seminars for health care program professionals who work with patients who have diabetes or are at risk for diabetes. Presented by experts in the field, these seminars will discuss what's new, update your knowledge and skills, and describe practical tools you can use to improve the care for people with diabetes. No registration is necessary. The accredited sponsors are the IHS Clinical Support Center and IHS Nutrition and Dietetics Training Program.

For information on upcoming seminars and/or previous seminars, including the recordings and handouts, click on this link and see Diabetes Seminar Resources: *http://www.diabetes.ihs.gov/index.cfm?module=training Seminars*

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.*

Tenth Annual Native Women's and Men's Wellness Conference
March 27 – 31, 2011; Albuquerque, New Mexico

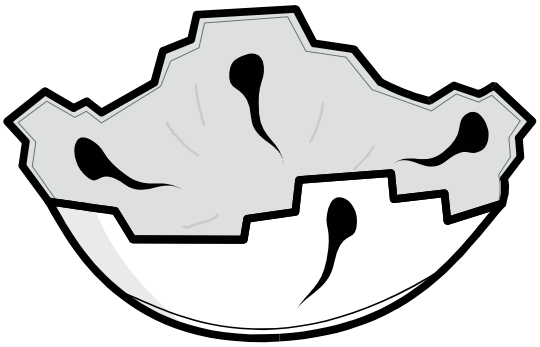
Hosted by the American Indian Institute at the University of Oklahoma, this annual event is the longest running comprehensive wellness conference for Native and Indigenous people throughout North America. The conference will be held March 27 – 31, 2011 at the Hotel Albuquerque at Old Town in Albuquerque, New Mexico. The conference will provide both personal and professional development, as well as activities to inform and inspire tribal community leaders, health advocates and health consumers in best practices. "Healing Connections" is this year's theme, with a focus on mind (behavioral health), body (physical health), spirit (traditional healing and ceremony), and community (public health wellness and chronic disease prevention). Presenters will provide academic and experiential learning experiences for workshop participants, offering a total of 2.8 CEUs (28 contact hours). Please visit our conference webpage for more information or to register online: *http://aii.ou.edu/conferencestrainings/*.

2011 Native Fitness Training and
14th Annual Native Diabetes Prevention Conference
June 12 – 17, 2011; Santa Fe, New Mexico

The American Indian Institute at the University of Oklahoma is pleased to announce the 2011 Fitness Training and 14th Annual Native Diabetes Prevention Conference to be held at the Eldorado Hotel and Spa in Santa Fe, New Mexico in June. The Native Diabetes Prevention Conference will be held June 13 – 17, 2011, offering a total of 2.0 CEUs (20 hours). The conference brings together individuals representing academia, tribal health systems, public health researchers, practitioners, behavioral health, and tribal members from AI/AN and Canadian First Nation communities. General sessions, workshops, and wellness activities will focus on diabetes prevention, methods of healing for individuals living with diabetes, and self-management practices. Conference sessions include evidence and practice-based programs, AI/AN and First Nations diabetes research, and experiential learning. The deadline to submit a proposal for presentation is Friday, March 18, 2011.

Falling just before the conference, the Native Fitness Training will be held June 12 – 14, 2011, offering 1.6 CEUs (16 hours). Topics covered during the training include anatomy and physiology, biomechanics, nutrition, exercise and weight management, instructional skills, class development, marketing, injury prevention and safety, special populations, choreography, and legal considerations. In addition to building a strong knowledge base, participants will learn how to organize, instruct, and market a Native-specific fitness program in tribal communities. Training is limited to 50 participants.

Please visit our conference webpage for more information or to register online: *http://aii.ou.edu/conferences °trainings/*.



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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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