THE IHS PRIMARY CARE PROVIDER

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

February 2010 **Volume 35 Number 2**

Challenges to Injury Surveillance at the Local Level

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Introduction

Accurate data on the incidence of injuries is vital to identify priorities for action, obtain resources, and evaluate the effectiveness of interventions. To obtain local data, many tribes and Indian Health Service (IHS) service units have utilized a "severe injury surveillance system" (SISS).[1] In its most basic form, the SISS uses emergency room (ER) logs from the nearest IHS hospital to identify potential injury victims. Medical records are then reviewed to confirm the injury diagnosis, and to obtain additional relevant data, such as demographic information and circumstances of injury.

An unexpected, dramatic decline in the number of motor vehicle crash (MVC) victims at one service unit led us to suspect that the traditional SISS might no longer be satisfactory. Between 1991 - 1997, there were an average of 157 serious injuries (defined as injuries resulting in hospitalization or death), compared with 91 annual injuries in the years 1998-2001. This translated to a *58% decline* in the annual number of injuries, despite an *increase* in population. Yet there had been no major changes in tribal laws (e.g., regarding DUI, speeding, or occupant restraints), no increased enforcement of existing laws, and no extensive environmental changes (e.g., widespread elimination of major roadway hazards). Our hypothesis was that the ER-based surveillance system was no longer capturing a large proportion of the MVC victims due to substantial changes in the utilization of services at the local IHS hospital.

Background

The tribe has approximately 10,000 people living on reservation land more than 100 miles from the nearest large city. The local IHS hospital has fewer than ten inpatient beds. There are about 25,000 visits per year to the emergency room. Patients requiring surgery, high-risk obstetrics, or complex medical care are referred out. Ground transportation for emergency care is provided by the tribe's ambulance system. A private, contract care company provides helicopter and fixed-wing transports.

Methods

We sought reasons for the statistical decline in injuries by focusing on one year of data (2001 -- the most recent year included in the SISS report) and one type of injury: motor vehicle crashes, which account for more than half of the annual serious injuries in this community. Figure 1 is a flow chart summarizing the disposition of patients from a motor vehicle crash scene.

We compared the traditional, ER-based method of injury data collection (SISS) with an expanded approach that sought data from multiple sources for severe injury case identification. These sources included:

- Police-reported motor vehicle crashes;

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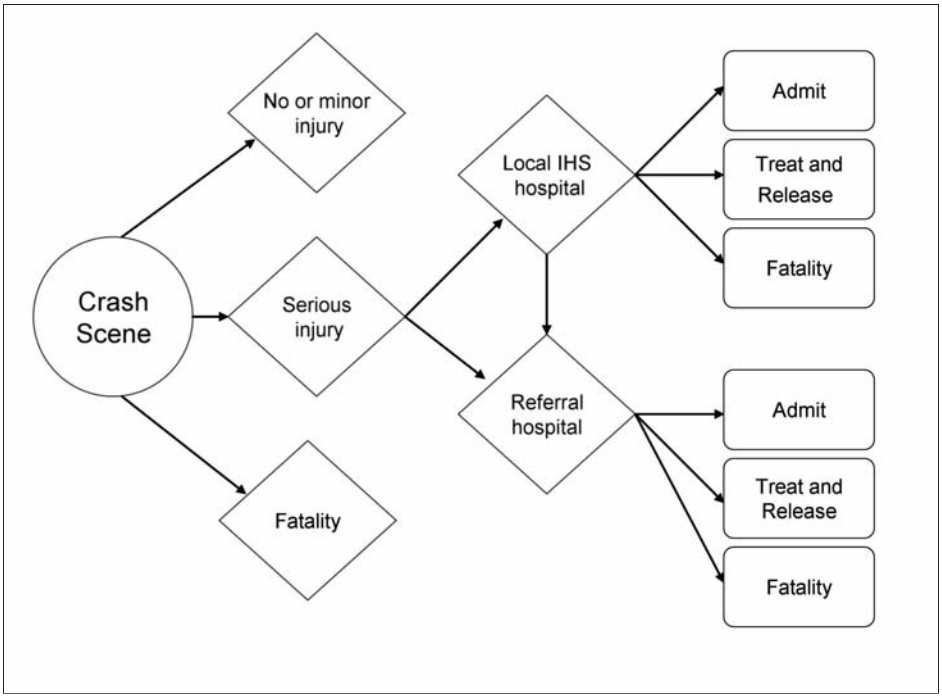
- Emergency service run logs for MVC victims transported via ground and air;
- Hospitalization data from referral hospitals and from state agencies;
- Hospital discharge planning records;
- Contract health care records;
- Fatality statistics from the tribe's and state's offices of vital statistics; the IHS Deceased Patients Report; and the local Office of Criminal Investigation.

Patient identifiers (name, gender, date of birth, date and time of injury) were recorded to eliminate duplicate records. Only one author (GT) had access to the identifiers. Written approval to conduct this study, and to publish the results without identifying the tribe, was obtained from the tribe's Health and Human Services Department.

Figure 1. Disposition of motor vehicle crash victims



Results

Table 1 summarizes the results by data source for tribal residents who were injured in motor vehicle crashes during 2001. Using traditional SISS methods involving ER log identification of motor vehicle victims and subsequent medical record review (column 1), we identified 21 visits to the IHS hospital ER, no hospitalizations, and no fatalities. All 21 victims were transported from the ER to other hospitals. However, there was no documentation of admission to any of these hospitals in the IHS medical records. Therefore, they would not have been included in the final SISS report.

Tribal police reports (column 2) contained narrative reference to two hospitalizations, six fatalities, and 29 transports to the IHS hospital ER. Medical record review of these 29 individuals revealed that five were subsequently transported to other hospitals. An additional 50 victims were transported from the crash scene to other hospitals, 35 by air and 15 by ground.

Logs from tribal EMS (ground transports only) showed 67 transports, 34 to the local IHS hospital and 33 directly to other hospitals. Those records documented nine hospitalizations and one fatality. None of the 35 air transports (fixed wing and helicopter) reported by the police appeared in the EMS data. Conversely, 18 ground transports documented by the EMS did not appear in the police reports.

The state health department's vital statistics database (column 6) contained nine motor vehicle fatalities involving tribal members residing on-reservation. These included three victims who died in off-reservation crashes, and whose deaths therefore did not appear in tribal police reports.

Discussion

A traditional, minimalist approach to injury surveillance in which the local IHS hospital's ER logs serve to identify potential victims, and the IHS medical records are used to confirm cases and provide additional information (such as subsequent hospitalization or death, length of stay, etc.), proved woefully inadequate in this study. If we assume that 100% of motor vehicle crash victims transported to outside hospitals by air, and 50% of victims transported by ground, were admitted to the referral hospitals, there would have been 62 hospitalizations and six fatalities in 2001. The total number of severe injuries would therefore be 68. The number identified through the ER log was zero. Even if we were to include as severe injuries all victims (n = 21) who were transported, but whose admission to a hospital was not documented in the IHS medical record, the ER-based approach would have missed 47 severe injuries (69% of the total).

The primary reason for the failure to capture information about motor vehicle crash victims was the high proportion of patients who were transported to other facilities. In 2001, patients from the tribe received care in at least eight referral hospitals. Of the transported patients, 76% were taken directly to other facilities, bypassing triage at the local IHS hospital ER. Nationally, dramatic changes in health services utilization have resulted from:

- Reduction or elimination of inpatient services at IHS hospitals because of cost containment, difficulties in recruiting staff, and other factors;[2]
- Improved pre-hospital care and emergency medical transport services;[3]
- Regionalization of emergency care;[3]
- Expanded options for medical coverage of American Indians and Alaska Natives through Medicaid, Medicare, and third party insurance.[4]

For patients transported to hospitals off the reservation, police reports and tribal ambulance logs did not indicate whether the individuals were admitted to the referring hospital, died in transit, or were treated and released without admission to the hospital. This information no doubt is available from the referral hospitals. However, obtaining it would involve seeking approvals to access the records, searching databases to link patient identifiers with medical record numbers, and manually reviewing charts from at least eight different hospitals. Remarkably, the office of contract health services (CHS), which pays charges submitted by outside providers, did not have any diagnostic or cause-of-injury information, only billing information. This is often the case at both tribal and IHS facilities.[5]

We did not seek crash reports from police jurisdictions other than the tribal police department (PD). According to the tribe's Chief of Police, the state Highway Patrol (HP) notifies the tribal PD if HP officers respond to a crash on the reservation and tribal police officers are not on the scene. The county sheriff and local city police do not respond to incidents on the reservation unless they receive a request from tribal police. Obviously, in communities where multiple law enforcement agencies (tribal, Bureau of Indian Affairs, state, county, and/or city police) respond independently to crash incidents, multiple police data sources must be consulted to obtain a full picture of the extent of police-reported injuries.

For motor vehicle fatalities, the state's vital statistics records were the most complete source because they are based on death certificates. A patient who dies at the scene of a crash, en route to a hospital, or post-admission – or whose death occurs off-reservation – are likely to be captured by this data source. However, identification of tribal membership, assignment of residence on- or off-reservation, and classification of cause of death can be sometimes be

Table 1. Motor Vehicle Crash-Related ED Visits and Emergency Transports, hospitalizations, and Fatalities by Data Source, 2001

	(1) IHS SISS = ER log + IHS medical records	(2) Tribal PD reports + IHS medical records	(3) Tribal EMS + IHS medical records + discharge planning records	(4) State's Health Department Data	(5) IHS Contract Health Services	Total unduplicated cases from all data sources
IHS ER visits – no record of emergency transport to another hospital	0	24	25	0	0	**29**
Transport to IHS ER, subsequent transport to another hospital	21	5	9	0	0	**21**
Direct transports from the scene to other hospitals, disposition unknown	0	50	33	0	0	**68**
Hospitalizations	0	2	9	0	0	**11**
Fatalities	0	6	1	9	0	**10**

problematic and result in incomplete reporting.

Tribal police reports included all six of the motor vehicle crash victims who died on-reservation in the state's statistics. Other potential sources of mortality data were disappointing. The local Office of Criminal Investigation (OCI) is supposed to be notified of all deaths of tribal members. However, the office did not respond to our request for data. It is likely that the OCI does not open a file for some individuals who die from non-suspicious causes (such as a motor vehicle crash). The tribe's office of vital statistics reported only one death resulting from a motor vehicle crash in 2001. The IHS Deceased Patients Report consisted of a list of individuals without any indication of the cause of the death.

Recommendations and Conclusions

To facilitate an accurate account of injury cases treated outside the local IHS health care system, SISS data collection methods should include additional data sources for case identification. These may include the local IHS Discharge Planning Office, Contract Health Services, tribal EMS, tribal PD, and (where available) the state's hospital inpatient discharge data system.

Table 2 summarizes potential data sources for local injury surveillance. The strengths and weaknesses of various data sources for surveillance will vary by community and by type of injury. For example, police reports would probably not be the best source of data on victims of falls or suicide attempts, but can be invaluable to identify victims of motor vehicle crashes, assaults, and incidents of domestic violence. The local ER is an essential source of data on non-hospitalized injuries (e.g., most incidents of domestic violence, self-inflicted injuries, child abuse and neglect, sports injuries). Emergency departments at larger IHS hospitals (those with more inpatient beds than our target community's) also serve a larger proportion of seriously-injured individuals.

Injury surveillance protocols should consider expanding the criteria for what constitutes a "severe injury" beyond hospitalizations and deaths. Many SISS protocols already have added injuries resulting in fractures or loss of consciousness, even in the absence of hospitalization. Few have incorporated episodes of non-hospitalized self-inflicted injuries or violence (e.g., sexual assault, intimate partner violence). The electronic health record (EHR) will provide new opportunities for the expanded collection of patient data and for the timeliness of reporting among multiple providers.

IHS and tribes need to collaborate with state agencies to develop more comprehensive injury surveillance systems. State trauma registries, Crash Outcome Data Evaluation System (CODES) projects,[6,7] and offices of vital statistics are invaluable resources. Some states are now requiring hospitals to submit discharge summaries to a state database. Especially for tribes whose members are treated at many different facilities, and who have options for payment (Medicare, Medicaid, third party insurance) beyond contract health care coverage, these databases may become essential for injury surveillance. Memoranda of agreement will be necessary to accurately report tribe-specific data while respecting the confidentiality of individuals and the sovereignty of tribes.

Contract Health Services is increasingly important as a source of information about the nature, cause, and severity of injuries.[5] Organized primarily for billing purposes, data systems of local CHS offices often do not contain information about the nature of injury (diagnosis), cause of injury (circumstances of injury or E-code),[8] or length of stay information. However, this is changing. Many CHS offices now are computerized; require notification requests from emergency transport services, hospitals, and providers prior to authorization of payment; and link data with the hospital's discharge planning office. Complete and accurate CHS records of diagnoses and clinical services would not only improve the care of patients, but also provide valuable data for surveillance of injuries and all other medical conditions. It also offers opportunities to bill insurance providers for specific conditions (e.g., work-related injuries, motor vehicle crashes), thus preserving precious contract care dollars.

Data issues have become far more complex than in the past. To address this, tribes can invite experts from the Centers for Disease Control and Prevention (CDC) to consult on how to improve their medical data systems. In addition, each IHS Area might recruit a full-time epidemiologist, or collaborate with a local Epidemiology Center or university, to assess and improve approaches to surveillance.[9,10] What is at stake in obtaining accurate data is the ability to determine what works and what doesn't to improve health and safety; to obtain adequate resources to address critical health priorities; and to better treat and prevent the leading causes of suffering and mortality in communities.[11]

Table 2. Improving Specific Injury Data Sources

Data Source	Potential weaknesses	Possible Solutions
IHS hospital ER log	Cause of injury not consistently noted in the log.	Train ER providers to write cause of injury (e.g., "MVC") in log; assign ER staff person to monitor adherence every shift.
IHS medical records	Contain information generated almost exclusively by IHS providers at IHS facilities. Information from referral sources often absent. Details on circumstances of injury often missing.	Explore electronic health record for data-sharing with referral providers and facilities; improve interface with IHS contract health care data and discharge planning.[5]
IHS RPMS	Contains information generated almost exclusively by IHS providers at IHS facilities. Incomplete data entry of hard copy information from referral sources. E-codes for injuries often missing.	Explore electronic health record for data-sharing with referral providers and facilities; improve interface with contract health care data; reinforce to providers the importance of recording cause of injury information.[8]
IHS hospital discharge planning records	No uniform data elements. Not computerized. No system for recording discharge information when discharge planner position is vacant.	Standardize and computerize discharge planning records.
Contract Health Services records	Bills paid to providers without diagnosis, cause of injury (E-code), length of stay, or other clinical information.	Before paying charges, Contract Health Services Office could require referral hospitals to provide a clinical summary including nature and cause of injury. [5]
Referral hospitals	(1) Multiple referral hospitals. (2) No clinical information routinely provided to the tribe or IHS, only billing information.	(1) Obtain hospitalization data from the state, rather than seeking individual MOAs for data from multiple facilities. (2) Before paying charges, Contract Health Services Office could require referral hospitals to provide a clinical summary including nature and cause of injury.[5]
Non-Tribal emergency transport companies	(1) No clinical information provided to the tribe or IHS, only billing information. (2) No reporting of non-CHS victims.	(1) Before paying charges, Contract Health Services Office could require transport services to provide a transport summary including nature and cause of injury, time of dispatch and arrival, and destination hospital.[5] (2) Obtain run logs from each transport service.

Tribal EMS transport logs	(1) "Other" category may include additional MVC victims. (2) Don't have follow-up, disposition.	Use identifiers to link with records from receiving hospitals to confirm cause of injury and disposition (admit, death, treated-and-released).
Tribal police department reports	(1) Little overlap with EMS run logs. (2) No information on the reliability of the information. (3) Incomplete narratives. (4) Often not computerized.	(1) Conduct study using CODES approach.[6,7] Train officers in improved reporting of crash circumstances and triage of victims. (2) Computerize police reports; have chief of police consider complete and timely reporting in pay raises and promotion of officers.
Local Office of Criminal Investigation (CI) records of deaths of tribal members	(1) Non-suspicious deaths (e.g., from MVCs) may not be referred to CI office. (2) Data requests may be ignored.	Establish a process for the local CI Office to submit annual reporting of causes of death to tribal police and health department.
State mortality data	(1) Incomplete enumeration of deaths of tribal members. (2) Non-reporting of tribe-specific data.	(1) Establish MOU between state vital statistics office and tribe regarding policies and procedures for issuing and submitting death certificates. (2) Establish procedures for identifying tribal members in vital statistics data (e.g., by linking with tribal enrollment or RPMS service population lists) and reporting aggregate data while protecting confidentiality.
State hospitalization data	(1) Non-reporting of tribe-specific data. (2) Incomplete enumeration of hospitalizations.	(1) Establish procedures for identifying tribal members in hospitalization (e.g., by linking with tribal enrollment lists) and reporting aggregate data while protecting confidentiality.[4] (2) Expand the number of hospitals required to provide hospitalization to the state.
State CODES project	Data available only for limited grant periods.	Restore funding to state CODES initiative.[6,7]

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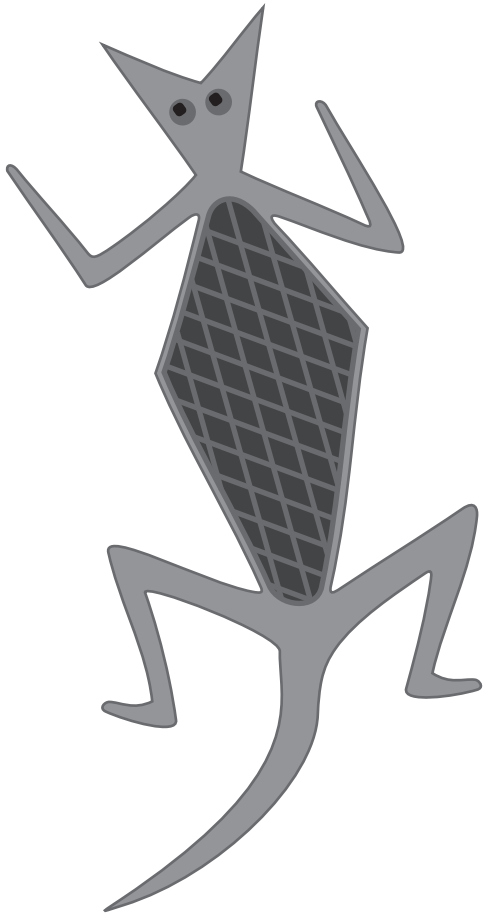
Acknowledgements

Among the persons who provided insights and data for this project was Dr. Tim Flood, Bureau Medical Director, Arizona Department of Health Services. We are also grateful to other individuals employed by the tribe and IHS, including members of the hospital staff, tribal EMS department, and tribal law enforcement. To maintain the anonymity of the tribe, we thank them collectively for their insights, information, and assistance.



The Indian Health Service and FDA's Drug Safety Oversight Board

CDR Michael Lee, Director of Pharmacoeconomic and Therapeutics Research and Vice Chair of IHS National Pharmacy and Therapeutics Committee (NPTC), Oklahoma City, Oklahoma; and LCDR Joseph Bryant, Supervisor of the Pharmacy Support Branch at the IHS National Supply Service Center, Oklahoma City, Oklahoma

CDR Michael Lee and LCDR Joseph Bryant, two Indian Health Service (IHS) pharmacists, joined FDA's Drug Safety Oversight Board (DSB or Board) in September 2009. CDR Lee and LCDR Bryant provide the DSB with a clinical perspective on how various drug regulatory actions might affect the care of American Indian and Alaskan Native patients. This article provides information about the DSB and insight into how the IHS and FDA mutually benefit from this new collaboration.

The IHS and FDA Collaboration

The Indian Health Service (IHS) and the Food and Drug Administration (FDA) recently entered into a Memorandum of Understanding (MOU) to agree to work together to promote safety initiatives related to FDA-regulated drugs, biologics, medical devices, and foods, including dietary supplements. The MOU provides for information and expertise sharing between the FDA and the IHS.

Under the auspices of the MOU, the IHS may provide summary pharmaceutical and clinical data to the FDA for approximately one million patients cared for in over 400 health care centers, hospitals, and clinics. The IHS can offer information on the most common medical conditions treated, medications used, and adverse event information in their patient population. Currently the IHS participates in a risk communication sharing program with the FDA. In this sharing program, the IHS receives a draft of the drug risk communication at least 24 hours in advance of FDA publicly issuing the risk communication.

The FDA and the IHS recognize that shared information, such as confidential commercial information, personal privacy information, or other information protected from public disclosure by Federal statutes and regulations, must be protected from unauthorized disclosure.

The IHS and DSB Collaboration

The Drug Safety Oversight Board (DSB), created in 2005 and mandated by law in the FDA Amendments Act of 2007, is an internal management council that provides advice to the Center for Drug Evaluation and Research (CDER) Center Director on handling and communicating important, and often emerging postmarket drug safety issues. The DSB provides FDA with a forum for discussion and input about how to address potential drug safety issues. The Board meets monthly and is composed of representatives throughout FDA and six other federal agencies: the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC), the Department of Defense (DOD), the Indian Health Service, the National Institutes of Health (NIH), and the Veterans Administration (VA). An important function of the DSB is to be able to discuss drug safety issues with other federal government agencies involved in health care. Each federal partner brings with them their agency's unique expertise and perspective. The Board, with its diverse makeup, allows the FDA to hear other perspectives on drug safety issues and to discuss the impact of the FDA's drug safety decisions on the health care systems of its Federal partners.

DSB meetings are internal, and meeting minutes, presentations, and background materials are not publicly posted. However, they are subject to the US Freedom of Information Act (FOIA, Public Law 89-554, 80 Stat.383; Amended 1996, 2002, 2007). A public summary of each meeting is posted on FDA's website at *http://www.fda.gov/AboutFDA/CentersOffices/CDER/ucm082129.htm*.

Recent Board Topics

September 2009. An IHS representative attended and provided input at the DSB meetings beginning in September 2009. At the September 17, 2009 meeting, the FDA's Sentinel Initiative presented an overview of the initiative and sought the Board's advice on how to identify and prioritize medical product exposure-adverse outcome "pairs" for evaluation in the Sentinel pilot programs.

The Sentinel Initiative aims to develop an active electronic safety monitoring system to strengthen the FDA's ability to monitor the postmarket performance of medical products. Its intent is to augment, not replace, existing safety monitoring systems. It can allow the FDA to access existing automated health care data by partnering with health care insurance providers, academic institutions, federal and state government agencies, health care providers, and other owners of various electronic health records.

The Sentinel Initiative Team has several ongoing projects to evaluate potential drug-adverse event signals. They collaborate with the Center for Medicare and Medicaid

Services (CMS), DoD, and VA. Sentinel, along with CMS, launched SafeRx, a project to develop near-real time active surveillance methods using Medicare data. In addition, Sentinel has established a Federal Partner Working Group that discusses issues related to complementary efforts being carried out by the Federal partners. The IHS is one of the many Federal Agency participants. Other Agencies include FDA, CDC, CMS, DoD, Office of the National Coordinator for Health Information Technology, NIH, VA, AHRQ, Health Resources and Services Administration, Office for Human Resource Protection, and the Consumer Product Safety Commission.

October 2009. At the October 15, 2009 meeting, the DSB discussed the practice of tablet splitting. Some insurance companies and doctors are increasingly recommending patients to split tablets to adjust their dose or to reduce medication costs. FDA's Office of Pharmaceutical Sciences conducted internal research on tablet splitting and concluded that there are possible safety issues, especially when products are not scored or evaluated for splitting. The FDA's concerns with splitting a tablet include variations in the tablet content, weight, disintegration, or dissolution, and potential stability issues.

The FDA, the American Medical Association, the National Association of Boards of Pharmacy, the American Pharmaceutical Association, and other medical organizations do not recommend splitting tablets unless specified in the FDA-approved product labeling. The FDA posted an article for consumers on tablet splitting in July 2009 at *http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm171492.htm*, after which the FDA received letters from various organizations expressing concerns about the article. The FDA subsequently posted a follow-up article in October 2009 at *http://www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/EnsuringSafeUseofMedicine/ucm184666.htm*.

The Board also discussed safety issues associated with splitting tablets that appear to be scored but for which there is no scoring and splitting information in the FDA-approved labeling. If the tablet is scored, then the intent is that it can be split for clinical reasons. A lack of scoring indicates no prior intent to split the tablets. There are some dosage forms that should not be split (e.g., modified release, combination tablets, odd shaped tablets). The Board discussed the importance of conveying this information to health care professionals and patients so that these types of tablets are not split.

Another discussion item included tablet and patient considerations when recommending tablet splitting. The FDA considers the tablet score, patient reliability, and tablet characteristics when examining whether certain tablets should be split. Tablet characteristics, such as shape and coating, as well as the tablet splitting device, affect ease of splitting. Not all tablet splitting devices are equally effective. Moreover, many geriatric patients have manual dexterity issues and have difficulty opening bottles and splitting tablets. The following are considerations for clinicians when deciding to split tablets:

1. Does the patient require an intermediate dose not commercially available?
2. Is the patient or caregiver reliable to adequately perform the task of splitting tablets?
3. Will variability and stability have clinical significance in the therapeutic outcome (e.g., the drug's dose response curve and the likelihood that small differences in the tablet half may have clinical implications)?
4. Do tablet characteristics (shape, hardness, coating) and the patient's personal status (cognition, dexterity, visual acuity) permit easy splitting?
5. Will a split tablet cause a taste problem or increase local irritation due to loss of tablet coating?

Finally, the Board discussed how the FDA can do a better job of capturing adverse event information associated with tablet splitting.

November 2009. At the November 19, 2009 meeting, the DSB discussed the clinical implications and impact of the FDA action regarding a drug interaction involving clopidogrel and omeprazole on health care professionals, patients, and health care institutions.

On November 17, 2009, the FDA released three risk communications regarding clopidogrel (*http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/DrugSafetyInformationforHeathcareProfessionals/ucm190784.htm*). Board members from the DoD, the VA, and the IHS provided information on clopidogrel and proton pump inhibitor (PPI) usage patterns in their hospitals and clinics. They also provided input on how the recently issued risk communications affected their health systems. A guest speaker, the Director of the Cardiac Catheterization Laboratory and Professor of Medicine at the Mayo Clinic in Rochester, Minnesota, provided the Board with a clinical perspective on the use of clopidogrel and PPIs.

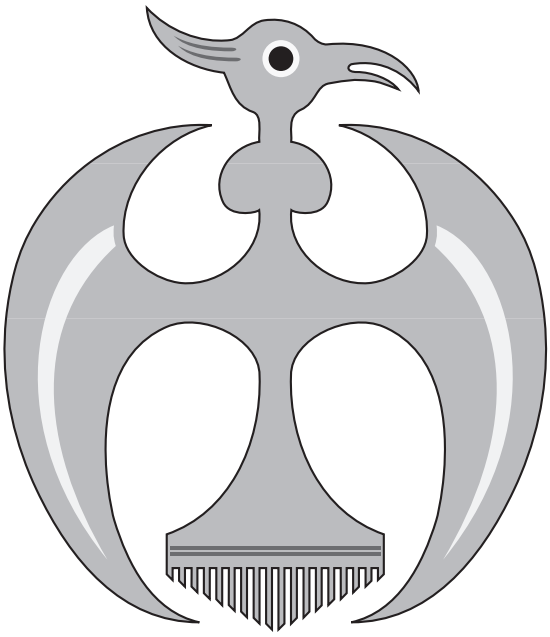
The Board discussed clopidogrel's metabolic pathway, pharmacogenomics of clopidogrel's metabolism, and its interaction potential. The FDA's Division of Cardiovascular and Renal products presented pharmacokinetic (PK) and pharmacodynamic (PD) data demonstrating reduced blood levels of clopidogrel's active metabolite and reduced inhibition of platelet aggregation with co-administration of omeprazole. The Board also discussed several observational and epidemiological studies, as well as a clinical trial (COGENT) evaluating clinical outcomes in patients taking clopidogrel with omeprazole or another PPI.

There are strong PK and PD data demonstrating a clopidogrel-omeprazole drug interaction, a reduction of clopidogrel's active metabolite, and reduced platelet inhibition. However, the clinical consequences of this are not well documented, and there are differing opinions on how well the

PK and PD data translate to clinical outcomes. The Board received input from its Federal partners and external sources and gleaned important information on how to communicate messages that have conflicting conclusions from ex-vivo data versus clinical data. In addition, the FDA continues to study the clopidogrel-omeprazole drug interaction issue and plans to notify the public as new information becomes available.

Summary

FDA is excited to have the Indian Health Service as a new member on the FDA Drug Safety Oversight Board. The FDA recognizes the importance of clinical input from the IHS as they provide health care to almost two million American Indian and Alaskan Native patients. The FDA looks forward to input from the IHS on many fronts, including input on critical, ongoing drug safety issues discussed by the DSB and input on how the FDA's decisions affect the IHS patient population.



How to Obtain AAFP Prescribed Credit

Up until several years ago, the Indian Health Service, as a part of the Federal government, was exempt from charges that the American Academy of Family Physicians levied for each course for which AAFP Prescribed Credit was requested. Beginning in 2005, this exemption was lifted, and, since then, there has been another increase in the fees. Because of limited resources, the Clinical Support Center has asked those requesting AAFP credit to reimburse us for this additional expense. In the last year, very few activities have requested submission for AAFP Prescribed Credit.

The Clinical Support Center has made a decision to change the procedure used to submit activities to AAFP. We will ask that, when AAFP sponsorship is sought, the coordinator of the activity recruit a family physician at the local facility who is willing to serve on the planning committee and who is able to complete and sign the AAFP application for Prescribed Credit. This is done on line (go to: *http://www.aafp.org/cmea/online*), where the family physician will create his or her own login/password to access the necessary form and upload the supporting documents. This physician will need to be a member of the AAFP, and the application will need to be accompanied by a check or credit card payment for the appropriate fee.

Please let Ms. Sandra Sorrell (*sandra.sorrell@ihs.gov*) know if you have any questions about how to get started.

IHS OIT Launches Meaningful Use Web Site

The Office of Information Technology is pleased to announce the launch of a web site dedicated to providing information about "meaningful use." Providers are encouraged to become familiar with "meaningful use" and how it relates to financial incentives authorized by the American Recovery and Reinvestment Act (ARRA), also called the Recovery Act.

The Recovery Act authorizes the Centers for Medicare and Medicaid Services (CMS) to provide a reimbursement incentive for physician and hospital providers who are successful in becoming "meaningful users" of certified electronic health record (EHR) technology. These incentive payments begin in 2011 and gradually phase down. Starting in 2015, providers are expected to have adopted and be actively utilizing an EHR in compliance with the "meaningful use" definition or they will be subject to financial penalties under Medicare.

The new web site was created as a resource that can help answer questions about "meaningful use" and will be updated as new information becomes available. The information presented on this site is subject to change until the CMS rule has been finalized, which was anticipated by 12/31/2009.

The IHS-OIT Meaningful Use web site may be found at *http://www.ihs.gov/recovery/index.cfm?module=dsp_arra_meaningful_use*.

Electronic Subscription Available

You can subscribe to *The Provider* electronically. Any reader can now request that he or she be notified by e-mail when the latest issue of *The Provider* is available on the Internet. To start your electronic subscription, simply go to *The Provider* website (*http://www.ihs.gov/Provider*). Click on the "subscribe" link; note that the e-mail address from which you are sending this is the e-mail address to which the electronic notifications will be sent. Do not type anything in the subject or message boxes; simply click on "send." You will receive an e-mail from LISTSERV.IHS.GOV; open this message and follow the instruction to click on the link indicated. You will receive a second e-mail from LISTSERV.IHS.GOV confirming you are subscribed to *The Provider* listserv.

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.

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.

Women's Health Notes
Breastfeeding as a SIDS Reduction Strategy

Sudden infant death, SIDS, is the leading cause of death in babies between one month and one year of age. SIDS is nearly three times more common among American Indian/Alaska Native infants when compared to the general population. Parents are encouraged to use the "back to sleep" sleeping position on a firm sleeping surface for their baby, to not smoke around their baby, to eliminate soft items (toys, pillows, thick blankets, etc.) from their baby's environment, and to not allow their baby to fall asleep on recliners, sofas, or couches.

Now there is another way families can reduce their babies' risk of SIDS. Choosing to breastfeed can make a difference. While research has linked breastfeeding with reduced risk of SIDS, study methods have improved and the evidence has become more compelling.

A recent summary by Ip, et al. from the Agency for Healthcare Research and Quality reviews evidence on the effects of breastfeeding on term infant and on maternal health outcomes in developed countries. They found that any breastfeeding reduced SIDS risk. The report looked for research that included an objective definition of SIDS (autopsy confirmed SIDS in infants one week to one year of age, clear reporting of breastfeeding data, and outcome adjustment for important confounders such as sleep positions, maternal smoking, and socio-economic status. Six studies were included: three rated as good, and three rated as fair. Ranking in the ratings was based on study design: systematic reviews, experimental (randomized controlled trials), observational studies (prospective cohort and case-control studies only), population (healthy term infants in developed countries), and the intervention being the use of breast milk compared to formula. The meta-analysis of the studies showed that ever breastfeeding was linked with a statistically significant reduction of SIDS for both crude and adjusted risk (crude OR 0.41, 95% CI [0.28, 0.58] and adjusted OR 0.64, 95% CI [0.51, 0.81]).

A study in Germany by Vennemann, et al. reviewed 333 infants who died of SIDS and 998 age-matched controls. Strengths of this study included size, pre-existence of back-to-sleep type educational campaign, standardized autopsy procedures using a multidisciplinary panel to determine cause of death, and data collection of feeding patterns by month for most participants (exclusively breastfed, partially breastfed, or not breastfed). The study found that after adjustment for potential confounders, exclusive and partial breastfeeding reduced SIDS risk by 50% at all ages.

The study also found similarities to other SIDS studies regarding age distribution; 59% of SIDS victims died between two and five months, and 73% died before six months. This pattern suggests that supporting breastfeeding in the first few months when SIDS risk is highest and through six months as the risk lowers could be especially promising for reducing SIDS.

Although research has not been able to identify what part of breastfeeding reduces risk, some suggestions have been made. The unique and changing immunological properties of human milk may be one factor. That breastfed infants are more easily aroused than formula fed babies has also been noted. There may be other variables not yet found that also make a difference.

But at the end of the day, the reasons for why breastfeeding protects babies from SIDS is not nearly as important to families as knowing that they are doing the best they can to prevent it. For information about supporting breastfeeding, please see the resources section below.

References

1. Ip S, Chung M, Raman G, Trikalinos TA, Lau J. A summary of the Agency for Healthcare Research and Quality's evidence report on breastfeeding in developed countries. *Breastfeed Med*. 2009 Oct;4 Suppl 1:S17-30. *http://www.ncbi.nlm.nih.gov/pubmed/19827919*
2. US Department of Health and Human Services. Regional Differences in Indian Health, *2002-2003 edition*. March 2008.
3. Vennemann MM, Bajanowski T, Brinkmann B, et al.; GeSID Study Group. Does breastfeeding reduce the risk of sudden infant death syndrome? *Pediatrics*. 2009 Mar;123(3):e406-10. *http://www.ncbi.nlm.nih.gov/pubmed/19254976*

Resources

IHS Breastfeeding Support Website:
http://www.ihs.gov/MedicalPrograms/MCH/M/bf.cfm

IHS guidance on recording infant feeding choices in EHR:
http://www.ihs.gov/MedicalPrograms/MCH/M/documents/FAQs-Infant%20Feeding%20Choice_110207.doc

Office of Women's Health:
http://www.womenshealth.gov/breastfeeding/index.cfm

NIH free web-based database for checking medication compatibility with breastfeeding:
http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT
(This can be added to the EHR website links as a resource for EHR users.)

WHO Baby-Friendly Hospitals Initiative:
http://www.babyfriendlyusa.org/

WIC: *http://www.fns.usda.gov/wic/breastfeeding/breastfeedingmainpage.htm*

The Women's Health Notes, an online newsletter for those working in women's health at IHS, tribal, and urban sites, is available for subscription through the IHS listserv:
http://www.ihs.gov/cio/listserver/index.cfm?module=list&option=list&num=87&startrow=76

The full content of the IHS Women's Health Notes are available on-line at:
http://www.ihs.gov/MedicalPrograms/MCH/index.cfm

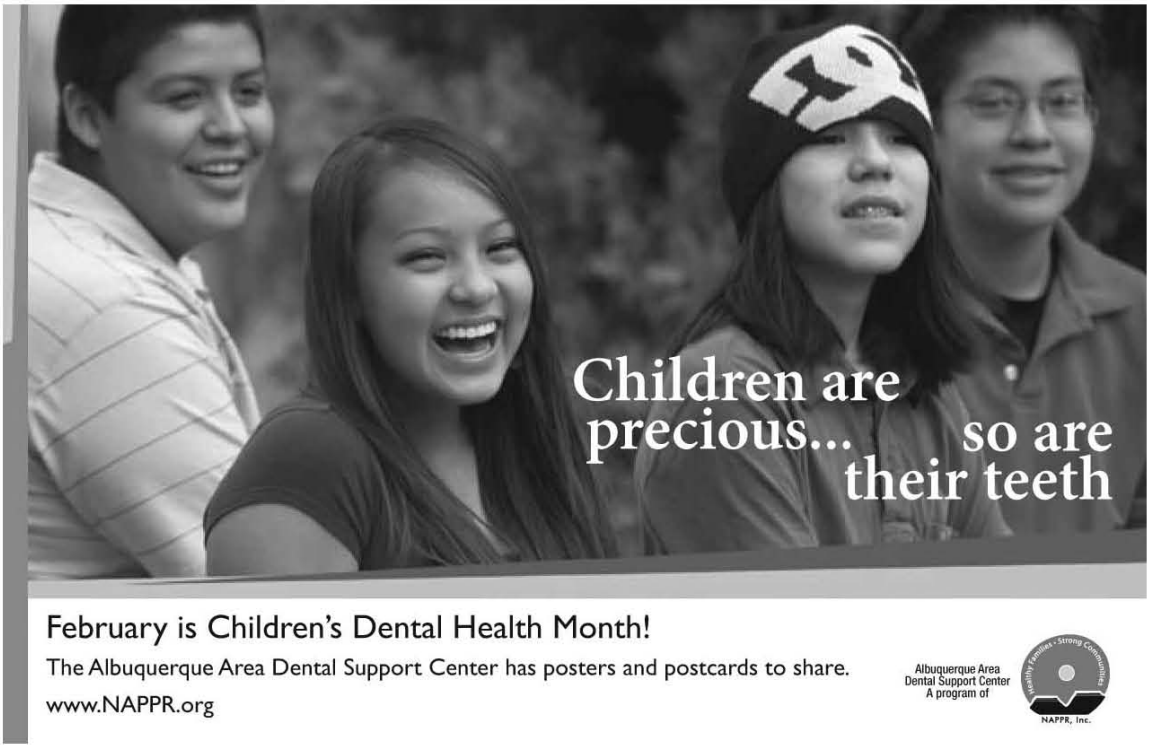
If you have comments or suggestions, or would like to contribute to a future issue, please contact *jean.howe@ihs.gov*.

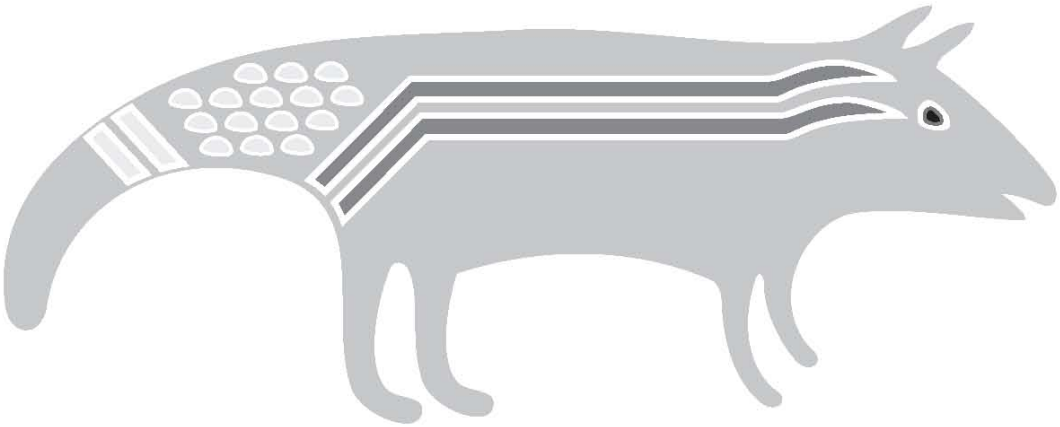
The 15th Annual Elders Issue

The May 2010 issue of THE IHS PROVIDER, to be published on the occasion of National Older Americans Month, will be the fifteenth 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.

Help us Update Our Mailing List

If you see copies of *The Provider* being delivered to your facility addressed to individuals who have left, please take a moment to e-mail *cheryl.begay@ihs.gov* to let her know so that she can remove these individuals from the mailing list. This will save us postage and printing expenses, and eliminate a minor inconvenience in your mailroom.


Children are precious... so are their teeth
February is Children's Dental Health Month!
The Albuquerque Area Dental Support Center has posters and postcards to share.
www.NAPPR.org
Albuquerque Area Dental Support Center
A program of
NAPPR, Inc.



Changes in *The IHS Provider* Distribution

As most of our readers know, we are still having problems with the timely distribution of paper copies of *The Provider*. The transition to the UFMS has proved more difficult than anticipated, and we realize that these problems may persist for the coming year. We have instituted the following changes.

We will continue to publish monthly issues with all articles, meetings, announcements, position vacancies and so on, but we will distribute these electronically, using the *Provider* listserv to let those subscribed to that service know when issues are published to the website. This will assure that all who are interested can receive all of this information in a timely manner. Currently, about 15% of our readership has subscribed to the listserv (see the instructions elsewhere in this issue about how to do this) and the list has been growing at an annual rate of about 20 percent.

We will publish and mail paper issues on a quarterly basis (March, June, September, and December), and these will contain only the *articles* for the past three issues. This will assure that those without Internet access will still be able to see all of the clinical information, although these paper issues will not include the time-sensitive information described above.

A significant proportion of the cost of publishing *The Provider* is the postage needed to distribute the 6000 copies that go out monthly, and so, by mailing only quarterly issues, we will be able to save the agency money, as well.

We are interested to hear feedback from readers to know if this idea poses any hardships, or if there are suggestions about how to revise this plan to better meet the needs of our readers. Send these by e-mail to *john.saari@ihs.gov*.

Erratum

The name of the author of the article, *Bariatric Surgery: Who is a Candidate and Where to Refer* in the November 2009 (Volume 34, Number 11, pages 320 - 321) issue of *The Provider* was misspelled. The correct spelling is Dr. Hope Baluh. She was also incorrectly listed as being from the Cherokee Indian Hospital in Cherokee, North Carolina. She is actually located at the Cherokee Nation W. W. Hastings Hospital in Tahlequah, Oklahoma.

In the online December issue (Volume 34, Number 12), the footer at the bottom of pages 354 and 355 shows the wrong year. The correct year is 2009.

We apologize for these errors.

A PROGRAM FOR CURRENT AND FUTURE INDIAN HEALTH CARE EXECUTIVES

WHAT?
A concentrated executive leadership program designed specifically for current and future leaders. The program will benefit individuals who are either serving in or aspire to be in leadership positions.

WHO WOULD BENEFIT?
Chief Executive Officer · Service Unit Director · Health Director · Medical/Clinical Director · Nursing Executive · Director of Nursing · Administrative Officer

Individuals who are program coordinators or managers of clinical, community, environmental or engineering programs will find this beneficial. The interactive curriculum includes topics that will be integrated through the use of exercises, case studies, and team projects.

Challenges in Indian Health Care
Change and Transition
Personnel
Motivation
Organizational Skills
Personal Vision and Goal Setting
Law
Financing Health Care
Budgets and Financing
Data and Information Technology
Integrity and Ethics
Conflict Resolution
Critical Thinking
Negotiation
Executive Communications
Partnerships, Collaborations
Decision Making
Visionary Strategic Planning
Building Constructive Relationships

WHY?
The purpose of the Executive Leadership Development Program is to provide a forum where participants learn new skills and encounter different approaches to reduce barriers, increase innovation, ensure a better flow of information and ideas, and lead change. The goal is to provide essential leadership training and support for Indian health care executives whether they work in Federal, tribal, or urban settings.

WHO?
Faculty for the Executive Leadership Development Program have been selected from the private, public, and academic sectors. They have experience teaching in executive programs and understand the unique needs of the Indian health care system. Coordination of the Executive Leadership Development Program is through the Indian Health Service, *Clinical Support Center* in Phoenix, Arizona in partnership with different universities and foundations.

HOW?
The Executive Leadership Development Program will be presented in three 4½ day sessions over

12 months. Each session builds on the previous session. Participants should anticipate an intense experience to develop and practice skills to be an effective leader. Independent time is used for reading assignments or working with fellow team members on business simulations, cases, or presentations. At the end of each session, participants will receive certificates of accomplishment from the academic institutions that sponsored the training. After all three sessions have been completed, participants will receive a certificate of completion from the Indian Health Service.

WHEN/WHERE*?

Session One (03/10)	**March 15-19, 2010** Western Management Development Center Aurora, Colorado
Session Two (04/10)	**April 19-23, 2010** Western Management Development Center Aurora, Colorado
Session Three (05/10)	**May 24-28, 2010** Western Management Development Center Aurora, Colorado

*Note: Attendees must enroll for all three sessions.

CONTINUING EDUCATION CREDITS ACCREDITATION

The Indian Health Service (IHS) Clinical Support Center is accredited by the *Accreditation Council for Continuing Medical Education* to sponsor continuing medical education for physicians. The IHS Clinical Support Center designates this continuing education activity for up to 28 hours of Category 1 credit toward the Physician's Recognition Award of the *American Medical Association*. Each physician should claim only those hours of credit he or she actually spent in the education activity.

The Indian Health Service Clinical Support Center is approved by *the American Council on Pharmacy Education* as a provider of continuing pharmaceutical education.

The Indian Health Service is accredited as a provider of continuing education in nursing by *American Nurses Credentialing Center* Commission on Accreditation, and designates this program for 36 contact hours for nurses.

Continuing Education Units for Chief Executive Officers, Administrative Officers, and Dentists designates this program for 36 CEUs.

TUITION

Tuition for all three sessions is **$4500**. The tuition includes three 4½ day-session, books, instructional handouts, leadership assessments, and continuing education credits. Payment should be by tribal organization check or approved SF-182 Form. Travel and per diem are not included in the tuition.

CONTACT:

Gigi Holmes or Wes Picciotti
Phone: (602) 364-7777
FAX: (602) 364-7788
e-mail: gigi.holmes@ihs.gov
Website:
http://www.ihs.gov/nonmedicalprograms/eldp/

Indian Health Service
Clinical Support Center
Two Renaissance Square, Suite 780
40 North Central Avenue
Phoenix, Arizona 85004-4424

This is a page for sharing "what works" as seen in the published literature, as well as what is being done at sites that care for American Indian/Alaskan Native children. If you have any suggestions, comments, or questions, please contact Steve Holve, MD, Chief Clinical Consultant in Pediatrics at sholve@tcimc.ihs.gov.

IHS Child Health Notes

Quote of the month

" Laughter is the shortest distance between two people."
Victor Borge

Articles of Interest

Impact of rapid viral testing for influenza A and B viruses on management of febrile infants without signs of focal infection. *Pediatr Infect Dis J*. 2006 Dec;25(12):1153-7. *http://www.ncbi.nlm.nih.gov/pubmed/17133161?itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_RVDocSum&ordinalpos=1*

This study show that infants < 90 days of age who have a positive rapid tests for influenza during the winter respiratory season are at much lower risk for serious bacterial illness than those with negative rapid flu tests (2.6% versus 17%). In particular, the risk for bacteremia and meningitis appears to be almost zero. The risk for urinary tract infections was much less in an infant with a positive rapid flu test (4% versus 14%) but was not zero. The inclusion of rapid influenza testing for the evaluation of febrile young infants without signs of focal infection during influenza season decreases the need for additional studies and reduces the length of stay in the ED, the use of antibiotic treatment, and unnecessary hospitalizations.

Editorial Comment

Respiratory season is here. There will be lots of febrile, well-appearing infants. Some infants, especially those > 30 days of age might not need a blood culture drawn if they appear well and have a positive rapid flu test. The risk for urinary tract infection is lower in infants with a positive flu test but is not zero. Prudence dictates that all febrile infants < 90 days old should probably still have a urine culture obtained.

Infectious Disease Updates
Rosalyn Singleton, MD, MPH

The 2010 National Immunization Schedule was just published in the MMWR at *http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5851a6.htm?s_cid=mm5851a6_e*

There are only minor changes at present:

- The last IPV is now recommended to be given > 4 years of age. If four doses were administered before age 4, an additional dose should be administered at 4 - 6 years.
- Revaccination with meningococcal conjugate vaccine is recommended for children who remain at increased risk for meningococcal disease at 3 years (if first dose at 2 - 6 years of age) or 5 years (if first dose >7 years of age).
- HPV vaccine footnotes are revised to include: 1) availability of bivalent HPV (Cervarix) and 2) permissive recommendation for Gardasil® in males 9 - 18 years to reduce the likelihood of acquiring genital warts.

In addition, we expect the FDA to license Prevnar 13™ (PCV13) to replace Prevnar® (PCV7) early in 2010. PCV13 adds protection against 6 additional pneumococcal serotypes, including 19A. When PCV13 is available, it will just replace PCV7 on the same schedule. Children 14 - 59 months who have completed their PCV7 series will need one PCV13 dose to provide the added protection against the 6 additional serotypes in PCV13.

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

Centers for Disease Control and Prevention (CDC). Deaths related to 2009 pandemic influenza A (H1N1) among American Indian/Alaska Natives - 12 states, 2009. *MMWR*. 2009 Dec 11;58(48):1341-4.

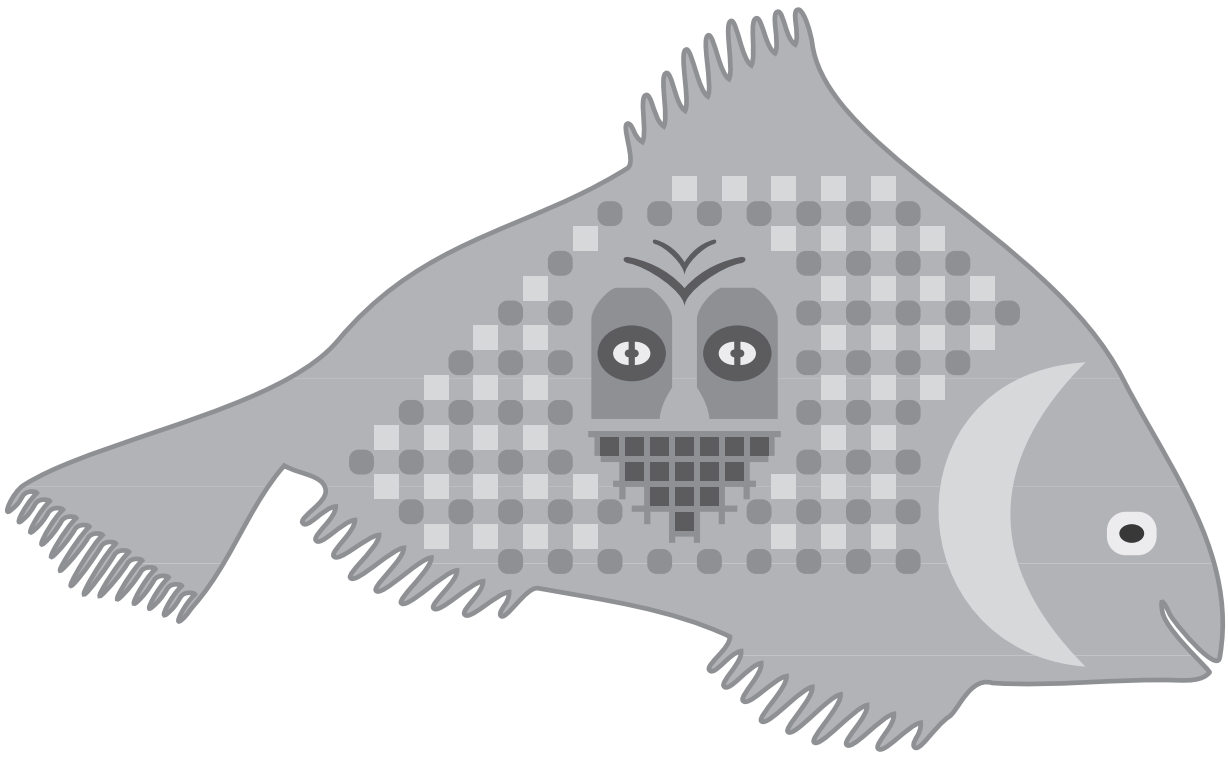
With recent reports suggesting that indigenous populations in Canada, Australia, and New Zealand have higher rates of hospitalizations and deaths associated with 2009 pandemic influenza A (H1N1) virus, representatives from the Centers for Disease Control and Prevention (CDC), Indian Health Service, Tribal Epidemiology Centers, 12 state health departments and the Council of State and Territorial Epidemiologists convened in November 2009 to review the recent disproportionate increase of deaths related to H1N1 among American Indian/Alaska Natives (AI/ANs) in two states (Arizona and New Mexico).

This workgroup investigation revealed that 42 (9.9%) of the 426 H1N1 deaths reported during April 14 through November 13, 2009 in 12 States (Alabama, Alaska, Arizona, Michigan, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Washington, and Wyoming; representing approximately 50% of the AI/AN US population), occurred in

AI/ANs. The overall AI/AN death rate related to H1N1 was higher than all other racial/ethnic groups combined (3.7 per 100,000 versus 0.9 per 100,000). The mortality rate ratio was 4.0. AI/ANs had a higher H1N1 death rate in all age categories than all other racial/ethnic populations.

The authors point out that although the AI/ANs H1N1 associated mortality rate is four times higher than all other racial/ethnic groups, the higher rate is consistent with the previous increased mortality rates associated with influenza among this population. The reasons for this higher rate are unclear but may be related to a higher prevalence of chronic illness (such as asthma and diabetes), poverty, and limited access to health care among American Indians/Alaska Natives.

Despite the limitations of the study (misclassification, data collection, delayed reporting), the authors conclude that community education and awareness of the signs and symptoms of influenza, risks, vaccination, treatment and medical complications associated with influenza should be increased and promoted among AI/AN communities. Accurate and timely reporting of data related to H1N1 will further aid in development of effective public health responses. Lastly, "factors that might contribute to increased influenza-related mortality in the AI/AN population, including the role of underlying chronic medical conditions and social determinants of health, should be topics for future investigation."



SAVE THE DATE!!!

July 19-23, 2010

2010 Nurse Leaders in Native Care Conference

"Transforming Indian Health Care through Nursing Leadership"

Renaissance Mayflower Hotel
1127 Connecticut Avenue NW
Washington, DC 20036
1-800-266-9432

http://www.marriott.com/hotels/travel/wassh-renaissance-mayflower-hotel/

Click the Link Below for ON-LINE Hotel Reservations:
https://resweb.passkey.com/Resweb.do?mode=welcome_ei_new&eventID=2152927

Hotel: The government room rate is guaranteed at $165.00 per room, per night, plus tax, single/double occupancy. Be sure to mention the "IHS Clinical Support Center" if making your reservations by telephone. **July 2, 2010** is the deadline for making room reservations at the guaranteed government rate. Limited room space is available 3 days before and 3 days after the conference at this special rate, please make your reservations as early as possible if you are planning to extend your stay in the DC area.

Target Audience: nurse administrators, directors of public health nursing, clinical nurses, public health nurses, advanced practice nurses, nurses from all specialty areas. This annual seminar provides an opportunity to network with peers/colleagues on nursing topics of common concern, update knowledge, competence, and performance in current nursing trends/issues and amplify nursing practice to improve patient care.

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

FOR MORE INFORMATION CONTACT LCDR LISA PALUCCI, MSN, RN; NURSE EDUCATOR/LEAD NURSE PLANNER AT (602) 364-7740 OR E-MAIL: Lisa.Palucci@ihs.gov

This event is jointly sponsored by the IHS Division of Nursing, the IHS National Nurse Leadership Council, and the Arizona Nurses Association.

Maternal and Child Health Distance Learning Graduate Certificate Program Announcement

The University of Arizona will be offering a Maternal and Child Health Public Health Distance Learning Graduate Certificate Program starting in the summer of 2010! This program has been developed by the University of Arizona and the University of Kentucky in partnership with the United South and Eastern Tribes (USET) to meet the educational needs of individuals working in tribal and rural health care settings throughout Indian Country. 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. This program will provide students with skills to

1. Enhance in depth knowledge of maternal and child health;
2. Use epidemiology tools for clinical and managerial decision-making;
3. Design health intervention programs and evaluations;
4. Identify key components in project grant applications;
5. Create and use health messaging effectively;
6. Engage families and communities in health interventions; and,
7. Develop leadership skills for public health practice.

This will be a twelve-month, 14-credit online graduate certificate program that is open to all individuals who have completed a four year degree. These credits may be transferred from the University of Arizona if a student chooses to seek a master in public health degree. Interested individuals will be applying for admission to the University of Arizona. A limited number of scholarships will be available to qualified individuals currently working in tribal or rural health settings. To find out how to apply or for more information, please go *to http://www.usetinc.org/Programs/USET-THPS/TribalEpiCenter.aspx* and click on the MCH Certificate Program link found on the left hand side of the page, or contact Nichole Blackfox, USET Project Assistant at *nichole@usetinc.org*.

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.

Upcoming seminars include:

Date and Time	Topic	Speaker
February 17 at 1 pm MST	Improving Diabetes Care: The Diabetes Audit	Dr. Ray Shields, Dr. Ann Bullock, and Karen Sheff, MS
March 17 at 1 pm MST	Chronic Kidney Disease: Screening and Laboratory Tests	Dr. Ann Bullock
April -- TBA	Update on Diabetes Guidelines	Dr. Kelly Acton
March -- TBA		

For Information on upcoming seminars, go to *www.diabetes.ihs.gov*, (*http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=home*) and click on **Advancements in Diabetes Seminar**.

For information about previous seminars, including the recordings and handouts, click on the following link and visit 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*.

The 2010 Meeting of the National Councils for Indian Health
March 21 - 26, 2010; Phoenix, Arizona

The National Councils (Clinical Directors, Chief Executive Officers, Chief Medical Officers, Oral Health, Pharmacy, and Nurse Consultants) for Indian health will hold their 2010 annual meeting March 21 - 26, 2010 in Phoenix, Arizona. Engage in thought-provoking and innovative discussions about current Indian Health Service/tribal/urban program issues; Identify practical strategies to address these health care issues; Cultivate practical leadership skills to enhance health care delivery and services; Share ideas through networking and collaboration; and receive accredited continuing education. Indian health program Chief Executive Officers, clinico-administrators, and interested health care providers are invited to attend. The meeting will be held at the Hyatt Regency Phoenix, 122 North Second Street, Phoenix, Arizona 85004. Please make your hotel room reservations by March 1, 2010 by calling 1-(800) 233-1234 or (602) 252-1234. Be sure to ask for the "Indian Health Service" group rate. On-line registration and the conference agenda will be available late December at the Clinical Support Center web page at *http://www.csc.ihs.gov*. The IHS Clinical Support Center is the accredited sponsor for this meeting. For more information, contact Gigi Holmes or CDR Ed Stein at (602) 364-7777; or e-mail *gigi.holmes@ihs.gov*.

Native Fitness Trainings
March 25 - 28, 2010; San Diego, California
April 19 - 20, 2010; Norman, Oklahoma

The American Indian Institute at the University of Oklahoma is offering two Native Fitness Trainings in San Diego, California, March 25 - 28, 2010, and Norman, Oklahoma, April 19 - 20, 2010. This is an introductory level training designed for anyone interested in fitness, those who have never had any fitness training, and for those who work in tribal wellness programs. Topics covered during the training include anatomy and physiology, biomechanics, nutrition, exercise and weight management, instructional skills, class development, marketing, injury prevention and safety, special populations, choreography, and legal considerations. Continuing education units and a certificate will be offered by the University of Oklahoma. All participants must have current CPR certification. For more information, please

contact *Chelsea-Southerland@ou.edu* or visit *www.aii.ou.edu*.

Ninth Annual Native Women and Men's Wellness Conference
March 28 - April 1, 2010; San Diego, California

The American Indian Institute at the University of Oklahoma will be presenting the Ninth Annual Native Women and Men's Wellness Conference in San Diego, California, March 28 - April 1, 2010. Areas of focus include diabetes prevention and care, gender specific health, wellness, and spirituality. The conference will provide both personal and professional development, and activities to inform and inspire tribal community leaders, health advocates, and health consumers in best practices. Continuing education units will be offered by the University of Oklahoma. There will be no registration fee for presenters. For more information, please contact *Chelsea-Southerland@ou.edu* or visit *www.aii.ou.edu*.

2010 American Indian Prevention Services Conference
April 21 - 22, 2010; Norman, Oklahoma

The American Indian Institute will be presenting the 2010 American Indian Prevention Services Conference in Norman, Oklahoma from 8 am – 5 pm, April 21 - 22, 2010. This conference will bring together the expertise of prevention, public health, and wellness professionals to assist in the exploration, development, and sustainability of our individual and community strengths. Workshops will cover a broad range of topics to enhance the community-building foundation upon which prevention is built, such as strategic and community planning; services for returning veterans and their families; problem and compulsive gambling; substance abuse issues and prevention; suicide prevention; domestic violence prevention; chronic disease and diabetes prevention; culturally relevant methods for American Indians; and developing inter-agency and inter-tribal relationships. There will be no registration fee for presenters. Continuing education units will be offered by the University of Oklahoma. For more information, please contact *Chelsea-Southerland@ou.edu* or visit *www.aii.ou.edu*.

Advances in Indian Health
April 27 - 30, 2010; Albuquerque, New Mexico

The Advances in Indian Health Conference, April 27 - 30, 2010 will be held at the Sheraton Uptown in Albuquerque, New Mexico. "Advances" is IHS's primary care clinical conference and attracts over 350 clinicians from across the Indian health system. The conference covers many primary care topics with special emphasis on diabetes, mental health, substance abuse, women's health, geriatrics, pediatrics, and the EHR. With low tuition and a government rate available for the conference hotel, Advances is a low cost way for clinicians to receive up to 28 hours of CME/CE on issues of particular importance to Indian health patients and practices. The conference brochure will be available in early 2010 on the UNM Office of CME website: *http://hsc.unm.edu/som/cme/2010_Conferences.shtml*. For more information, contact the course director, Ann Bullock, MD, at *ann.bullock@ihs.gov*.

The IHS Southwest Regional Pharmacy Continuing Education Seminar (the "Quad"),
June 6 - 8, 2010; Scottsdale, Arizona

The largest annual meeting of Public Health Service pharmacists and technicians, and pharmacists from tribally operated programs, this seminar provides up to 15 hours of ACPE approved pharmacy continuing education credit. Hosted by the IHS Phoenix and Navajo Areas, the target audience is made up of pharmacists and technicians working in Indian health system clinics and hospitals. It will be held at the Chaparral Suites Hotel, 5001 North Scottsdale Road, Scottsdale, Arizona 85258. For more information, look for "Event Calendar" at *http://www.csc.ihs.gov/* or contact CDR Ed Stein at the IHS Clinical Support Center by e-mail at *ed.stein@ihs.gov*.

Introduction to Social Marketing
June 25 - 29, 2010; Santa Fe, New Mexico

The American Indian Institute will be offering the "Introduction to Social Marketing" training in Santa Fe, New Mexico, June 25 - 29, 2010. This training is designed for tribal health administrators and directors who are interested in the field of social marketing. The course will include an overview of social marketing, focus group research, program design, and implementation. This is the first course in a series of four that will include 1) Introduction to Social Marketing; 2) Advanced Social Marketing, for those who are in the process of implementing a project; 3) Program Evaluation; and 4) Focus Group Research. Continuing education units will be offered by the University of Oklahoma. For more information, please contact *Chelsea-Southerland@ou.edu* or visit *www.aii.ou.edu*.

The Pharmacy Practice Training Program: a program in patient-oriented practice (PPTP)
August 2 – 5 or August 23 - 26, 2010; Scottsdale, Arizona

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

Join your colleagues from around the Indian Health System!

10th Annual IHS Advances in Indian Health Conference

Sheraton Albuquerque Uptown Hotel
2600 Louisiana Blvd NE
Albuquerque, New Mexico

April 27-30, 2010

Earn up to 28 hours of CME/CE specific to Indian Health!

99 Sessions, including many choices on diabetes, mental health, substance abuse, geriatrics, women's health, pediatrics, and EHR.

The Advances in Indian Health Conference is Indian Country's Primary Care Conference: all primary care clinicians who work with American Indian and Alaskan Native populations at federal, tribal and urban sites are invited to attend. The conference format includes three and a half days of lectures and workshops. Low-cost tuition and government hotel room rates make this an economical source of professional education. Most types of continuing education credit will be offered—see the brochure for details.

To link to the brochure, conference registration, and hotel reservations, go to the Advances page on the UNM Office of CME web site at http://hsc.unm.edu/som/cme/2010/AIH/AIH.shtml. For additional information please contact the UNM Office of CME at (505) 272-3942, or email at CMEWeb@salud.unm.edu .

Presented by:

Indian Health Service & Office of Continuing Medical Education

POSITION VACANCIES

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

Family Physician
SouthEast Alaska Regional Health Consortium

The SEARHC Clinic in Juneau, Alaska has an excellent opportunity for a family physician with obstetrics skills to join a medical staff at a unique clinic and hospital setting. Have the best of both worlds in a practice where we share hospitalist duties and staff an outpatient clinic, all with an excellent quality of life. We have the opportunity to practice full spectrum family medicine. Southeast Alaska has amazing winter and summer recreational activities. Enjoy Alaska's capital with access to theater, concerts, and annual musical festivals. Now a NHSC Loan Repayment Site. For information contact Dr. Cate Buley at (907) 364-4485; e-mail *cbuley@searhc.org*; or visit the website at *www.searhc.org*. (2/10)

Family Physician
Kodiak Area Native Association; Kodiak, Alaska

Come practice on Alaska's Emerald Isle. Looking for a board certified or board eligible family physician to join Kodiak Area Native Association in providing comprehensive family medicine. Coastal temperatures and endless outdoor recreation. Contact Robert Onders, MD with further questions or, to send a CV, at *Robert.Onders@kanaweb.org*. KANA is an EOE employer exercising Native preference in accordance with PL 93-638. For a complete list of job qualifications, description, and application, please contact Kodiak Area Native Association Human Resources Department by e-mail at S*amuel.towarak@kanaweb.org*; mailing address 3449 E. Rezanof Drive, Kodiak, Alaska 99615; telephone (907) 486-9805; or fax (907) 486-9896. (2/10)

Physician
Puyallup Tribal Health Authority; Tacoma, Washington

The Puyallup Tribal Health Authority is currently recruiting a full time physician to join a team of nine other physicians. PTHA is a tribally operated ambulatory clinic located in Tacoma, Washington, and is accredited by AAAHC, CARF and COLA. This position will evaluate, diagnose, and treat medical, obstetric, psychiatric, and surgical diseases and emergencies as credentialed and privileged; oversee the medical evaluation, diagnosis, and treatment of patients by other medical professionals, including precepting midlevel providers as needed; perform histories and physicals, and direct the evaluation, diagnosis, and treatment of PTHA patients in local hospitals, including participation in scheduled rounding; make referrals to specialists as per PTHA protocol and follow-up to assure quality care; provide on-site health education and counseling to patients and staff; participate in after-hours on-call duty as scheduled; provide back-up consultation to other on-call PTHA providers as scheduled; and participate in utilization review studies and quality improvement committee work as assigned.

Minimum requirements include a Doctorate of Medicine or Osteopathy from an accredited institution; board certified (or eligible to sit for exam) in family practice or appropriate field; licensed to practice medicine in the State of Washington; and current certification in ACLS.

PTHA offers a competitive salary, benefits, and a generous time off schedule. To apply, a completed PTHA employment application is required (resume optional). Please submit applications to the Human Resource Department prior to the closing date. Indian hiring preference by law. Telephone (253) 593-0232 ext 516; fax (253) 593-3479; e-mail *hr@eptha.com*; website, *www.eptha.com*. The mailing address is PTHA Human Resource Department, KCC bldg #4, 1st Floor, 2209 E. 32nd St.. Tacoma, Washington 98404. (2/10)

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

The Sells Service Unit (SSU) in southern Arizona is recruiting for board certified/board eligible family medicine or internal medicine physician to join our experienced medical staff. The SSU is the primary source of health care for approximately 24,000 people of the Tohono O'odham Nation. The service unit consists of a Joint Commission accredited 34-bed hospital in Sells, 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. Commuter van pool from Tucson is available for a monthly fee. For more information, please contact Peter Ziegler, MD, SSU Clinical Director at (520) 383-7211 or by e-mail at *Peter.Ziegler@ihs.gov*. (2/10)

Family Practice Physician
Jicarilla Service Unit; Dulce, New Mexico

The Jicarilla Service Unit (JSU) is a new, beautiful 65,000 square foot facility nestled in the mesas of northern New Mexico with views of the edge of the Colorado Rockies. We provide care to the Jicarilla ("Basket-maker") Apache community with a population of 3,500. Our clinic has an opening for a board certified/eligible family practice physician for purely outpatient care with a 40 hour work-week. Our site qualifies for IHS and state loan repayment programs. JSU has a fully functional electronic health record system. Our pharmacy has a robust formulary including TNF-alpha inhibitors and exenatide. The clinic also has an urgent care clinic for acute walk-in cases. Our staff currently consists of a family practice physician, an internist, a pediatrician, a part-time FP physician (who focuses on prenatal care), three family practice mid-levels, an optometrist, and two dentists. We also have a team of dedicated public health nurses who specialize in home visits for elders and prenatal follow-up. The Jicarilla Apache Nation is self-sufficient with profits from oil and natural gas. Much has been invested in the infrastructure of the reservation, including a large fitness facility with free personal training, a modern supermarket, a Best Western Hotel and Casino, and more. We are also located 45 minutes from the resort town of Pagosa Springs, which has year-round natural hot springs and winter skiing at renowned Wolf Creek Pass. We welcome you to visit our facility in person. To take a video tour of the Nzh'o Na'ch'idle'ee Health Center online, go to *http://www.usphs.gov/Multimedia/VideoTours/Dulce/default.aspx*. Please call Dr. Cecilia Chao at (575) 759-3291 or 759-7230; or e-mail *cecilia.chao@ihs.gov* if you have any questions. (01/10)

Registered Nurse
Yavapai-Apache Nation; Camp Verde, Arizona

The Yavapai-Apache Nation has an immediate opening for a clinic nurse. This nursing opportunity is for a registered nurse at the Yavapai-Apache Health Center, in Camp Verde, Arizona. The position is in a tribally run facility, with an IHS provider, and IHS public health nurse. The clinic is an outpatient facility, built in 1998, with family medicine, dental, optometry, and behavioral health services. We work closely with Phoenix Indian Medical Center and local specialists. We expect to have telemedicine capabilities in the near future. The clinic fully utilizes the IHS Electronic Health Record. We work regular hours, and have 15 paid holidays. Full benefits are included.

The facility is located in the beautiful Verde Valley, home to the Yavapai-Apache Nation. The Yavapai-Apache Nation has about 2300 enrolled tribal members. We are located 90 miles north of Phoenix. The Verde Valley offers many outdoor activities such as hiking, canoeing, and fishing; other mountain and desert activities are just a short drive away. The applicant should be an outgoing, energetic, team player who is compassionate and focused on patient care.

For more information and an application, contact the Yavapai-Apache Nation, Human Resources, at (928) 567-1062. (12/09)

Family Physician
SouthEast Alaska Regional Health Consortium Clinic; Juneau, Alaska

The SEARHC (SouthEast Alaska Regional Health Consortium) Clinic in Juneau, Alaska has an excellent opportunity for a family physician with obstetrics skills to join a medical staff at a unique clinic and hospital setting. Have the best of both worlds in a practice where we share hospitalist duties and staff an outpatient clinic, with excellent quality of life. We have the opportunity to practice full spectrum family medicine. Juneau is a National Health Service Corp Loan Repayment Site. Southeast Alaska has amazing winter and summer recreational activities. Enjoy Alaska's capital with access to theater, concerts, and annual musical festivals. Join a well rounded, collegial medical staff, with generous benefits. For information, contact Dr. Cate Buley, telephone (907) 364-4485; e-mail *cbuley@searhc.org*; or go to *www.searhc.org*. Job Requirements are a board certified family physician who has completed an accredited family medicine residency. (11/09)

Mid-Level Provider
Aleutian Pribilof Islands Association, Inc.

Provide health care services to whole generations of families. We are recruiting for a mid-level provider based in beautiful and interesting St. Paul Island or 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. Minimum experience: 2 - 3 years in a remote clinical setting to include emergency care services and supervisory experience. Indian Health Service experience a plus. Will be credentialed through Alaska Native Tribal health Consortium. Positions available immediately. Work 37.5 hours per week.

Qualifications/required knowledge and skills include the following: graduate of an accredited ANP, FNP, or PA-C program; requires a registration/license to practice in the State of Alaska; credentialing process to practice required; knowledge of related accreditation and certification requirements; three to five years experience (two years of supervision preferred) or an equivalent combination of education and/or experience; ability to perform medical examinations using standard medical procedures; knowledge of patient care charging to include "superbill" coding, patient histories, clinical operations and procedures, primary care principles and practices; ability to observe, assess, and record symptoms, reactions, and patient progress; ability to react calmly and effectively in emergency situations; up-to-date CPR and ACLS certifications; knowledge of drugs and their indications, contraindications, dosing, side effects, at proper administrations; knowledge of emerging trends in technologies, techniques, issues, and approaches in area of expertise; ability to clearly communicate medical information to professional practitioners and the general public; ability to educate patients and/or families as to the nature of disease and to provide instruction on proper care and treatment; ability to maintain quality, safety, and/or infection control standards; ability to self-manage assigned patient caseload, including organizing, prioritizing, and scheduling appointments, services, and work assignments; ability to make administrative and procedural decisions; computer literate; ability to give oral and written reports; willingness and means to travel on rotation throughout the Aleutian Pribilof Islands Region; valid Alaska driver's license; willing to take training and attend workshops and meetings periodically to enhance job performance and knowledge.

Salary DOE, includes benefits. Contractual commitment. Job description available upon request. Open until filled. Submit resumes with at least three professional references to Aleutian Pribilof Islands Association, Inc., Attn: Human Resources Director, 1131 E. International Airport Road, Anchorage, Alaska 99518; e-mail *nancyb@apiai.org*; telephone (907) 276-2700; fax (907) 279-4351. Native preference will be given to qualified applicant pursuant to P.L. 93-638. (11/09)

Family Practice Physician/Medical Director
Carl T. Curtis Health Education Center
Omaha Tribe of Nebraska, Macy, Nebraska

The Omaha Tribe of Nebraska is seeking a full-time, permanent physician medical director for the Carl T. Curtis Health Education Center. The CTCHEC is a comprehensive, tribal community-based ambulatory family medicine facility. Services include primary care, dental, behavioral health, substance abuse treatment, and diabetes. The physician medical director functions as the supervisor of the outpatient clinic, ambulance service, and a 25-bed long term care facility. A 12-chair hemodialysis unit operates within the facility with a contracted nephrologist as medical director. Specialty consultants with regular clinics operating include podiatry, optometry, psychiatry, audiology, endocrinology, physical therapy, and occupational therapy.

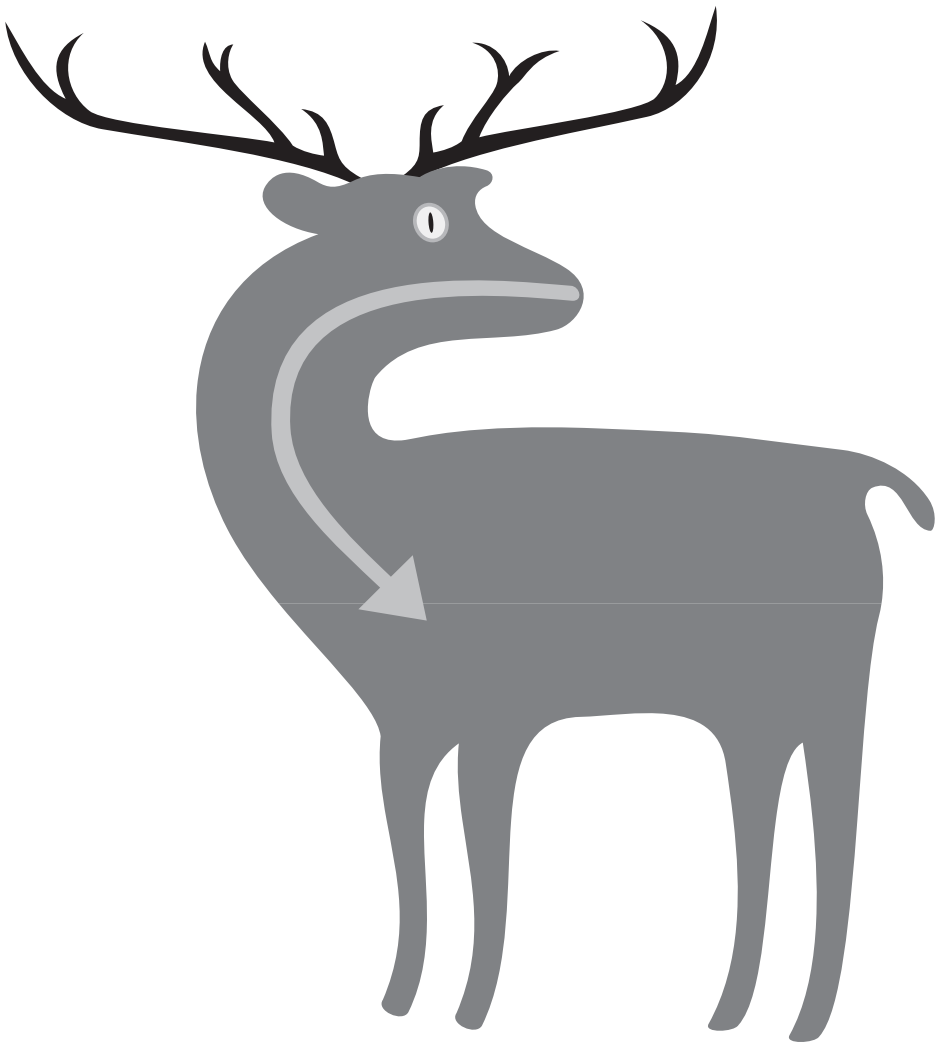
The people of the Omaha Tribe are the descendents of the original first Nebraskans. Their ancestral home is their current home and lies among beautiful timber filled rolling hills following the Missouri River. Abundant wildlife with hunting and fishing available is a bonus benefit for the outdoors person. Driving times to nearby cities are 40 minutes to Sioux City, Iowa and 70 minutes to Omaha, Nebraska.

The physician that we are looking for in this position will appreciate a comprehensive, patient and family-first philosophy of practice. Our physician medical director will be interested in the broad, rural, "frontier" medical experiences. He/she will have daily access to behavioral health professionals, certified diabetes educators, and an energetic, multi-disciplinary team of colleagues anxiously awaiting his or her arrival. Hopefully, you are looking for us if you are a compassionate highly skilled physician. You practice medicine according to adopted evidence-based standards and are an exceptional listener and diagnostician. The Carl T. Curtis Health Education Center and the staff members are seeking a physician leader who is interested in excellence with experience in managing resources. If you are our physician medical director, a competitive salary; a full health, vision, and dental benefits package; student loan repayment; four weeks of paid vacation plus 20 paid holidays per year; and a retirement plan await you. Please help us find you by contacting Jessica Valentino, Administration by e-mail at *Jessica.valentino@ihs.gov* or Kelly Bean, Medical Staff, at *Kelly.bean@ihs.gov*. (10/09)

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

The Warm Springs Health and Wellness Center will have an opening for a board certified/eligible family physician starting April 1, 2010. Located in the high desert of central Oregon, we have a clinic that we are very proud of and a local community that has much to offer in recreational opportunities

and livability. Our facility has been known for innovation and providing high quality care and has received numerous awards over the past ten years. We have positions for five family physicians, of which one is retiring after 27 years of service. Our remaining four doctors have a combined 62 years of experience in Warm Springs. This makes us one of the most stable physician staffs in IHS. Our clinic primarily serves the Confederate Tribes of Warm Springs. We have a moderately busy outpatient practice with our doctors seeing about 15 - 18 patients per day under an open access appointment system. We were a pilot site for the IHS Innovations in Planned Care (IPC) project and continue to make advances in how we provide care to our patients. We fully utilize the IHS Electronic Health Record, having been an alpha test site for the program when it was created. We provide hospital care, including obstetrics and a small nursing home practice, at Mountain View Hospital, a community hospital in Madras, Oregon. Our call averages 1 in 5 when fully staffed. For more information, please call our Clinical Director, Miles Rudd, MD, at (541) 553-1196, ext 4626. (10/09)



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Indian Health Service
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THE IHS PRIMARY CARE PROVIDER
A journal for health professionals working with American Indians and Alaska Natives

THE IHS PROVIDER is published monthly by the Indian Health Service Clinical Support Center (CSC). Telephone: (602) 364-7777; fax: (602) 364-7788; e-mail: *the.provider@ihs.gov*. Previous issues of THE PROVIDER (beginning with the December 1994 issue) can be found on the CSC Internet home page *(http://www.ihs.gov/Provider)*.

Opinions expressed in articles are those of the authors and do not necessarily reflect those of the Indian Health Service or the Editors.

Circulation: The PROVIDER (ISSN 1063-4398) is distributed to more than 6,000 health care providers working for the IHS and tribal health programs, to medical schools throughout the country, and to health professionals working with or interested in American Indian and Alaska Native health care. If you would like to receive a copy, send your name, address, professional title, and place of employment to the address listed below.

Publication of articles: Manuscripts, comments, and letters to the editor are welcome. Items submitted for publication should be no longer than 3000 words in length, typed, double-spaced, and conform to manuscript standards. PC-compatible word processor files are preferred. Manuscripts may be received via e-mail.

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