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Scoring a Perfect 19: Insights from the Facilities that Met All GPRA Targets in 2011

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The Government Performance and Results Act (GPRA), enacted in 1993, required federal agencies to establish standards measuring their performance and effectiveness. The Indian Health Service (HIS) reports its GPRA measures to Congress once per year, which uses the information in its budgetary decisions. GPRA is also an important indicator of the quality of care delivered by IHS sites.

In GPRA year 2011, nine sites in three Areas were "GPRA champions" and reached all 19 national GPRA targets. In the Nashville (NAS) Area, those facilities were Micmac Health Service, Passamaquoddy Indian Township, Catawba Health Service, and Oneida Nation. In the Alaska (AK) Area, the champions were Kodiak Alaska Native Association and Bristol Bay Area Health Corporation; in Oklahoma (OK) Area, the champion sites were the Wilma P Mankiller, Muskogee, and Stigler Choctaw Health Centers.

GPRA Indicators Were Prioritized as Measures of Quality of Care Provided to the Community

While it is not a requirement for tribal sites to report for GPRA, it is notable that most champion sites are, in fact, tribal. Sites indicated their facilities had an "internal" responsibility to meet GPRA targets. They viewed GPRA as a measure of how well they served their patients, not just a reporting tool. Despite any human resource shortages or turnover, the sites have adapted to optimally utilize the core set of staff, principles, methods, and policies instituted throughout the clinic to continually improve.

In addition to the local sites making GPRA a priority, Area and tribal organizations in both Nashville and Alaska provide a consistent message that GPRA is important as a minimum standard of care for the patients receiving care at the Area clinics.

Facilities Had Monthly GPRA Reports and Easy Access to Lists of Patients Whose Care Had Not Met GPRA Standards

Identification of measures and patients who need service are critical parts of meeting and improving GPRA rates. Either an in-house Clinical Applications Coordinator (CAC) or the Area GPRA coordinator, or both, ensure that staff know their progress towards meeting GPRA targets each month, as well as which patients need follow-up.

In NAS and AK, the Area- and tribally-based GPRA coordinator shares monthly GPRA numbers directly with facility leadership and relevant front-line staff, including medical practitioners at all levels (doctors, mid-levels, nurses, and health aides), Quality Improvement staff, Data Entry/Medical Records staff, Behavioral Health, and specialized staff members such as diabetes or immunization coordinators.

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In OK, Cherokee Nation and Choctaw Nation have SharePoint sites that allows sites to see each others' data, such as preventive screenings. This data sharing has allowed sites to contact sites that are excelling in any particular measure to learn about their policies and procedures.

Facilities Were Consistent in Sharing and Discussing GPRA Numbers Among All Staff Members.

Communication is a vital part of improving GPRA and patient care. Champion facilities had consistent interaction on indicators via a morning huddle, a weekly medical meeting, a GPRA committee, or other group meetings that helped keep staff informed about progress or patient needs. These meetings were also an important way to get input and ideas from a wide range of staff members, such as what taxonomies need to be updated for GPRA, the best way to follow up with hard-to-reach patients, targeting lagging indicators, and other practicalities.

Services Were Delegated Away from Provider Level

At many champion sites, responsibility for meeting individual GPRA measures is divided amongst the staff (medical providers and non-medical providers). This team approach helps foster an organizational goal for meeting and improving GPRA and patient care. It also enables all staff to have clear responsibilities for meeting GPRA targets, rather than creating the feeling that everyone is responsible for all measures. This helps make the targets feel more attainable and provides a sense of ownership for the staff assigned to each measure.

For example, at one site, the Chief Nursing Assistant is responsible for ensuring her staff performed screenings as indicated for depression, tobacco, alcohol use, and domestic violence. At another site, the contract health representative makes follow-up calls to patients who are overdue for certain screenings to set up appointments. Utilizing nursing staff to perform all needed screenings prior to their visit with the physician allows the patient and provider to spend more time discussing the patient's needs. This is time that can be spent building a relationship with the patient, which in turn leads to more successful counseling on issues such as nutrition, exercise, or other lifestyle choices.

Local Innovation and Special Services

Many of the champion sites have unique ways in which they approach certain GPRA measures. Creative solutions to providing services in-house or through referred care are important to ensuring patients receive the care that they need. A short list of examples includes the following.

Specialty Clinics: A diabetes clinic serves as a "one stop shop" to meet all aspects of diabetes care, and the staff ensures that all patients make their clinic appointments, including offering incentives for some patients.

Active Patient Follow-up: The contract health representative calls patients who are overdue for screening to schedule appointments.

Transport: Providing transportation support dedicated to getting patients to their contracted services appointments (such as mammograms).

Data Management: The medical records department takes the lead responsibility for prenatal HIV screening, as most tests are done outside the clinic. Medical records takes the lead on tracking down outside HIV tests, entering them in RPMS, and identifying prenatal patients who have not been tested.

Facility and Medical Team Friendly Competitions: The Area offers awards for facilities that meet certain goals and improvements. At the provider level, a site can use iCare to chart providers' and provider teams' scores for various GPRA measures. These numbers spur provider teams to increase their scores, and are a catalyst for identifying and sharing best practices. Providers are more actively involved in GPRA and provide valuable input into improvement activities.

Innovative Use of Information Technology

- Use of electronic clinic reminders to identify patients who are overdue for preventive care. In Alaska, reminders have proven highly effective both in improving patient care by ensuring needed care isn't overlooked, while also improving the efficiency of data entry
- Use of iCare for a comprehensive check of community members who are overdue for preventive care
- To - capture services done by contract health services/external sites for its patients in GPRA, one site uses the RCIS package to better track services provided by referral sites. Other sites used more basic measures for contract health data such as faxing of lab panels or other records on an as-needed basis
- Monitor patient lists pulled from the Clinical Reporting System and correcting data entry errors (for example, patients who reside in a community outside of the facility's catchment area)
- Monitor -the state's immunization registries (VacTrak system in Alaska) to identify patients who may have received vaccinations at other facilities or pharmacies
- Gather -historical information by using the Provider Portal system to monitor procedures/tests that may have occurred while the patient was visiting. While entering historical information can certainly improve the GPRA numbers, the real value is in ensuring the patient record in their home community is as accurate as possible. This improves care quality while also reducing costs associated with duplicative vaccinations, tests, procedures, etc.

For Further Action and Information

Different sites will have different challenges to reach all GPRA measures. The ability to use these best practices may depend on facility size, mobility of their patient population, human resources turnover in provider staff and CACs, and other factors. However, many of the GPRA champions' ideas can be applied successfully in the Indian Country setting.

The concept of a 'medical home' for patients, as used in the IPC initiative, has also shown success, and many (but not all) of the GPRA champions are IPC sites.

For more information about any of the above programs, including sharing ideas about how to improve any individual GPRA measure, contact Erika Wolter in AK (*ewolter@anthc.org*); Kristina Rogers in NAS (*kristina.rogers@ihs.gov*); or Tina Isham-Amos in OK (*tina.isham-amos@ihs.gov*).

Acknowledgements

The authors would like to recognize and thank the many Area, tribal, and facility providers and staff members whose hard work and contributions to this discussion made this article possible.

Area-Level Initiatives in AK, NAS, and OK

The Nashville Area instituted program award incentives and other tools in 2008 to encourage sites to meet GPRA targets. Those tools included - teaching/coaching about the utilization of the Model for Improvement and Plan-Do-Study-Act (PDSA) cycles, customizable GPRA report cards, and the use of stretch goals. Since that time, the incentives have tapered down, and now the drive to meet all targets is part of their facility culture.

OK uses extensive information sharing within tribal nations. The Area has GPRA awards, and provides frequent trainings for sites about how to generate and use their local data using CRS and iCare so sites have many persons who can create patient lists to identify who is overdue for what preventive care measures.

In 2010, the Alaska Area added GPRA-based awards - to help facilities better understand and be better motivated to reach targets. This has created a friendly, but rather competitive, atmosphere where tribal health organizations each want to be the next one to reach the 100% target and/or where they want to be the best on a certain measure - or measure set that is of particular importance to their community.

The Alaska Area has implemented a number of tools/programs to assist and encourage improved patient care. Those tools include a virtual helpdesk and the "Measure of the Month" program. The virtual helpdesk (*https://anthc.adobeconnect.com/ipc*) allows for sharing of files, best practice ideas, and other information, while expanding capacity to provide technical assistance to sites without having to actually be at the site. This helpdesk also serves as a way for staff from the participating tribal health organizations to connect frequently for support, sharing, or simply networking. Given Alaska's vast geographic area, this tool has proved invaluable. The "Measure of the Month" program focuses on one measure or set of measures. The goal is to see how much improvement can take place over the specified time period by providing a focused effort to improve the particular measure(s). As much as possible, these measure(s) are tied to the National Health Observance months or seasonal needs. For example, the August Measure of the Month is immunizations, as August is the time when children are getting immunizations updated for school or day care and when the start of influenza and pneumonia season is on its way. -

Both Alaska and Nashville Areas are also in the process of developing a website that integrates support and training for a variety of improvement programs including GPRA, the IHS Improving Patient Care initiative, and Meaningful Use. A major component of this website is the easy viewing of video vignettes that provides information and training "on demand."

Advancements in Diabetes Seminars

Join us monthly for a series of one-hour live WebEx seminars for health care professionals who work with patients who have diabetes or are at risk for diabetes.

- Seminars are generally held at 1:00 pm Mountain Time.
- 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 care for people with diabetes.
- No cost CME/CE credit is available for every seminar. Accredited Sponsors: IHS Clinical Support Center, the IHS Nutrition and Dietetics Training Program, and the IHS Division of Oral Health.
- Registration - for each of the seminars starts approximately two weeks prior to the seminar and goes all the way up until the start of the seminar. Registration and seminar information, including handouts, is available via the following link: *http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=trainingSeminars*
- Upcoming seminars include:
  - January 25, -2012 @ 1:00 pm MST: Update on Diabetes and Nutrition, by Brenda Broussard, MPH, MBA, RD, CDE, BC-ADM.
  - February 22, 2012 @ 1:00 pm MST: Periodontitis and Diabetes, by G. Todd Smith, DDS, MDS.

Web-Based Diabetes Trainings

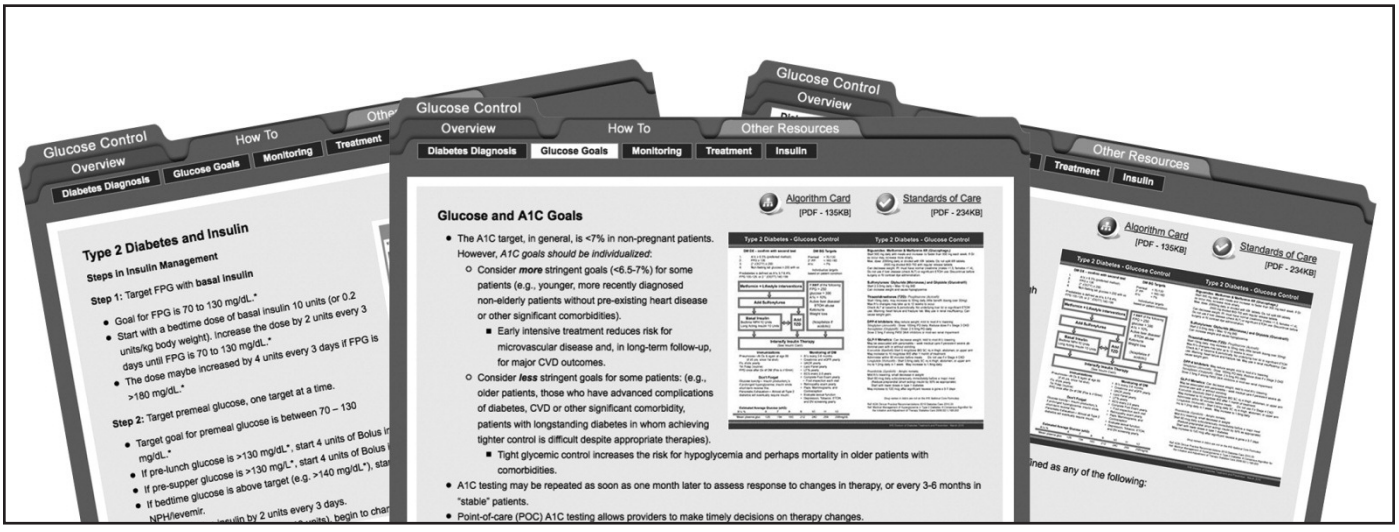
CME/CE trainings, available 24/7 at no cost. Some of these trainings, based on the live WebEx seminars, include:

- Preventing Amputations, by Greg Caputo, MD (new)
- Diabetes Standards of Care and Treatment Targets, by David Kendall, MD (new)
- Chronic Kidney Disease Screening, by Ann Bullock, MD
- Chronic Kidney Disease Management, by Andy Narva, MD
- Chronic Kidney Disease Nutrition, by Theresa Kuracina, MS, RD, CDE
- Physical Activity and Cardiovascular Risk Reduction, by Ralph LaForge, MSc, Exercise Physiologist
- Prenatal and Early Life Risk Factors, by Ann Bullock, MD
- Diabetes Foot Care, by Stephen Rith Najarian, MD
- Obstructive Sleep Apnea: New Links to Diabetes and Home Sleep Testing, by Kelly Acton, MD, MPH, FACP, and Teresa Green, MD

These trainings and others are located at: *http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=trainingWebBased*

Quick Cards

Also, check out training related clinical tools; Quick Guide Cards are available at: *http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=toolsQuickGuides&nav=99*



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

The 16th Annual Elders Issue

The May 2012 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.

Apply to Graduate Certificate in Maternal and Child Health (MCH) Epidemiology

Application Deadline: March 1, 2012

The MCH Epidemiology Graduate Certificate is a one year, 15-credit hour online certificate program aimed at increasing the capacity in MCH Epidemiology for MCH professionals serving rural and underserved Indian Health Service Regions and Appalachian counties. The program runs from June 4, 2012 to June 2012

Course Topics:

- Basic Principles of Epidemiology
- Maternal and Child Health
- MCH Epidemiology

Elective Courses:

- Program Design, Implementation and Evaluation in MCH
- MCH Health Information and Data Systems
- Cultural Competence for MCH Care

Who should apply?

- Health Professionals who hold a bachelor's degree and work with MCH populations.
- This may include public health nurses, registered nurses, dieticians, nurse practitioners, physicians, physician assistants, health planners, health educators, social workers, program planners, WIC staff, or other health professionals who serve populations in Indian Health Service Areas.

Program Faculty:

Our faculty is comprised of recognized leaders in the Public Health/MCH field.
The program has been developed by the University of Arizona and the University of Kentucky in partnership with the United South and Eastern Tribes (USET).

Required documents to apply for the MCH EPI Graduate Certificate:

- application form
- official transcripts
- resume/CV
- personal statement
- letters of recommendation
- letters of support

THE UNIVERSITY OF ARIZONA.
Mel and Enid Zuckerman College of Public Health

For more information, application and program brochure, visit the MCH Epi Graduate Certificate Program http://www.mch-epitraining.arizona.edu or contact Maribel Tobar, Program Coordinator, (520) 626-6560 email matobar@email.arizona.edu

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

Special Notice

Community Access to Child Health (CATCH) grants of up to $12,000 for pediatricians and $3,000 for pediatric residents are available to work collaboratively with local community partners to ensure that all children have medical homes and access to health care services.

The AAP Committee on Native American Child Health has partnered with CATCH in the funding of its Native American child health grants for projects that benefit American Indian/Alaska Native (AI/AN) children. Indian Health Service (IHS) and tribal 638 family physicians and community family physicians serving Native American children may apply in partnership with a pediatrician. According to the IHS Manual, IHS physicians may accept grants less than $100,000 and no approval is required from Area or headquarters. In 2011 three AI/AN clinics were awarded CATCH grants, so chances of a successful application are quite good.

For more information visit *www.aap.org/catch/implementgrants.htm*, e-mail *catch@aap.org*, or telephone (847) 434-4916. The deadline to apply is January 31, 2012.

Infectious Disease Updates
Rosalyn Singleton, MD, MPH
New Guidelines for Management of Infants and Children With Community-Acquired Pneumonia

American Indian/Alaska Native children experience hospitalization rates for pneumonia that are two-fold higher than the general US child population. The Pediatric Infectious Diseases Society and Infectious Diseases Society of America just published new guidelines for management of community-acquired pneumonia (CAP), which are important for AI/AN providers to review:

When does a child with CAP require hospitalization?

1. - Respiratory distress (e.g., tachypnea, retractions, grunting, flaring, apnea, SaO2 <90%)
2. - Infants 3 - 6 months old with suspected bacterial CAP
3. - Children with suspected CAP caused by an organism with increased virulence (e.g., MRSA)

What lab and imaging tests should be used in a child with suspected CAP?

1. - Blood cultures should be obtained in hospitalized children and those failing to improve
2. - Repeat blood cultures to document resolution should be obtained if *S. aureus* bacteremia
3. - Sensitive/specific tests for rapid diagnosis of influenza/respiratory viruses should be used in evaluation of children with CAP, and may avoid antibiotic therapy
4. - Routine CBC is not necessary in outpatients, but may be useful in severe pneumonia
5. - Acute-phase reactants can't determine viral vs. bacterial CAP, but may be useful in inpatients
6. - Chest radiographs are not necessary for outpatient CAP, but should be obtained for severe/hospitalized CAP.
7. - Follow-up CXRs should be done in children who fail to improve, or progress within 48 - 72 hours

Which antibiotics should be used for outpatient CAP?

1. - Antibiotics not routinely required for preschoolers with CAP; majority are viral pathogens
2. - Amoxicillin should be used as first line therapy for previously healthy, immunized infants and preschoolers with mild/moderate CAP, and for school aged children for *S. pneumoniae*.
3. - Macrolides for children with findings compatible with CAP caused by atypical pathogens
4. - Influenza antiviral therapy ASAP to children with mod/severe CAP consistent with influenza

What antibiotics should be used for inpatient CAP?

1. - Ceftriaxone/cefotaxime for hospitalized children not fully immunized, or in regions where high-level penicillin resistance for *S. pneumoniae*, or children with empyema
2. - Ampicillin or Penicillin G can be used in regions with lack of high-level penicillin resistance
3. - Combination therapy with macrolide plus a βlactam for child with suspected mycoplasma pneumonia
4. - Vancomycin or clindamycin should be provided for infections consistent with *S. aureus*

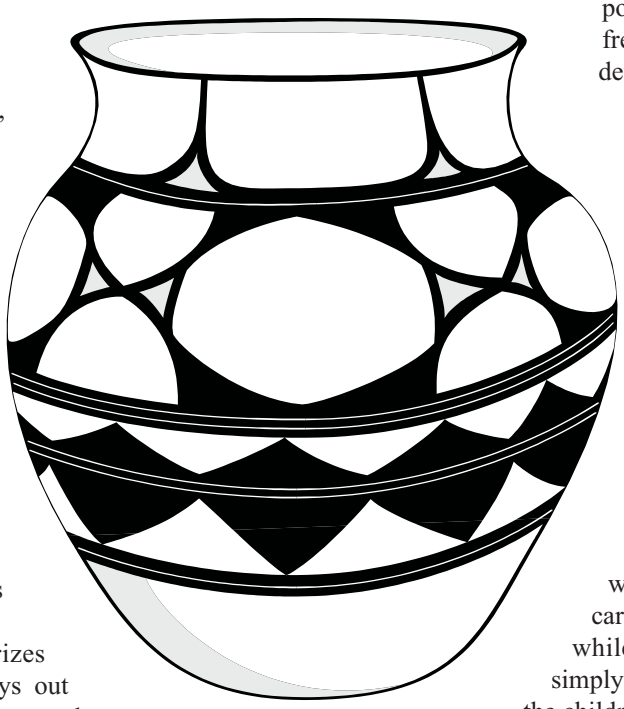
Clin Infect Dis. 2011 Oct;53(7):e25-76. Epub 2011 Aug 31

Recent Literature on American Indian/Alaskan Native Health

Jeff Powell, MD, MPH

Council on Communications and Media. *Media use by children younger than two years. Pediatrics*. Vol 128 (No. 5): 1040 - 1045

This month's Child Health Notes AI/AN literature review marks a bit of a departure; rather than focus on new research specific to AI/AN youth, I will use this space to highlight an important AAP Policy Statement: "Media Use by Children Younger Than Two Years." This statement is published in the November 2011 *Pediatrics* journal, and was written by the AAP Council on Communications and Media. I have chosen to focus on this policy statement because of the pervasive and large health impacts media consumption has on our children. In addition, excessive media use and exposure is a public health problem for which primary care systems and providers can play a role. We have the capacity to raise these issues in prevention programming and routine preventive health care visits. Currently, only 15% of parents report that their pediatrician discusses media use with them. This policy statement provides an argument that pediatricians should discuss media use with every child.



The statement summarizes relevant recent literature and lays out several key points. Central to the discussion are the ideas that 1) the use of "educational" media for children under two years of age is inappropriate; 2) the exposure to large amounts of "background" media (e.g., the TV is constantly on) is harmful to early child development; 3) young children develop far more effectively while doing non-media child activities (anything from unstructured play to reading with an adult); and 4) heavy media exposure, including the use of TV in children's sleeping areas, is likely to have negative health and developmental consequences.

Taking a look at the first concept, above, the AAP is discouraging all media use for children less than two years of age. The statement reviews literature on the ability of very young children to "learn" from video material specifically designed to teach young children. They reveal that these video resources have not been shown to benefit development, and that they are likely harmful to child language development. In addition, there may be a negative effect of TV exposure to the attention spans of very young children. The statement clearly describes some of the developmental reasons that video media are not helpful for "teaching" young children zero to two years of age.

Background media is another significant concern, and there is a growing body of literature about how harmful this is. When adult caregivers watch television or other video media, there will often be children in the same space. This has the impacts of reducing the amount of direct engagement, and in particular the amount of "talk time," when caregivers directly speak to children. In addition, children exposed to heavy amounts of background media have been shown to be more distractible and to have poorer abilities to sustain independent free play. All of these factors impact development for the worse.

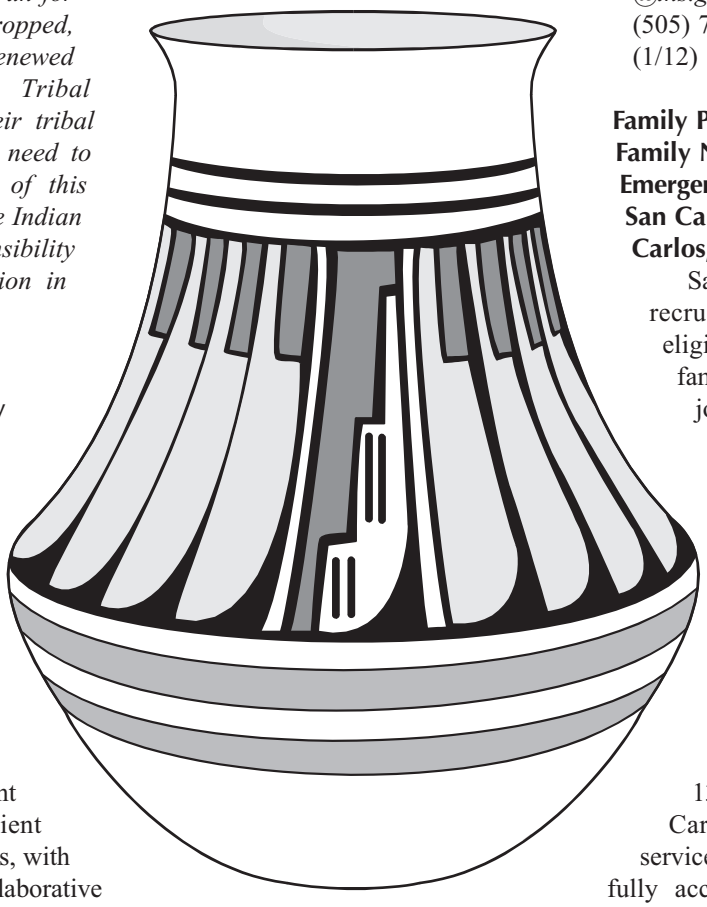
So then the question becomes, "how else should my child be spending time when I am busy working at home?" The answer, it seems, is they *should spend their time doing just about anything else*. Unstructured free play is proven to improve problem-solving skills and creativity. Direct engagement with children is proven to improve language development. Reading to children is proven to improve language skills and increases the likelihood that children will learn to read. When adult caregivers are busy working at home while supervising children, they can simply provide a safe environment and allow the children to play freely. Even playing on the floor with nesting measuring cups is a learning opportunity for a very young child.

Finally, the statement reviews what is known about health and developmental consequences of heavy media use among very young children. While the literature is limited, what is known is that media use has negative effects. Impacts on sleep are one area highlighted in the statement. The very large proportion of children under *ONE* with a TV in their bedroom (nearly 20%) are at risk for increased bed-time resistance, delayed onset of sleep, and shorter sleep durations. Developmental studies have shown negative short term impacts of media use on language development and mixed results on attention spans.

Screen Free Week/TV Free Week/Digital Detox Week is April 30 to May 6, 2012. Consider promoting this week, and consider talking to all our patients year-round about the importance of regulating young children's media exposure.

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.*



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

The Zuni Comprehensive Community Health Center (Zuni-Ramah Service Unit) has openings for full-time primary care physicians starting in fall 2012. This is a family medicine model hospital and clinic providing the full range of primary care, including outpatient continuity clinics, urgent care, emergency care, inpatient (pediatrics and adults) and obstetrics, with community outreach, in a highly collaborative atmosphere. For a small community hospital, we care for a surprisingly broad range of medical issues. Our professional staff includes 17 physicians, two NPs, one CNM, a podiatrist, dentists, a psychiatrist, a psychologist, optometrists, physical therapists, and pharmacists. Our patient population consists of Zunis, Navajos, and others living in the surrounding area.

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

For more information, contact John Bettler, MD at (505) 782-7453 (voice mail), (505) 782-4431 (to page) or by e-mail at *john.bettler @ihs.gov*. CVs can be faxed to (505) 782-7405, attn. John Bettler. (1/12)

Family Practice Physician (3)
Family Nurse Practitioner (2)
Emergency Medicine Physician (4)
San Carlos Service Unit; San Carlos, Arizona

San Carlos Service Unit is recruiting for board certified/ eligible emergency room and family practice physicians to join our experienced medical staff team. Additionally, we are recruiting for family nurse practitioners. We are located approximately 90 miles east of Phoenix.

The San Carlos Service Unit is the primary source of health care for approximately 13,000 people of the San Carlos Apache Nation. The service unit is a Joint Commission fully accredited eight-bed hospital and outpatient services facility with a satellite clinic. Clinical services include family medicine, pediatrics, internal medicine, prenatal and women's health, dental, optometry, physical therapy, nutrition and dietetics, social work services, and diabetes management education.

Currently there is a new hospital under construction that is scheduled for completion in the later part of 2013 or early 2014. We offer competitive salary, relocation/recruitment/ retention allowance, federal employment benefits package, and loan repayment. For more information, please contact Richard Palmer, MD, SCSU Clinical Director at (928) 475-7201 or by e-mail at *richard.palmer@ihs.gov*. (1/12)

Family Practice Physician
Family Nurse Practitioner
Physician Assistant
Registered Dietician (Renal)
Toiyabe Indian Health Project, Inc.;
Bishop, California

Toiyabe Indian Health Project is seeking qualified applicants to fill provider vacancies within the organization. We are looking for highly motivated candidates who are California licensed/Board certified and ready to join our team of providers. We offer competitive pay, an excellent benefits package including health insurance, life insurance, long-term disability insurance, 401k, CME, vacation and sick leave, paid holidays, and relocation assistance. Toiyabe is located in the Eastern Sierra Region of California, with abundant outdoor recreational activities such as hiking, biking, skiing, rock climbing, fishing, camping, etc. There are small communities, safe neighborhoods, and great schools/day care facilities. If interested in applying, please contact Sara M. Vance, Personnel Officer, at (760) 873-8464, ext. 224; e-mail *sara.vance@toiyabe.us*; or visit our website at *www.toiyabe.us* for complete job descriptions and applications. (12/11)

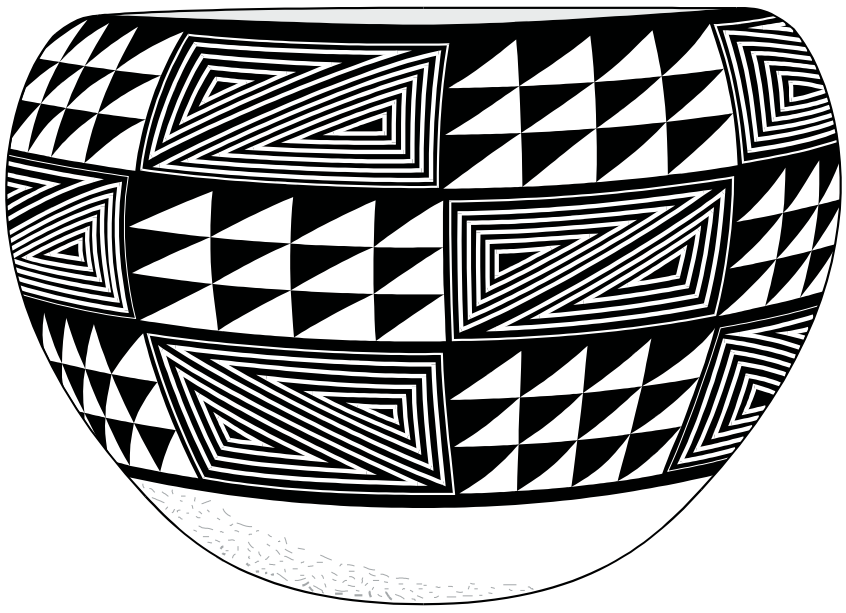
Physician
Family Nurse Practitioner
Northern Valley Indian Health, Inc.;
Chico And Willows, California

Northern Valley Indian Health, a well-established provider for the Glenn and Butte County service area, has immediate openings for a physician and a family nurse practitioner. The vacancies are in our Chico and Willows clinics and present a great opportunity for professional growth. The successful applicants will demonstrate a commitment for excellence and possess well-developed interpersonal skills. You must be a graduate of an accredited United States medical school, and possess current California physician or FNP licensure and DEA controlled substance registration. Great benefits package; salary is commensurate with experience. Student loan repayment programs available. Apply at *nvih.org*; e-mail *jobs@nvih.org*; or fax to (530) 896-9406. (11/11)

Licensed Clinical Social Worker
Medical Clinic Manager
Consolidated Tribal Health Project, Inc.;
Calpella, California

Consolidated Tribal Health Project, Inc. is a 501(c)(3) non-profit, ambulatory health clinic that has served rural Mendocino County since 1984. CTHP is governed by a board comprised of delegates from a consortium of nine area tribes, eight of which are federally recognized, and one that is not. Eight of the tribes are Pomo and one is Cahto. The campus is situated on a five-acre parcel owned by the corporation; it is not on tribal land.

CTHP has a Title V Compact, which gives the clinic self governance over our Indian Health Service funding allocation. An application for either of these positions is located at *www.cthp.org*. Send resume and application to Karla Tuttle, HR Generalist, PO Box 387, Calpella, California 95418; fax (707) 485-7837; telephone (707) 485-5115 (ext. 5613). (10/11)



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Indian Health Service
Clinical Support Center
Two Renaissance Square, Suite 780
40 North Central Avenue
Phoenix, Arizona 85004

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