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Effects of Pharmacist Intervention and Education on Medication Safety and Compliance in an Indian Country Correctional Facility

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Introduction

American Indians and Alaska Natives accounted for 1.2% (28,388) of the inmates in US correctional facilities in 2008.[1] This included 14,264 in state prisons, 9,000 in local jails, 2,989 in federal prisons and 2,135 in Indian country jails.[2]

These facilities are subject to the Eighth Amendment of the US Constitution, which includes the provision of adequate medical care.[3] The average expected length of stay in Indian country jails as of 2008 was 5.1 days, with a maximum length of imprisonment limited to one year.[2] Warm Springs Police Department and Adult Detention Center (WSADC), the only tribal correctional facility in the state of Oregon, has the capacity to house 48 inmates.

One of many health care issues faced by correctional facilities is the conflict between health care needs of individuals and the purpose of prison systems. Prisons are designed to separate and confine inmates, punish for crimes, and rehabilitate prior to reentering society. Thus the provision of health care is generally not a primary concern in prison design, becoming more problematic when correctional officers are placed in health care provider roles, often with minimal training.[4]

Background

There has been an ongoing effort by Warm Springs Health and Wellness Center (WSHWC) to improve the provision of health care to inmates at WSADC. In 2006 WSHWC began the process of identifying and resolving problems with the medication system at WSADC and was tasked with assisting in developing a pharmacy system, including recommendations for medication use policies and procedures, and medication packaging, storage, and record keeping.[5]

Upon initial inspection it was found that all medications were kept in a locked room primarily used to store chains and handcuffs; however it was later agreed that space would be made in the treatment room for medication storage. Medications were divided into two large plastic bins based on inmate's gender. The officer on night duty had the responsibility of placing all medications for the following day

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into individual 4-compartment pill boxes; however several officers stated this task was often not done, forcing officers on the following shift to sort through bags of medications to find a needed dose. Medications were only dispensed to inmates who specifically requested them. Obtaining an accurate health history from arriving inmates was also inadequate. Inmates were given a questionnaire to fill out listing current medications, but there was no process to verify accuracy. It was also difficult for inmates to get medications unless they were brought from home or requested through a visiting community health nurse (CHN).[5]

Documentation of medication administration was also lacking. Medications were entered into a medication log book by officers, but this step was often overlooked when officers were busy at the time of medication arrival. The log book form for documenting medication administration was not used consistently and was perceived by officers as being unusable. It was difficult to read the handwritten names of medications and directions for use, and this information was often written partially or incorrectly (e.g., acetaminophen identified as aspirin). This initial inspection found that only 15 of 35 medications were recorded in the log book, and several records existed for inmates who were no longer in custody. Inmate interviews revealed that some medications were being administered even if they were not logged into the medication book. One inmate was only receiving three of her eight medications, none of which were logged into the medication book. There was no system in place for requesting refills of medications from the WSHWC pharmacy or for returning medications to inmates upon their release; medications were rarely returned to inmates due to the difficulty of digging through unorganized bins. These unreturned medications were eventually returned to the WSHWC pharmacy for disposal, leading to an increase in health care costs from duplicate filling of medications. Unreturned medications collected between March and June 2006 were estimated to cost $285.56.[5]

Several officers expressed anxiety concerning the medication system, as they were concerned about committing medication errors, potentially harming inmates. One officer admitted to accidentally switching medications for two inmates, although there was no record of this error. Officers were frustrated by a lack of medication knowledge, such as an inmate requesting Vicodin® and the officers not knowing to look for hydrocodone/acetaminophen. Officers were also not trained in Health Insurance Portability and Accountability Act (HIPAA) regulations and confidential patient information was being discarded inappropriately.[5]

As a result of these investigations a collaborative agreement between WSADC and WSHWC was implemented in 2007 to improve the medication system. The agreement included implementing policies and procedures, introducing Medication Administration Records (MARs), bubble packaging medications, purchasing a lockable medication cart, HIPAA training of officers, and providing drug reference materials.[6]

While a significant amount of progress was made with these interventions, adherence to the agreement diminished over the years with staffing changes at both facilities, leaving safety issues to be addressed at the onset of this study.[7]

Objectives

To assess improvement of:

- Accuracy and documentation of medication administration
- Communication between WSADC and WSHWC
- Officers' confidence with medication administration
- Safety of medication storage

Methods

Data were collected in three phases. A baseline phase occurred in December 2010, one month prior to the interventions, and the second and third phases occurred in March and April 2011, approximately one month and three months after the interventions.

Interventions included redesigning current MARs and implementing new MARs for prescription, controlled substance, and common over-the-counter (OTC) medications. The new and redesigned MARs incorporated suggestions from officers as well as ideas gathered from sample MARs from state and local correctional facilities.

Changes to the general medication MAR included the addition of a column for documenting the administration time and changing the dosing time labels to better match actual medication administration times (i.e., changed to Breakfast, Lunch, Dinner, and Bedtime rather than 06:00, 12:00, 18:00 and 22:00). Changes to the controlled substance MAR included the addition of a second page for documenting controlled substance audits conducted during each shift.

The WSADC health care policies and procedures were also revised with assistance from the CHN department and are currently undergoing final review prior to implementation.

Medication education classes were conducted for officers in January 2011. Topics for education included:

- Documentation of medication administration
- Drug reference materials
- Common prescription and OTC medications
- Potentially abused medications
- Hypertension and diabetes mellitus overviews

Drug reference materials including contact information for Poison Control, WSHWC pharmacy, and Warm Springs Fire and Safety Department; two drug reference books were provided.

Data Collection

Data from current and historical MARs from inmates with an incarceration time of at least 14 days were analyzed including:

- Administration of prescription and OTC medications

- Administration time of each dose
- Documentation of medication refusal

Data were also collected from pre- and post-intervention surveys of officers. An agreement of consent to participation in the study was included in each survey. Data from the surveys were anonymous, with pre- and post-survey matching accomplished through a unique identifying number. Surveys were used to assess the officers':

- Perceptions of problems and suggestions for improvement of medication system
- Knowledge of prescription and OTC medication use
- Confidence related to medication administration
- Attitudes regarding the importance of inmates' health care and appropriate medication administration
- Availability and use of medication reference materials
- Demographic information

Pre- and post-intervention inspections of the medication cart and controlled substance drawer were conducted to assess compliance with:

- Locking the medication cart and controlled substance drawer
- Organization of the medication cart
- Returning medications upon inmate release

Analysis

Descriptive statistics were used to assess study outcomes. All data were used in a pre- and post-intervention comparison to determine percent changes of performance improvement from baseline.

Results

An analysis of MAR data was used to determine percent changes of doses given, doses missed, doses refused, and extra doses. Medications prescribed for use on an as-needed basis were not included in these calculations as the number of intended doses was variable. A dose was considered missed if there was nothing written on the MAR to indicate that the dose had been given or refused. A dose was considered an extra dose if it was administered after the total number of prescribed daily doses had been administered or if two doses of a medication were indicated as given at the same time (e.g., duplicate MARs for a medication).

Data from MAR analyses are provided in Table 1.

Documentation of OTC medication administration was improved upon implementation of three new OTC MARs for acetaminophen, chlorpheniramine, and phenylephrine. Prior to the study there was an OTC log book used to document OTC medication administration. Upon review of two months of entries from this log during the baseline data collection, it was determined that safety issues existed, including difficulty determining the total daily dose of medications received by inmates, a lack of dosing guidelines, and no place to indicate medication name. Officers would handwrite information for each OTC dose on the log, including inmate's name, number of pills administered and if the medication received was acetaminophen or "allergy."

Analysis of the log indicated that no inmates received an overdose of OTC medications; however two inmates approached the daily acetaminophen limit by receiving ten tablets per day. The individual OTC MARs were implemented to better track inmate's total daily doses of OTC medications and provide officers with a readily accessible reference for dosing guidelines and common adverse effects. The new OTC MARs only allow for four doses of OTC medications per day, thus reducing the chance of overdose. Despite this improvement in documentation of OTC medication administration, it was noted in phase 2 of data collection that for several inmates the officers had used a general medication

Table 1. MAR Data

	Baseline	Collection 1	Collection 2	Absolute Change	Change from Baseline
# Inmates	18	14	15		↓
# Meds	112	43	47		↓
Average Meds/Inmate	6.22	3.58	3.13		↓
# Doses	2156	783	603		↓
Average Doses/Inmate	119.78	65.25	40.2		↓
% Doses Given	71.13%	87.16%	91.75%	20.62% ↑	28.99% ↑
% Doses Missed	15.1%	8.59%	5.94%	9.16% ↓	60.66% ↓
% Doses Refused	7.07%	3.86%	4.93%	2.14% ↓	30.27% ↓
% Extra Doses	3.87%	1.62%	1.75%	2.12% ↓	54.78% ↓

Table 2. Additional MAR Data

	Baseline	Collection 1	Collection 2	Change from Baseline
Duplicate MARs	7	1	4	↓
Extra Dose Offered but Refused	8	1	3	↓
Wrong Administration Time	11	3	0	↓
Med not Discontinued	4	0	0	↓
Meds Remaining after Inmate Release	8	12	4	↓
Cost of Meds Remaining after Release	$78.96	$84.21	$15.03	↓

MAR with the OTC medication name handwritten on the MAR rather than using the OTC medication-specific MAR.

Additional results from MAR analyses are detailed in Table 2.

Duplicate MARs resulted in a doubling of medication doses for one medication in data collection phase 1 (sulindac; duplicate doses received twice) and for three medications in data collection phase 2 (ibuprofen, methocarbamol and naproxen; duplicate doses received once each). In data collection phase 2 it was noted that all of the duplicate doses were administered at bedtime.

There were two occurrences in the baseline data collection and three in data collection phase 2 when extra doses of medication were given that were not related to duplicate MARs. Fortunately, none of these instances resulted in inmates receiving an overdose of medication. In the baseline data collection diphenhydramine was intended for use at bedtime but given twice daily 16 times and three times daily six times while hydrocodone/acetaminophen was intended for use once daily but given twice daily three times and three times daily once. The occurrences in data collection phase 2 included baclofen intended for use every eight hours but given four times daily on six occurrences; clindamycin intended for use twice daily and instead given three times daily once; and naltrexone intended to be given once daily but given twice daily on two occasions. Again in data collection phase 2 it was noted that all extra doses were administered at bedtime.

Medications were often offered to an inmate and then refused after they had already been given for the day (e.g., medication intended for use once daily was given with breakfast but then offered again later that day). While there was no harm to the inmates from these occurrences as extra doses were not administered, it does increase the risk of inmates receiving too many doses per day if the extra doses were not refused.

Several medications, including lithium, risperidone, benztropine, and trazodone, were given to inmates at times other than when they were prescribed (e.g., medication intended for use at bedtime but given at breakfast). No extra doses were received in these instances; however there is the potential for increased risk of adverse effects, such as daytime drowsiness.

Instances of medications being administered after discontinuation due to the addition of a similar medication included risperidone with paliperidone for five days, nabumetone with naproxen for 28 days and amitriptyline with both fluoxetine and mirtazapine for 19 days. The inmate receiving risperidone with paliperidone was noted to be experiencing an increase in adverse effects during the overlapping period. As a result of these occurrences WSHWC staff have increased communication with officers whenever medication changes are implemented.

In the baseline data collection there were two occurrences when antibiotic therapy was not initiated in a timely manner, including cotrimoxazole started five days after being prescribed and amoxicillin started 45 days after being prescribed. In the amoxicillin case it was noted that this medication was brought to WSADC from the inmate's home along with their maintenance medications.

WSADC was not compliant with locking the medication cart when not in use for administering medications as the locking mechanism is no longer in working order. However when not in use the cart is kept in the locked inmate treatment room, so access is controlled. The controlled substance drawer of the medication cart was consistently locked during each inspection. There was one incident in the baseline data collection when a controlled substance was found in the medication cart with an inmate's non-controlled medications rather than in the locked controlled substance drawer. No controlled substances were being used by inmates during the second or third data collection periods.

Organization of the medication cart improved over the course of the study. While bubble packaging of medication has not been reintroduced as planned, discussions are continuing between administration at WSADC and WSHWC pharmacy to determine the feasibility of this project. Currently, prescription medications are stored in the medication cart in bags labeled with each inmate's name, which are further organized by cell areas, while OTC medications for use by all inmates are stored in a separate drawer.

Results from pre- and post-intervention surveys of officers are discussed in Tables 3 and 4.

Survey response choices were based on a Likert scale with five answer choices per question. A percent of survey responses indicating a positive response (e.g., "very knowledgeable" or "moderately knowledgeable") was calculated for each question,

Table 3. Correction Officer Demographics

	Pre-intervention Survey	Post-intervention Survey
Response Rate	6/12 (50%)	4/12 (33%)
Average Age (years)	32.5	29.75
Average Length of Employment at WSADC (years)	2.5	2.6
Female	4/6 (66%)	3/4 (75%)
High School Diploma/GED	5/6 (83%)	3/4 (75%)
Associate's Degree	1/6 (16%)	1/4 (25%)
Prior Health Care Employment	0/6 (0%)	0/4 (0%)
Prior Correction Officer Employment	1/6 (16%) (City/County Facility)	1/4 (25%) (State Facility)

Table 4. Survey Data

Assessment of Correction Officers':	Pre-intervention Survey	Post-intervention Survey	Overall Change
Knowledge of:			
• **Use of Rx Meds**	0/6 (0%)	1/4 (25%)	↑
• **Safety Issues of Rx Meds**	0/6 (0%)	1/4 (25%)	↑
• **Appropriate Administration of Rx Meds**	1/6 (16%)	2/4 (50%)	↑
• **Side Effects of Rx Meds**	0/6 (0%)	0/4 (0%)	↔
• **Use of OTC Meds**	2/6 (33%)	2/4 (50%)	↑
• **Safety Issues of OTC Meds**	1/6 (16%)	1/4 (25%)	↑
• **Appropriate Administration of OTC Meds**	3/6 (50%)	2/4 (50%)	↔
• **Side Effects of OTC Meds**	1/6 (16%)	1/4 (25%)	↑
Comfort with Med Administration	2/6 (33%)	2/4 (50%)	↑
Confidence During Med Administration	4/6 (66%)	2/4 (50%)	↓
Confidence Answering Inmate's Med Questions	0/6 (0%)	0/4 (0%)	↔
Opinions Regarding Importance of:			
• **Proper Use of Meds**	6/6 (100%)	4/4 (100%)	↔
• **Inmate Access to Meds and Healthcare**	5/6 (83%)	4/4 (100%)	↑

and then compared between the pre- and post-intervention surveys to determine a change in officers' responses from baseline.

The only area to show a decrease between pre- and post-intervention surveys was officer's confidence when administering medications. This decrease may not be a negative result as it could indicate the officer's increased awareness of the safety issues involved in medication administration. As knowledge of these issues increases it is likely that confidence would decrease.

Due to the low survey response rate and staffing turnover of officers, there was only one survey that was able to be matched and compared pre- and post-intervention. This officer indicated either no change or an improvement in all areas assessed.

Questions were included in the pre-intervention survey to assess officer's education needs and concerns, and responses to these questions were incorporated into the intervention and education topics. All responding officers reported a need for medication reference materials, stating they did not have access to references but would use them if they did. When asked what sources the officers used for medication information, four of the six officers responded that their only available source was the inmates' prescription medication bottles. Four of the six officers responded with suggestions for educational topics including medication effects, adverse effects, safe combinations, and proper administration. These officers also responded with the list of problems and suggestions for improvement shown in Table 5.

Questions were included in the post-intervention survey to

Table 5. Feedback from Officers

Problems	Suggestions
"Lack of education about medications," "Pill bottles," "Bubble packs"	"Bubble packs"
"Medication storage and organization could be better. Also, a lock on the drawer should be incorporated."	"More information about *why* an inmate is taking a certain med. Such as, Why do so many take 800 mg of Ibuprofen?"
"Inmates 'typically' only take tylenol and/or allergy pills to compensate for their addictions, or they just take them because they can. It's like candy for them."	"Have qualifiers for inmates to be able to take tylenol. The MARS book is very time consuming; maybe a higher tech way of documenting medication."
"Medication storage, dose, medication records, releasing medication to a person upon their release, overdosing – giving more than necessary."	No answer

assess officers' attendance at the education classes, opinions of changes implemented, and suggestions for further improvement. Three of the four officers surveyed attended all education classes, and two felt this had helped them improve their medication knowledge. Three of the four officers surveyed stated that they used the provided medication references sometimes, while the officer who had not attended the classes stated no use of references. When asked what sources the officers used for medication information, the responses included inmates' prescription and OTC medication labels, medication reference book, the Internet, WSHWC pharmacy, and Warm Springs Fire and Safety department. Three of the four officers stated that the changes implemented through the study had been helpful and improved medication safety, while the officer who was not involved in the classes stated these were not beneficial. When questioned which interventions were most helpful one officer stated it was the increased visits by CHNs and the weekly onsite provider clinic, both of which are discussed below. All four officers responded with a list of problems still existing with the medication system including:

- "Not knowing all the facts. In other words, reactions to pills being taken together. Side effects or if that person has a bad reaction to the meds."
- "WE NEED BUBBLE PACKS"
- "We NEED bubble packs, and on prescriptions that require ½ a pill, if they came already in proper dosage."
- "We are not qualified personnel to be distributing meds & signing off that we issued the meds."

Discussion:

The results indicate that the previously stated objectives for this study were met. Several issues warrant further discussion regarding study results, areas requiring continued improvement, and recommended future actions.

The implementation of weekly health care provider visits at WSADC was not a planned part of this intervention, but did occur concurrently. Prior to this project, inmates were transported to WSHWC and were seen by any available provider. With onsite visits, inmates now receive the majority of their health care, including routine medical examinations, immunizations, and collection of laboratory samples, from the same provider. Inmates are still transported to WSHWC for dental care, x-rays, and other procedures that would be difficult to conduct at WSADC. In the event of a medical emergency, inmates are transported to a local hospital facility. These changes ensure inmates are able to receive appropriate treatment for their medical conditions, while access to care is in no way restricted. These visits have resulted in prescribing that is more suited to a jail environment, such as prescribing non-narcotic medications instead of narcotic medications if appropriate, and have reduced the overall number of inmate prescriptions, in turn reducing the medication workload placed on officers.

Another factor unrelated to the study that may have contributed to the final results was increased involvement by the WSHWC CHN department. The CHN department has been working closely with WSADC to coordinate health care for inmates through twice weekly nursing visits and an increased nurse presence at the facility. During nursing visits a CHN triages inmate's health care concerns to determine which inmates should be examined by a provider. A CHN also delivers medications from WSHWC pharmacy, thus improving inmates' ready access to medications. The CHN department is coordinating a series of medical education classes for officers to be conducted by local health care providers with topics including alcohol withdrawal, communicable diseases, bloodborne pathogens, HIPAA regulations, and medical privacy. This increased involvement, in conjunction with the study, has led to increased awareness by WSHWC providers of medical concerns at WSADC and increased accountability for inmates' health care by both WSHWC staff and officers. The increased presence of WSHWC staff at WSADC during the course of the study may have also contributed to a Hawthorne effect.

Areas requiring continued improvement were identified at the study conclusion including:

- WSHWC staff continuing to be vigilant in communicating changes of inmates' medications to officers
- WSADC repairing or replacing the medication cart locking mechanism
- Implementing a bubble packaging system for medications
- Officers remaining attentive to the following issues:
  - Ensuring that controlled substance audits are conducted during each shift
  - Reducing the occurrence of duplicate MARs
  - Paying attention to the prescribed dosing schedule of a medication
  - Using specific OTC MARs rather than blank general medication MARs
  - Releasing medications to inmates once they are no longer incarcerated
  - Paying special attention to bedtime medication doses

Several future actions are planned to be continued after the study. Education classes for officers will be continued through a yearly medication in-service by WSHWC pharmacy residents as well as the previously mentioned CHN coordinated classes. The increased involvement of WSHWC medical, CHN, and pharmacy departments should also continue in order maintain communication and provide quality health care to inmates.

Conclusion

The medication system at WSADC, while still not ideal, has been improved over the course of this study. Maintaining these positive changes at WSADC has the potential to improve health care outcomes of inmates and the Warm Springs community, as well as to decrease costs at WSHWC.

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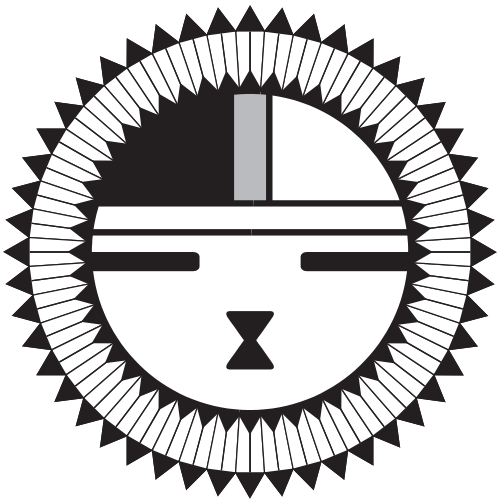

Implementing a Pharmacy Managed Tobacco Cessation Clinic at Gallup Indian Medical Center in New Mexico

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Introduction

According to the Centers for Disease Control and Prevention (CDC) September 2010 statistics, tobacco use in the United States is the principal preventable cause of illness and death, while nicotine dependence is the leading form of chemical dependence.1 Approximately 443,000 people die each year due to commercial tobacco use and secondhand smoke.1 Diseases related to smoking account for nearly $96 billion annually in health care costs. In the state of New Mexico, 16.3% of the adult American Indian/Alaska Native population are commercial tobacco smokers. New Mexico ranks fifth among the states for smoking-attributed deaths.[1]

The Government Performance and Results Act (GPRA) set tobacco cessation performance measures at 27% for the 2010 fiscal year.[2] The performance measure evaluates the proportion of tobacco-using patients who receive documented tobacco cessation intervention. Currently Gallup Indian Medical Center (GIMC) has a 4.2% documented intervention rate. This project was designed to evaluate the need for a pharmacy run tobacco cessation clinic, to review charts for patients who could potentially benefit from the clinic, to improve GPRA numbers, to develop a tobacco cessation protocol, to educate hospital personnel on the importance of tobacco screening and cessation advisement, and to certify pharmacists to run the clinic.

Methods:

A chart review was performed on patients who have ICD-9-CM diagnosis codes for tobacco use disorder, tobacco dependence, and/or a history of tobacco use in the past two years. Patient inclusion criteria include the following: live in the GIMC community taxonomy, alive during the time period of the study, American Indian/Alaska native, and had at least two visits to medical clinics in the three years prior to the end of the study. The retrospective study period covered September 01, 2008 to August 31, 2010. GPRA numbers were used to establish a baseline and evaluate outcomes. The results were compiled and used to evaluate the need for the clinic. A tobacco cessation protocol will be developed based on existing Indian Health Service tobacco protocols and the New Mexico Board of Pharmacy protocols for pharmacist prescribing for tobacco cessation. This protocol will be designed to obtain National Clinical Pharmacy Specialist (NCPS) approval. Hospital personnel and pharmacist training and certification will be based on the protocol developed for GIMC.

Results

Out of the 532 charts that were screened, 487 patients met all the eligibility requirements. During the study period, those 487 patients accounted for 4211 clinical visits. Each patient averaged approximately nine visits to GIMC during the two years. Out of the total clinical visits, 17 visits were identified as “exposure to smoke” and 44 visits were identified as “history of smoking.” Advisement to quit smoking was noted on 2.8% of the visits. The tobacco cessation protocol is currently being updated to meet NCPS approval. Electronic health record templates for referral consults, initial visits, and follow-up are under review and awaiting local approval. A local pharmacist competencies exam has also been developed and is awaiting approval. Three pharmacists are currently trained in tobacco cessation through The University of Arizona HealthCare Partnership and Indian Health Service. One pharmacist is certified as a trainer through the same program.

Discussion

Until the clinic is operational, it is impossible to determine the clinic’s effect on the GPRA tobacco cessation performance measures. In the future, these numbers may be used as part of the clinic’s annual report. A couple of limitations to this study include the fact that electronic health record (EHR) notes from clinical visits were not reviewed unless they were printed and placed in the paper charts. Printing EHR notes and placing them in the paper chart was the common practice during the study period. The second limitation involved review of complete paper charts. Researchers may not have had access to the complete paper chart if it was split between multiple charts during the study period. This is because archived charts are stored at off site locations.

Conclusion

Data suggest there is a need to educate hospital personnel on the importance of tobacco screening and cessation advisement, which would improve GPRA numbers. Patients were identified who would benefit from a pharmacy managed tobacco cessation clinic. Tobacco cessation protocols, electronic health record consult referral and visit templates, and local pharmacist competencies exam are currently under review and awaiting approval. Three pharmacists have been trained for tobacco cessation and one has been trained as a trainer.

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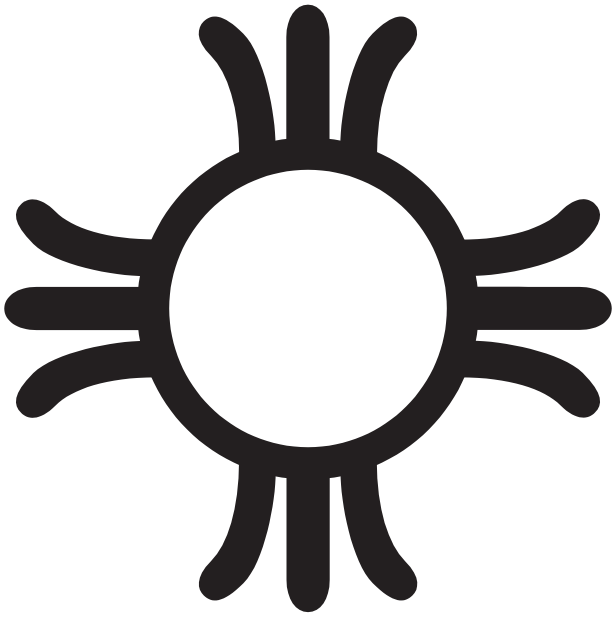

Impact of the EHR on Decision Making in the Clinical Setting

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Abstract

The electronic health record (EHR) can provide various tools to assist providers in making quality decisions based on real time information from the patient's record, which may affect clinical outcomes. Real time information is just one tool used to collect and communicate, effectively and efficiently with other health care providers. Such tools will improve efficiency and quality, promote safe care practices, and streamline patient flow, thereby allowing the provider to spend more time with the patient.

Types of Health Care Systems

Health care is becoming increasingly complex. Health care providers routinely deal with enormous amounts of medical information, yet often they cannot access the patient information needed to provide safe and high quality care. Health care in particular is a challenging environment for information systems. Health information systems (HIS) manage information, and capture and display data related to health care delivery. There are two components of HIS systems: the clinical information systems (CIS) and the administrative information system (AIS).

The CIS manages enormous amounts of data and supports several other types of activities. These activities include, but are not limited to the nursing information system, order entry, laboratory system, radiology system, pharmacy system, and other ancillary systems.[1] Patient data are accessed through these systems by way of the electronic health record. The electronic health record (EHR) stores patient information, making it easily assessable to providers. The EHR contains the same information as the paper chart. The use of the EHR promotes a better work flow environment and efficiency. The health care provider no longer has to wait for the arrival of the patient's chart to begin evaluation and treatment planning for the patient. The patient no longer spends hours waiting on medications, as the provider places the medication orders into the EHR, to which the pharmacy has immediate access and the ability to fill in a timely manner.

The AIS supports and manages both demographic and financial information. It has the capability to provide reports, schedule appointments, and bill insurance carriers. Activities such as client registration, financial systems, payroll systems, risk management, quality assurance, and contract management are supported under the AIS. A variation of this system is used to support patient care. For example AIS coding uses clinical information to bill for services rendered at the time care was provided. The administrative system is capable of extracting data to show trends, analyze data, or problem solve, thereby providing a mechanism for a decision support system.[2]

Effect on Organizational Decision Making

It is imperative that health care organizations institute a strategic plan prior to the implementation of the electronic heath record. There are two major components of a strategic plan. The first component is formulation; this component involves the mission and goals of the organization, and the initiatives used to achieve the mission and goals identified. Implementation establishes capabilities and alters processes to achieve those goals identified in the formulation phase. The formulation phase will allow for identification of changes to be made in all areas of the organization.

One main benefit to implementing EHR is that it provides decision-making support tools. Decision support tools are a branch of artificial intelligence; these tools can be especially useful when a decision needs to be made in a well defined area. This type of system allows the provider to input the patient symptoms, laboratory results, and medical history. The system will be able to provide a suggested diagnosis based on the information provided, or it may require additional information.[3] Providers may implement a clinical decision support rule that will allow monitoring of compliance to the rule within a high risk area or specialty area. Clinical decision support tools will be available to providers at the point of care. These tools will improve efficiency, quality, safety, and patient flow, thereby allowing the provider to spend more time with the patient.

Recommendation for Implementation and Improvements

Implementation of a comprehensive EHR improves quality of care. The primary focus is on decreasing overused health care services by enhancing access to data, providing real time analysis of clinical data, and acting as a platform for decision making support. In the health care environment, EHR offers a variety of benefits. One benefit of implementing EHR is to reduce medical errors. Introducing decision making and knowledge based tools into medical practice reduces the rate of errors due to the lack of knowledge or failure to apply that knowledge in the clinical practice.

Integration of the health information technology (HIT)

system will improve decision making and increase the chance of early diagnosis and early treatment. Implementation of EHR will improve the efficiency and will increase timely reimbursement. EHR will improve clinical practice by improving access to information and reducing duplication of documentation. Implementation of technology based e-prescribing tools will improve the efficiency and safety of prescribing practices in any health care setting. Adoption of HIT will expedite information exchange among providers not only locally and statewide, but nationwide. HIT can be used to increase reimbursement services per patient at the time services are provided. HIT can generate statistical reports to determine outcome measures and need for improvement within specified areas.[4]

Conclusion

There are, of course, milestones associated with any new system; these will need to be addressed in the organization's strategic planning phase. Implementation is a significant milestone, and one that should be carefully thought out before going live with any change or new process. If the implementation lacks in any category, the users will be tempted to bypass important features that were put in place for patient safety. Maintenance and evaluation are two other milestones in any system process. System maintenance is an ongoing and necessary process to ensure that the system runs smoothly. Any issue will be documented, prioritized, and tracked using a database. Evaluation should be part of every phase of implementation; these will be planned at least six months after implementation of any new system. A well planned and implemented system can provide numerous patient care benefits to include improved efficiency in documentation and communication.

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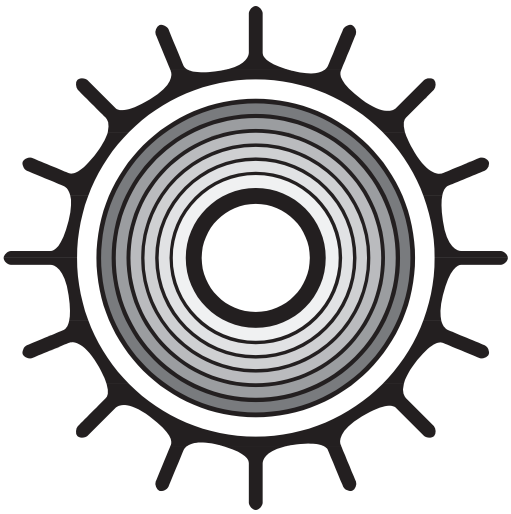

NATIVE STREAMS INSTITUTE

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SEPTEMBER 12, 2011

NATIVE STREAMS INSTITUTE

EDC HEALTH AND HUMAN DEVELOPMENT DIVISION

SPEAKERS:

Marilyn Zimmerman, MSW (Assiniboine/Dakota)
Director, National Native Children's Trauma Center & Associate Director, Institute for Education Research and Service, University of Montana

Theda New Breast, MPH (Montana Blackfeet)
Past President of the National Organization of Fetal Alcohol Syndrome Prevention & Board Member of "Well Nation Magazine"

Tawna Sanchez, (Shosone Bannock/Ute)
Director of Family Services, Native American Youth and Family Center, Past Buffet Award Nominee, Oregon Domestic and Sexual Violence Services Advisory Board

Petrice Post, MA
Senior Tribal Prevention Specialist for the National Suicide Prevention Resource Center, Arizona Suicide Prevention Coalition & Native Streams Institute

Native Streams Institute, a key initiative of Education Development Center's Health and Human Development Division; would like to invite you to attend this one day preconference that will examine, explore, and build your capacity to develop cultural based practices & programs that promote healing and wellness for Native Girls in your tribal community.

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For More Information: Susan Balbas sbalbas@edc.org or Petrice Post ppost@edc.org

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 organization
- 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):

- 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
- Creating the infrastructure to support active living and access to nutritious foods in a safe environment
- 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
- Assessing and implementing worksite wellness programming and incentives
- Working to highlight healthy options at restaurants and other food venues
- Prioritizing strategies to reduce racial and ethnic disparities, including social, economic, and geographic determinants of health
- 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

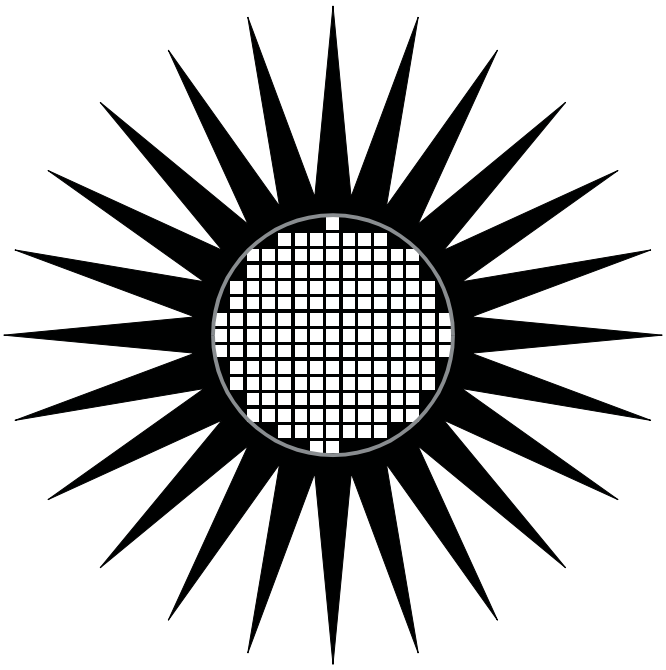
factors among community members participating in preventive health activities. In addition, the CDC will help devise a structure for evaluating programs.

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*.



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.*

Mid-Level Providers: Nurse Practitioners/ Physician Assistant
Aleutian Pribilof Islands Association (APIA); St. Paul and Unalaska, Alaska

This is a renowned bird watcher's paradise! Provide health care services to multiple generations of families. We are recruiting for mid-level providers for both sites: St. Paul and Unalaska, Alaska. Duties include primary care, walk-in urgent care, and emergency services; treatment and management of diabetes a plus. Must have the ability to make independent clinical decisions and work in a team setting in collaboration with referral physicians and onsite Community Health Aide/Practitioners. Sub-regional travel to other APIA clinics based on need or request. Graduate of an accredited NP or PA program. Requires a registration/license to practice in the State of Alaska and current ACLS and PALs. Minimum experience: 2 - 3 years in a remote clinical setting to include emergency care services and supervisory experience. Indian Health Service experience a plus. Will be credentialed through Southcentral Foundation. Positions available immediately. Clinic hours 8 am - 4:30 pm, Monday through Friday, and rotations scheduled and/or shared for on-call during evenings and weekends. Salary DOE, plus benefits. Contractual two-year commitment with hiring bonus, housing allowance, and continuing education to keep license current. Job description available upon request. Please send your curriculum vitae to Nancy Bonin, Human Resources Director, via e-mail to *nancyb@apiai.org*. (7/11)

Registered Nurse
Wassaja Memorial Health Center; Fort McDowell Yavapai Nation, Arizona

The Wassaja Memorial Health Center is currently seeking a registered nurse with a pay rate of $43,766 to $52,519 per annum (DOE). The registered nurse will provide direct patient care to patients of the Wassaja Memorial Health Center, an outpatient facility. This position requires a current active license as a registered nurse in the state of Arizona with at least two years experience in a clinical environment. Current Arizona driver's license and meet FMYN insurance standards.

The Wassaja Memorial Health Center is an outpatient facility located on the Fort McDowell Yavapai Nation in Arizona. Fort McDowell Yavapai Nation is located within Maricopa County about twenty-three miles northeast of Phoenix. The Wassaja Memorial Health Center provides care to all IHS eligible patients with proof of membership. The clinic operates Monday through Thursday from 7:30 am to 5:30 pm. The full-time medical staff includes a physician, a nurse practitioner, a physical fitness specialist, and a pharmacist. The facility offers the following clinical services: family medicine, dietician, podiatry, eye, community health, and on-site pharmacy.

The Fort McDowell Yavapai Nation offers a highly competitive compensation program ranging from medical and life insurance to disability and retirement plans. Some benefit programs require contributions from the employee, but most are fully paid by the company. If you are interested in applying, please contact Sarah Gonzales, HR, at (480) 789-7219; e-mail *sgonzales@ftmcdowell.org*, or submit application/resume to *recruiter@ftmcdowell.org*. To view the job description and print the application, please visit www.ftmcdowell.org. (7/11)

Family Practice Physician (4)
Physician Assistant (1)
Dentist (2)
Pharmacist (2)
Nurse (4)Standing Rock Service Unit; Fort Yates, North Dakota

The Standing Rock Service Unit is a fully accredited 12-bed hospital and outpatient services facility located along the Missouri River in Fort Yates, North Dakota. In addition to inpatient, outpatient, emergency, dental, behavioral health, and optometry services, a dialysis unit (eight stations) is also available to serve our patients' needs. Indeed, through strong partnerships with health care providers in nearby Bismarck, North Dakota (approximately 60 miles away) and extension outpatient centers in Cannonball, North Dakota, McLaughlin, South Dakota, Bullhead, South Dakota, and Wakpala, South Dakota, the Standing Rock Service Unit provides comprehensive services to over 9,000 American Indians in North and South Dakota. If you are interested in a position or would like more information, please contact Kim Lawrence at

(605) 226-7532; e-mail *kim.lawrence@ihs.gov* or Kara Todd-Iwen at (605) 226-7808; e-mail *kara.todd-iwen@ihs.gov*. (7/11)

Family Practice Physician (2)
Physician Assistant (1)
Pharmacist (2)
Nurse (4)
Cheyenne River Service Unit; Eagle Butte, South Dakota

Inpatient, emergency room and outpatient services including specialty care for obstetrics, physical therapy, and optometry services are provided. Hospital and emergency room services are the only services within 90 miles of Eagle Butte. A new six-bed short stay facility is under construction and due for completion in 2011. Five providers staff this 13-bed unit. The Cheyenne River Service Unit provides comprehensive services to over 9,000 American Indians in South Dakota. If you are interested in a position or would like more information, please contact Kim Lawrence at (605) 226-7532; e-mail *kim.lawrence@ihs.gov* or Kara Todd-Iwen at (605) 226-7808; e-mail *kara.todd-iwen@ihs.gov*. (7/11)

Family Practice Physician (2)
Pharmacist (1)
Spirit Lake Service Unit; Fort Totten, North Dakota

The Spirit Lake Nation in North Dakota is served by a four-physician ambulatory care facility as well as a dental clinic and a diabetes program, a pharmacy with three pharmacists, a radiology department with state-or-the-art ultrasound imaging, a complete clinical laboratory, in addition to a mental health department. The Spirit Lake Service Unit provides comprehensive services to over 6,000 American Indians in North Dakota. If you are interested in a position or would like more information, please contact Kim Lawrence at (605) 226-7532; e-mail *kim.lawrence@ihs.gov* or Kara Todd-Iwen at (605) 226-7808; e-mail *kara.todd-iwen@ihs.gov*. (7/11)

Family Medicine Physician
Internal Medicine Physician
Emergency Medicine Physician
Nurse Practitioner
Physician Assistant
Sells Service Unit; Sells, Arizona

The Sells Service Unit (SSU) in southern Arizona is recruiting for board certified/board eligible emergency room/family physician to join our experienced medical staff. We are also looking for a family/pediatric nurse practitioner or physician assistant for our school health program, and a family nurse practitioner for the Sells Hospital outpatient department.

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

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

We offer competitive salary, relocation/recruitment/retention allowance, federal employment benefits package, CME leave and allowance, and loan repayment. For more information, please contact Peter Ziegler, MD, SSU Clinical Director at (520) 295-2481 or by e-mail at *Peter.Ziegler@ihs.gov*. (7/11)

Associate Director for Tribal Support, Office for State, Tribal, Local, and Territorial Support
Centers for Disease Control and Prevention; Atlanta, Georgia

The Office for State, Tribal, Local, and Territorial Support (OSTLTS) is currently seeking exceptional candidates for the position of Associate Director of Tribal Support. The position requires knowledge of the unique cultural, environmental, social, economic, political, and other interrelated factors that impact the health of American Indian/Alaska Native (AI/AN) populations. The salary range is $118,846 to $154,501 per year.

The OSTLTS serves as the primary link between the Centers for Disease Control and Prevention (CDC), the Agency for Toxic Substances and Disease Registry (ATSDR), and Tribal governments. OSTLTS has responsibility for coordinating public health programs and policies that focus on AI/AN communities.

To apply, visit www.usajobs.gov. Candidates external to the federal government may apply to job announcement HHS-CDC-DE-11-487758. Federal government merit promotion job announcement number is HHS-CDC-MP-11-487665. The closing date for this job announcement is Wednesday, July 20, 2011. Questions may be directed to Dr. Melanie Duckworth at (404) 498-0300 or *mhd1@cdc.gov*. Please do not submit resumes to this e-mail address. (7/11)

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/DO, board certified. Must have completed a residency program and have a Michigan license or able to obtain one. New graduates are welcome to apply. We are also seeking a full time psychiatrist who is board certified, able to obtain a Michigan license and who 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, an FNP or a PA-C 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 are rich in culture. The area is the outdoor enthusiast's dream.

We are an outpatient facility open 8 am to 4:30 pm, Monday through Friday. We have an onsite laboratory, pharmacy, x-ray, behavioral health, dental, community health, and social service departments. Physicians see between 18 - 21 patients per day, with adequate time to be acclimated to the facility and procedures. There are no nights or weekends on call. The Bay Mills Health Center was established in 1976 and is a Federally Qualified Health Center. The health 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. We offer a competitive salary, student loan repayments options, CME leave and allowance, a generous leave policy, and comprehensive benefits. If you are interested, please contact Audrey Breakie at (906) 248-8327 daytime, (906) 437-5557 evenings, or e-mail *abreakie@baymills.org*. (7/11)

Family Practice Physician
Menominee Tribal Clinic; Keshena, Wisconsin

Join seven experienced primary care physicians in beautiful wooded 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 pristine Wolf River. Practice in an efficient setting with committed colleagues, your own nurse, and a robust electronic health record. Inpatient and obstetrical care is 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 8,000 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*. (7/11)

WIC Coordinator
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. Four years clinical nutrition and/or community nutrition work experience with progressive experiences in maternal/child nutrition, outpatient medical nutrition therapy, and program planning and administration. Must be a registered dietitian and eligible for dietetic licensure in the State of Alaska.

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

SEARHC is a nonprofit 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 online at www.searhc.org, or contact our Human Resources Office at (907) 966-8311 or send an e-mail to *hr-web@searhc.org*. (06/11)

Family Nurse Practitioner
Family Practice Physician
Physician Assistant
Pharmacist
Dentist
Clinical Social Worker (3)
School Social Worker
Behavioral Coordinator
Child Adolescent BHS Coordinator
Substance Abuse Treatment Coordinator
Alamo Navajo School Board, Inc.; Alamo, New Mexico

The Alamo Navajo Health Services is seeking applicants to fill numerous positions. Our organization requires background investigation as required by law. ANSB, Inc. offers a benefits package including medical, dental, vision, life, and disability insurance, and a 403B retirement plan. ANSB, Inc. gives Navajo/Indian Preference to qualified applicants. For information about qualifications and requirements, and to request for a position description or application, please call the Personnel Office at (575) 854-2543 ext. 1309 or 1304; or e-mail *rkelly@ansbi.org*. (5/11)

Clinical Director
Confederated Tribes of the Umatilla Indian Reservation; Pendleton, Oregon

Yellowhawk Tribal Health Center houses a fully accredited, primary care medical facility located on the Confederated Tribes of the Umatilla Indian Reservation. We are looking for a highly motivated, dedicated clinical director to join our already established two-provider practice. We offer excellent hours in a team environment, a well-funded and well-equipped clinic, a competitive salary, and an outstanding benefits package with relocation assistance, and signing bonus. Yellowhawk is located 10 minutes from Pendleton, Oregon, in the foothills of the beautiful Blue Mountains. Come and experience our culture and a rewarding practice where the focus is on quality patient care. Please contact Janyce Quaempts at YTHC, PO Box 160, Pendleton, Oregon 97801; telephone (541) 278-7549; e-mail *janycequaempts@yellowhawk.org*; or see our website at Yellowhawk.org. (5/11)

Hospital Quality Manager
Community Health Services Quality Manager
Safety and Infection Control Officer
Data Specialist
SouthEast Alaska Regional Health Consortium (SEARHC); Sitka, Alaska

Are you passionate about quality improvement and patient satisfaction? Do you enjoy applying new approaches to difficult problems? Do you have a positive attitude and desire to succeed? If so, an exciting opportunity awaits you in scenic Sitka, Alaska. SEARHC recently created a Performance Improvement Division and is recruiting for the following positions:

Performance Improvement Director: a new position responsible for management of all aspects of the program including customer service, accreditation, infection prevention and control, and patient safety. Position reports directly to the COO and works closely with other division directors in managing and directing the health programs of SEARHC.

Hospital Quality Manager: responsible for infection control, patient safety activities, patient satisfaction, risk management, hospital accreditation through the Joint Commission, and data management.

Community Health Services Quality Manager: responsible for infection control, patient safety activities, patient satisfaction, risk management, accreditation through AAAHC, and data management.

Safety and Infection Control Officer: responsible for infection control, emergency preparedness, risk assessments, and safety surveys.

Data Specialist: Part-time position responsible for data management, analysis, and reporting used to improved quality of care and customer satisfaction.

Native American preference applies. Apply online at www.searhc.org. For more information e-mail Connie Goldhahn at *connieg@searhc.org*; telephone (907) 966-8629. (4/11)

Family Practice PA-C
Family Nurse Practitioners
Family Practice Physicians
Fort Thompson Health Center; Fort Thompson, South Dakota

The Ft. Thompson Health Center in Ft. Thompson, South Dakota is seeking board eligible/board certified physicians and mid-levels with at least 1 - 2 years post-residency experience. We are also in need of family practice physician assistants and family nurse practitioners. Ft. Thompson is located in rural south central South Dakota, east of the Missouri River on the Crow Creek Indian Reservation, and is approximately 80 miles from the Nebraska border. We are a busy clinic that offers the following services: family practice, ob/gyn, pediatrics, optometry, dentistry, dietary counseling, and behavioral health. Our staff is dedicated and devoted to providing quality patient care. 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, Sioux cultural 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 Mr. Robert Douville, Clinical Services Administrator at (605)245-1514; e-mail him at

robert.douville@ihs.gov; or Diana Rodriguez, MD, Medical Director at (605) 245-1516; e-mail her at *diana.rodriguez@ihs.gov*. (4/11)

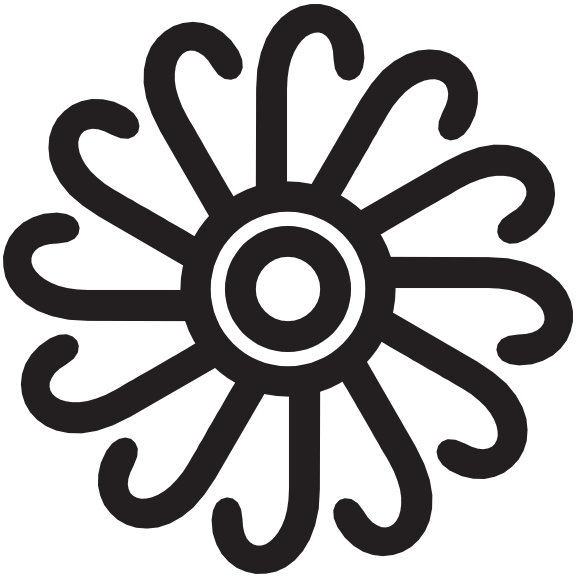
Internist
Family Practice Physician
Family Practice Nurse Practitioner
Internal Medicine Nurse Practitioner
Oklahoma City Indian Clinic; Oklahoma City, Oklahoma

The Oklahoma City Indian Clinic is a comprehensive ambulatory health care facility located in the Oklahoma City metropolitan area. The clinic is a non-profit Urban Indian health facility. From its beginning in 1974 as a volunteer, after hours clinic, it has grown to serve over 16,000 patients. Clinical services offered on-site include Family Medicine, Internal Medicine, Podiatry, Pediatrics, Dental, Optometry, Radiology, Public Health, Behavioral Health and WIC. The clinic also has a Laboratory and Pharmacy.

The full-time medical staff includes two family physicians, a pediatrician, two physician assistants and a pediatric nurse practitioner. We are currently recruiting for a board certified/board eligible family medicine physician and an internal medicine physician for our growing clinic. Operating hours for the clinic are 8:00 am – 5:00 pm Monday through Friday; no nights, weekends, or on-call. The clinic offers competitive salary, excellent benefits, retirement, and holidays off. The clinic pays 100% of premiums for medical and dental insurance for employee and family. The clinic also pays for licensures, liability insurance, and CME.

The Oklahoma City Indian Clinic is located in the heart of Oklahoma City and offers limitless entertainment, cultural, and recreational opportunities. Enjoy shopping, fine dining, downtown night life, museums, NBA basketball, Division 1 college football, professional baseball, and hockey. There are also major universities and colleges close by for continuing education opportunities. Oklahoma City's economy continues to grow. As reported in USA Today and Newsweek, Oklahoma City has proven to be one of the most recession-proof places to live in the United States.

For more information, inquiries, or if interested, please contact Dr. Mark James, Medical Director, at (405) 948-4900 ext. 238 or by e-mail at *mark.j@okcic.com*; or Monica Tippit, Director of Human Resources at (405) 948-4900 ext. 214 or by e-mail at *monica.t@okcic.com*. (4/11)



MEETINGS OF INTEREST

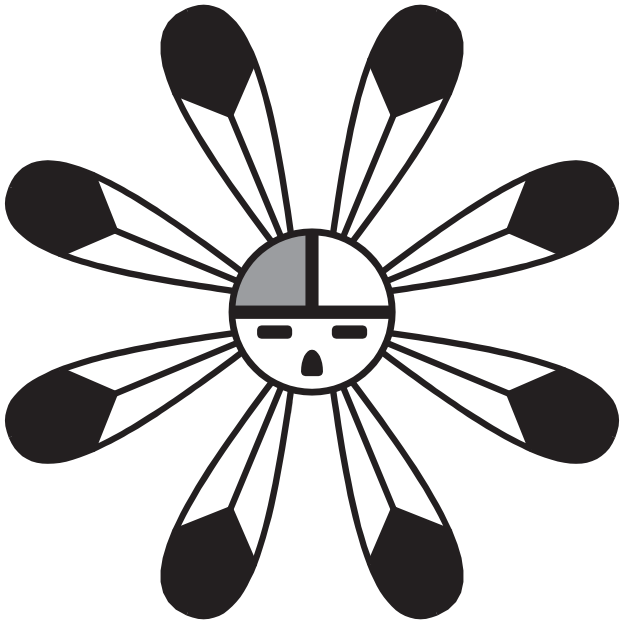
Advancements in Diabetes Seminars
Monthly; WebEx

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=trainingSeminars*

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*.



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