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## Native American Dermatology: a Preliminary Report on The Prevalence of Cutaneous Disorders at the Phoenix Indian Medical Center Dermatology Clinic

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### Introduction

The Merriam-Webster dictionary defines “Native American” as a member of any of the aboriginal peoples of the western hemisphere, especially a Native American of North America and especially the United States.<sup>1</sup> However, the term Native American has also been used in the molecular literature to describe the genetic migration of the Amerindians from northeastern Siberia to South America dating back 20,000 to 25,000 years ago.<sup>2-5</sup> Moreover, to add to the confusion about the definition of Native American, Cornelison,<sup>6</sup> Lane,<sup>7</sup> Everett,<sup>8</sup> Birt,<sup>9</sup> and Fusaro<sup>10</sup> utilized the term Native American, Amerindian, and American Indian interchangeably to delineate actinic prurigo, also known as hereditary polymorphous light eruption or solar prurigo, as one of the most common dermatologic disorders associated with Native Americans of North America. Thus, because of inconsistent usage of the term Native American in the previous literature, in this paper,

we are referring to our study population as Native Americans of North America.

The epidemiology of skin diseases in the Native American population has not been formally studied or monitored. Brandt<sup>11</sup> published the first observational paper on Native American dermatologic disorders on the Navajo reservation in

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1958. He was under the supervision of Leon Goldman, director of the Department of Dermatology and Syphilology at the University of Cincinnati. Brandt's observations provided insight into some common skin diseases of one Native American tribe, specifically the Navajo Indians. He accumulated about one hundred and fifty dermatologic cases in which the ten most frequent diagnoses included acne, vitiligo, scrofuloderma, atopic dermatitis, erythema nodosum, rhinophyma, molluscum contagiosum, stasis dermatosis, seborrheic dermatitis, and impetigo, in no specific order. Brandt also noted that psoriasis seemed to be rare on the Navajo Reservation, for there were only three reported cases by other physicians, and none by him. Additionally, Cornelison<sup>6</sup> reported that psoriasis was also rare in pure Native Americans, for which he quoted Kerdel-Vegas.<sup>12</sup> In reviewing Kerdel-Vegas' manuscript, his explanation of why the Amerindians were free from psoriasis was because this population lacked the antigen W17, which was constantly found to be associated with psoriasis. He noted that antigen W17 had never been found in the Amerindians in the various studies among Yanoamas, Makiritares, and Waraos tribes found in Venezuela. Farber<sup>13</sup> corroborated Kerdel-Vegas' findings, for he found psoriasis to be most common in whites of northern European origin, less frequent among people of Asian and Black ethnicity, and very rare among southern Native Americans.

The literature about Native American cutaneous disorders is sparse. The true prevalence of skin diseases in the Native American population can only be determined by large population surveys, which have not been done. Furthermore, there has been no study comparing the prevalence of cutaneous disorders and Native American percent tribal heritage (NAPTH) in North America.

### Objective

The purpose of our study is to gather information about cutaneous disorders that are seen with the highest frequency in the Native American population in the Phoenix Indian Medical Center (PIMC) service population. Once this information has been obtained, we would like to create a teaching model for dermatologists and primary care physicians who work in the Indian health system and/or who are treating Native Americans on a daily basis.

### Methods

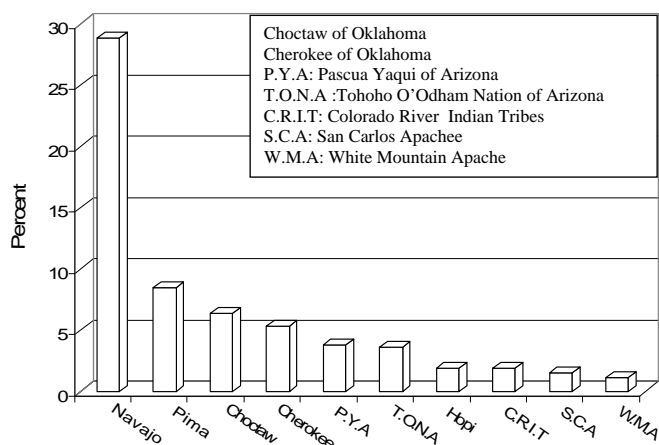
From June 2004 to December 2006, data were collected from five hundred and eighty five (585) patients at the PIMC dermatology clinic. A board certified dermatologist supervised the clinic. The dermatologist verified all patients' NAPTH through medical records. Data reflecting the primary medical and surgical dermatologic diagnoses, age, gender, and percent tribal heritage were collected on the first office visit. Surgical diagnoses were sent to dermatopathology for confirmation. A statistician analyzed the data by Chi square analysis for association of percent tribal heritage with dermatologic disorders, gender with dermatologic disorders, and age group with dermatologic disorders. A *p* value less than 0.05 was considered statistically significant. This observational study did not change the standard of care for the patients during their

office visit. One limitation of this study was the fact that only patients treated at the Indian Health Service dermatologic clinic in Phoenix, Arizona were included.

### Results

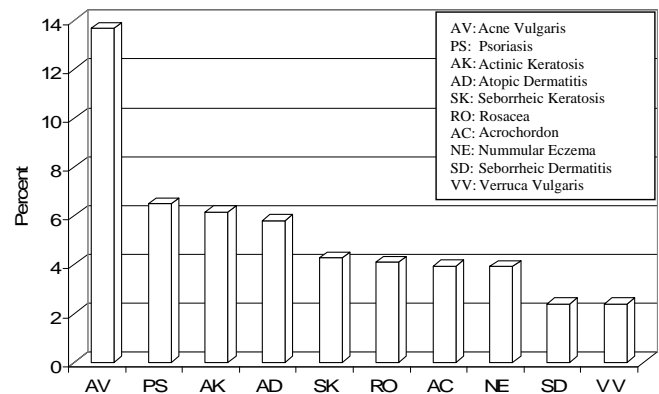
The mean age of the five hundred and eighty five (585) patients is 39 years. The gender ratio of females (398) to males (189) is approximately 2:1. The ten Native American tribes represented with the greatest frequency are Navajo, Pima, Choctaw of Oklahoma, Cherokee of Oklahoma, Pascua Yaqui of Arizona, Tohocho O'odham Nation of Arizona, Hopi, Colorado River Indian Tribes, San Carlos Apache, and White Mountain Apache (see Figure 1). The top ten Native American

**Figure 1. Top ten pure Native American tribes, n=585.**



cutaneous disorders in descending order are acne vulgaris, psoriasis, actinic keratosis, atopic dermatitis, rosacea, acrochordons, seborrheic keratosis, nummular eczema, seborrheic dermatitis, and verruca vulgaris (see Figure 2).

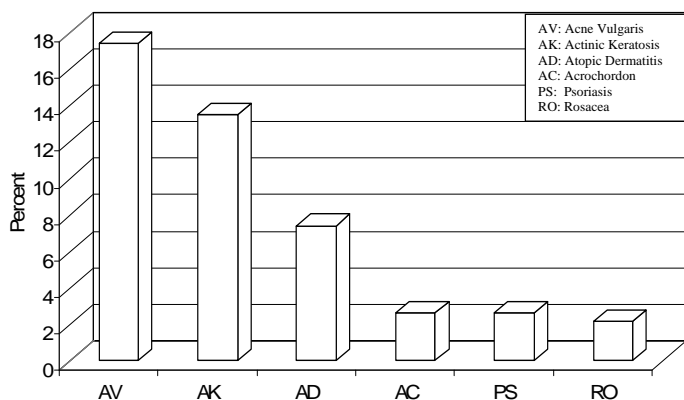
**Figure 2. Top ten Native American cutaneous disorders, n=585.**



Two hundred and twenty eight (228) of 585 (39%) patients presented with NAPTH of less than or equal to fifty percent ( $\leq$

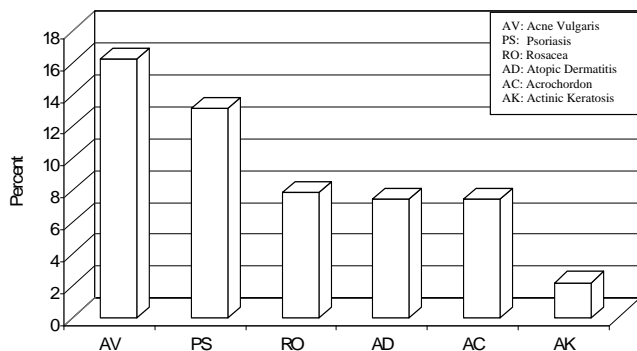
50%). The mean age in this group is thirty-seven (37) years old. The gender ratio of females (157) to males (71) is approximately 2:1. The top six cutaneous disorders are acne vulgaris (17.47%), actinic keratosis (13.54%), atopic dermatitis (7.42%), acrochordons (2.62%), psoriasis (2.62%), and rosacea (2.18%) (Figure 3). A Chi square test of association between the top six cutaneous disorders and NAPTH is significant ( $p < 0.0001$ ).

**Figure 3. NAPTH  $\leq$  50% Top Six Cutaneous Disorders, n=228. NAPTH and cutaneous disorders are correlated with each other ( $p < 0.00001$ , Chi-square test).**



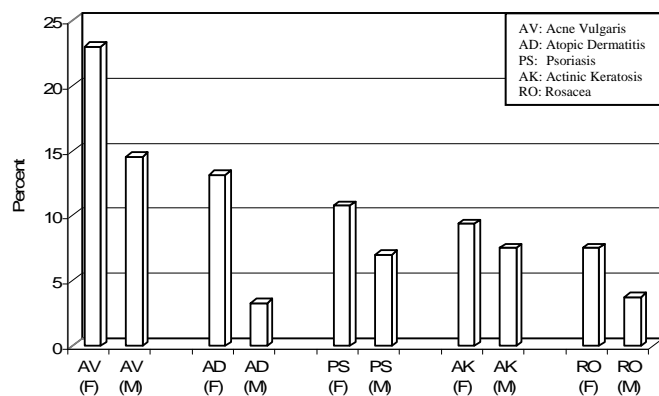
Three hundred and thirty three (333) of 585 (57%) patients presented with NAPTH of one hundred percent (100%). This group included patients who were of mono-tribal and multi-tribal heritage. That is, mono-tribal heritage might be, for example, 100% Navajo, while multi-tribal heritage might be 50% Navajo and 50% Choctaw, which totals 100% NAPTH. The mean age in this group is forty-one (41) years old. The gender ratio of females (224) to males (109) is approximately 2:1. The top six dermatologic disorders are acne vulgaris (16.16%), psoriasis (13.10%), rosacea (7.86%), atopic dermatitis (7.42%), acrochordons (7.42%), and actinic keratosis (2.18%) (see Figure 4). A Chi square test of association between the top six cutaneous disorders and NAPTH is significant ( $p < 0.0001$ ).

**Figure 4. NAPTH 100% Top Six Cutaneous Disorders, n=333. NAPTH and cutaneous disorders are correlated with each other ( $p < 0.00001$ , Chi-square test).**



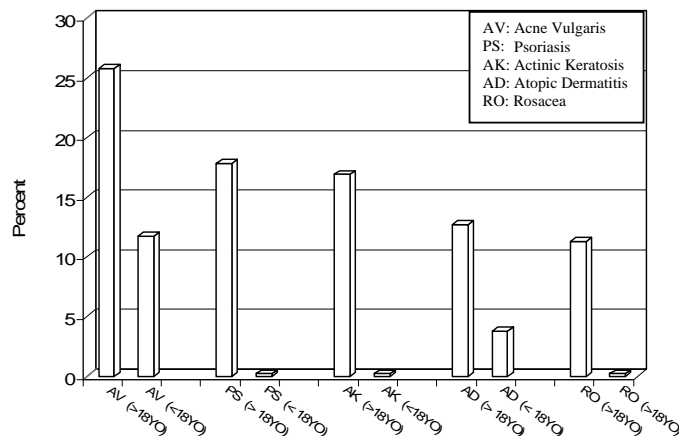
In analyzing gender and cutaneous disorders, the Chi square test of association utilized two hundred and thirteen (213) of 585 (36%) to categorize the top five cutaneous disorders. The top five female cutaneous disorders are acne vulgaris (23%), atopic dermatitis (13.15%), psoriasis (10.80%), actinic keratosis (9.39%), and rosacea (7.51%). The top five male cutaneous disorders are acne vulgaris (14.55%), actinic keratosis (7.51%), psoriasis (7.04%), rosacea (3.76%), and atopic dermatitis (3.29%) (see Figure 5). The Chi square test of association between gender and cutaneous disorders suggests that these are independent of each other ( $p = 0.2374$ ).

**Figure 5. Gender and Cutaneous Disorders: Top five cutaneous disorders, n=213. Gender and cutaneous disorders are independent of each other ( $p < 0.2374$ , Chi-square test).**



The age group and cutaneous disorders data revealed two hundred and thirteen (213) (36%) patients who were analyzed with the Chi square test of comparison. The top five cutaneous disorders of patients greater than eighteen years old are acne vulgaris (25.82%), psoriasis (17.82%), actinic keratosis (16.90%), atopic dermatitis (12.68%), and rosacea (11.27%) (see Figure 6). As for patients who are less than eighteen years

**Figure 6. Age and Cutaneous Disorders, n=213. Age group and cutaneous disorders are correlated with each other ( $p < 0.0001$ , Chi-square test).**



old, there are only two cutaneous disorders observed, which are acne vulgaris (11.74%) and atopic dermatitis (3.76%). The Chi square test of association between age group and cutaneous disorders suggests statistical significance ( $p < 0.0001$ ).

## Conclusion

This observational study is the first to formally assess the correlation between NAPTH and cutaneous disorders. Although the scientific literatures state that psoriasis is rare in pure Native Americans, we found this assertion to conflict with our data, for psoriasis is not rare in Native Americans. The prevalence of psoriasis is higher for those with 100% NAPTH as compared to those with  $\leq 50\%$  NAPTH. However, actinic keratosis is more prevalent in the  $\leq 50\%$  NAPTH, possibly due to gene dilution. Many authors have also reported that polymorphous light eruption is common in Native Americans;<sup>6-10</sup> however, we did not find this to be true in our population, for we only had one case. Although gender and cutaneous disorders were not statistically significant, it did show that females presented with higher percentage in the top five cutaneous disorders.

The study of age group and cutaneous disorders revealed that more Native American seek treatment for their acne over the age of eighteen. Furthermore, atopic dermatitis was noted to present more commonly over the age of eighteen as opposed to in childhood. In comparing our Native American office-based populations with the National Ambulatory Medical Care Survey (NAMCS) office-based population of 2002,<sup>15</sup> (Table 1)

**Table 1. Comparison of the top ten most frequent cutaneous disorders between NAMCS of 2002 to NAPTH  $\leq 50\%$  AND NAPTH 100%.**

	NAMCS 2002 Dermatology Office-Based	$\leq 50\%$ NAPTH Dermatology Office-Based	100% NAPTH Dermatology Office-Based
1	Acne Vulgaris	Acne Vulgaris	Acne Vulgaris
2	Actinic Keratosis	Actinic Keratosis	Psoriasis
3	Benign Skin Tumor	Atopic Dermatitis	Rosacea
4	Nonmelanoma Skin Cancer	Seborrheic Keratosis	Atopic Dermatitis
5	Seborrheic Keratosis	Basal Cell Carcinoma	Acrochordon
6	Verruca Vulgaris	Urticaria	Nummular Eczema
7	Dermatitis NOS	Seborrheic Dermatitis	Seborrheic Keratosis
8	Psoriasis	Psoriasis	Lichen Simplex Chronicus
9	Epidermoid Cyst	Verruca Vulgaris	Melasma
10	Rosacea	Rosacea	Seborrheic Dermatitis

it was noted that acne vulgaris remained the number one dermatologic diagnosis in all three office-based practices. Additionally, the top ten cutaneous disorders of NAMCS and the population with  $\leq 50\%$  NAPTH were very similar. This

parallelism of cutaneous disorders may possibly be due to gene dilution. Lastly, the comparison between the 100% NAPTH with the NAMCS showed less commonality than the  $\leq 50\%$  NAPTH, for psoriasis and rosacea were more prevalent in the 100% NAPTH.

The literature about Native American cutaneous disorders is limited. There need to be more formal studies to fully understand Native American dermatologic disorders. We feel that knowledge of the most prevalent cutaneous disorders and their NAPTH will not only serve to improve diagnosis of these disorders, but will also stimulate future research in this area.

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# Mercury Amalgam Waste

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## Introduction

Dentists and their staff use certain toxic substances that may lead to the contamination of water systems and the environment. In order to prevent contamination, dental offices should implement proper waste management procedures. As a consequence, the Indian Health Service (IHS) has developed waste management guidelines for the use of mercury amalgam.

Dental amalgam can contain up to 50 percent mercury. Although mercury in amalgam form is very stable, it should not be disposed of or rinsed down the drain. This is important because the amalgam waste could end up in municipal garbage, medical waste, or in the sewer system. If the waste is incinerated the mercury could be released to the environment, and if it reaches the sewer system it could contaminate drinking water or accumulate in fish. The best method of dealing with amalgam waste is by recycling it. Mercury can be recovered through a distillation process and reused in other products.

The following document summarizes the different types of mercury amalgam wastes, management practices for dealing with amalgam waste that conform to IHS guidelines, and some Do's and Don'ts when dealing with amalgam waste as outlined by the American Dental Association (ADA).

## Types of Amalgam Wastes

- Non-contact amalgam (scrap): excess mixture leftover after a dental procedure.
- Contact amalgam: amalgam that has been in contact with the patient. Examples include extracted teeth with amalgam restorations, carving scrap collected at the chair, and amalgam captured by the chair side traps, filters, or screens.
- Chair side traps: amalgam that is captured during amalgam placement or removal procedures.
- Vacuum pump filters: filters and traps contain amalgam sludge or water. Some recyclers will accept whole filters, while others may require special handling requirements for this material.

- Amalgam sludge: this is a mixture of liquid and solid material collected within the vacuum pump filters.
- Empty amalgam capsules: amalgam may be left over in the capsules after mixing the precapsulated dental amalgam.

## Amalgam Waste Management Practices

<b>Scrap Amalgam Handling</b>
<ul style="list-style-type: none"> <li>• Dental scrap amalgam should be collected and stored in two designated, air-tight, wide-mouthed plastic containers. One should be labeled CONTACT AMALGAM (amalgam that has been in contact with the patient's mouth), and the other should be labeled NONCONTACT AMALGAM.</li> <li>• NOTE: some recyclers may require special handling requirements for extracted teeth such as shipping the tooth in a disinfectant.</li> <li>• Make sure that the container lid is tightly sealed.</li> </ul>
<b>Amalgam Capsule Handling</b>
<ul style="list-style-type: none"> <li>• Stock capsules in a variety of different sizes.</li> <li>• After mixing the amalgam, place the empty capsules in a wide-mouthed, airtight container that is labeled AMALGAM CAPSULE WASTE.</li> <li>• Capsules that cannot be emptied should also be placed in containers labeled AMALGAM CAPSULE WASTE.</li> <li>• Make sure that the container lid is tightly sealed.</li> </ul>
<b>Disposable chair-side traps</b>
<ul style="list-style-type: none"> <li>• Open the chair-side unit to expose the trap.</li> <li>• Remove the trap and empty its contents into a wide-mouthed, airtight container that is marked CONTACT AMALGAM.</li> <li>• Make sure that the container lid is tightly sealed.</li> <li>• Chair-side traps that are only used for hygiene can be thrown in the regular garbage.</li> <li>• Different states have different requirements for the disposal of infectious waste that is in the traps with the amalgam such as blood or saliva. Check with your local recycler or contact the Area Office of Environmental Health for the proper procedures.</li> </ul>
<b>Reusable Chair-side Traps</b>
<ul style="list-style-type: none"> <li>• Open the chair-side unit to expose the trap.</li> <li>• Remove the trap and empty its contents into a wide-mouthed, airtight container that is marked CONTACT AMALGAM.</li> <li>• Make sure that the container lid is tightly sealed.</li> <li>• <b>DO NOT</b> rinse the trap under running water.</li> <li>• Replace the trap into the chair-side compartment.</li> <li>• Different states have different requirements for the disposal of infectious waste that is in the traps with the amalgam such as blood or saliva. Check with your local recycler or contact the Area Office of Environmental Health for the proper procedures.</li> </ul>
<b>Vacuum Pump Filters</b>
<ul style="list-style-type: none"> <li>• Change the filter to the manufacturers suggested schedule.</li> <li>• Remove the filter. Hold the filter over a tray or another container that can catch any spills. Next pour out as much liquid as possible without losing any noticeable amalgam. The amalgam-free liquid can then be rinsed down the drain.</li> <li>• Place the lid on the filter and put it in the box in which it was originally shipped. Once the box is full, the filters can be recycled.</li> </ul>
<b>Line Cleaners</b>
<ul style="list-style-type: none"> <li>• Use only non-bleach, non-chlorine containing solutions when flushing the wastewater lines and vacuum systems. A list of ADA approved cleaners is posted at the end of this document.</li> </ul>

## American Dental Association (ADA) Do's and Don'ts for Dealing with Amalgam Waste

DO	DON'T
Do use precapsulated alloys and stock a variety of capsule sizes	Don't use bulk mercury
Do recycle used disposable amalgam capsules	Don't put used disposable amalgam capsules in biohazard containers, infectious waste containers (red bags) or regular garbage
Do salvage, store, and recycle noncontact amalgam (scrap amalgam)	Don't put non-contact amalgam waste in biohazard containers, infectious waste containers (red bags), or regular garbage
Do salvage contact amalgam pieces from restorations after removal and recycle the amalgam waste	Don't put contact amalgam waste in biohazard containers, infectious waste containers (red bags), or regular garbage
Do use side-chair traps to retain amalgam and recycle the contents	Don't rinse chair-side traps containing amalgam over drains or sinks
Do recycle contents retained by the vacuum pump filter or other amalgam collection devices, if they contain amalgam	Don't rinse vacuum pump filters containing amalgam or other amalgam collection devices over drains or sinks
Do recycle teeth that contain amalgam restorations. (Note: Ask your recycler whether or not extracted teeth with amalgam restorations require disinfection)	Don't dispose of extracted teeth that contain amalgam restorations in biohazard containers, infectious waste containers (red bags), sharps containers, or regular garbage
Do manage amalgam waste through recycling as much as possible	Don't flush amalgam waste down the drain or toilet
Do use line cleaners that minimize the dissolution of amalgam	Don't use bleach or chlorine-containing cleaners to flush waste water lines

## Recycling

As mentioned earlier, the recommended method for amalgam disposal is by recycling the waste through an Environmental Protection Agency (EPA) approved vendor. The following actions should be taken to properly recycle your amalgam waste.<sup>1,3</sup>

- Carry the amalgam capsules in a variety of different sizes to reduce the amount of waste produced.
- Personal protective equipment such as gloves, masks, and protective eyewear should be worn when handling amalgam waste.
- Some vendors have special requirements for the handling, storing, and transportation of amalgam waste, so be aware of any special conditions. Dental clinics that need to find a recycler should contact their county or local waste authority to inquire about an amalgam waste recycling program.
- Amalgam waste should be stored in covered plastic containers that are clearly labeled.
- Always store different types of amalgam waste (e.g., contact and noncontact) in separate containers.
- Do not store amalgam waste under liquid. This would require the liquid to be treated as hazardous waste. Storage in tight-fitting covered containers and routine recycling should minimize any occupational exposures.

## Recycling Companies

Inclusion of a service in this list does not constitute approval or endorsement of that company by the IHS or provide any assurances with regard to the quality of services provided. All vendors should be asked to provide certification that your mercury waste is actually being recycled.

- Dental Recycling of North America (Dentalcare Waste Management) 1-800-360-1001
- Stericycle Dental Amalgam Mailback program 1-800-355-8773
- Bethlehem Apparatus Dental Amalgam Recycling Program 1-610-838-7034
- Advanced Environmental Recycling Corporation (AERC) 1-610-797-7608
- Amalgaway Mail Disposal Service 1-800-267-1467

Amalgam waste should be stored and managed in accordance with the instructions of the recycler. The vendors can provide shipping instructions. Most provide shipping containers that are already appropriately labeled.

## Additional Information

*American Dental Association.* For more information on mercury use, disposal, and safety, see the ADA website at <http://www.ada.org/prof/resources/topics/amalgam.asp>

*Indian Health Service.* See the Oral Health Program Guide for information regarding mercury use and safety.

*Environmental Protection Agency.* Check state legislation

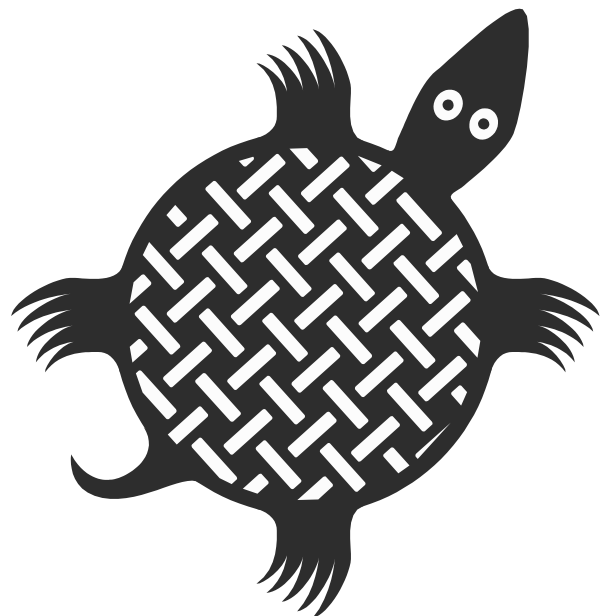
and regulations at the following site to assure you are acting in accordance with requirements of your state: <http://www.epa.gov/epaoswer/hazwaste/mercury/laws.htm>

## ADA Approved Line Cleaners

The following line cleaners do not contain bleach or chlorine. This will reduce the dissolution of amalgam. Check with your manufacturer to determine which line cleaner would be appropriate for use with your equipment: Biocide (Biotrol International), BirexSe (Biotrol International), DRNA Vac (Dental Recycling North American Inc.), E-Vac (L&R Manufacturing Co.), Fresh-Vac (Huntington), GC Spray-Cide (GC America Inc.), Green and Clean (Metasys), Microstat 2 (Septodont USA), Patterson Brand Concentrated Ultrasonic Cleaner/Disinfectant Solution (Patterson Dental Supply, Inc.), ProE-Vac (Cottrell Ltd.), Pure-Vac (Sultan Chemists Inc.), Sani-Treet Plus (Enzyme Industries Inc.), SRG Evacuation (Icon Labs), Stay Clean (Apollo Dental Products), Turbo-Vac (Pinnacle Products), Vacusol Ultra (Biotrol International), Cavicide (Metrex Research Corp.), Vacuum Clean (Palmero Health Care).

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# Benefits of Utilizing a Certified Foot Care Nurse in a Podiatric Practice

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Diabetes mellitus is on the rise in the United States, and we need to emphasize a multi-disciplinary approach to treatment in order to handle the large influx of cases we will be seeing in our practices. According to the ADA, in 2005 there were a total of 20.8 million people in the US with diabetes, up from 17 million in 2001.<sup>1</sup> Diabetic neuropathy is the leading cause of amputations, accounting for 50 - 70% of all non-traumatic amputations in the US.<sup>2</sup> Admissions for foot complications account for 20 - 25% of all hospital days for patients with diabetes.<sup>3</sup>

One way of assuring that we are providing our clientele with a higher standard of care is to incorporate in our practices a nurse that has his/her wound and foot care certification. Since January 2005, the Wound, Ostomy and Continence Nursing Certification Board has offered the credentials of Certified Foot Care Nurse (CFCN) to registered nurses who have completed a formal foot and nail program, as well as completion of a clinical pathway supervised by an expert. By following strict guidelines, the Board is assuring that the standard of care of podiatric patients will not be compromised.

In this way, practices that have a high volume and high risk diabetic patients can safely see a large number of patients and still maintain or improve amputation rates for and care of the patients. With the increasing prevalence of diabetes in our society, it is prudent to structure our clinics to efficiently see the high volume of patients with diabetic peripheral neuropathy and associated ulcers that will flood our practices. In our practice, utilization of a multi-discipline approach to diabetic foot care has yielded approximately a 45% decrease in amputation rates over the past three years.

The following are the major aspects that prove a Certified Foot Care Nurse is most beneficial when utilized as a member of any podiatric practice:

## **Semms Weinstein Monofilament Examinations**

Monofilament examinations can be performed on every patient with diabetes/impaired glucose metabolism each year, which is the Indian Health Services goal/guideline. Any patients with compromised peripheral neurological function can be tested at a closer interval of 3 - 6 months. In this way, we can detect neuropathic changes and institute corrective

therapy earlier, such as tight glycemic control, oral medications, or possibly nerve blocks for pain management.

## **Wound Care**

Utilizing the services of a Certified Wound Care Nurse (CWCN) definitely has advantages when it comes to a busy practice that sees a high volume of wounds. The nurse can perform the weekly wound care, from measuring the wounds to the application of the dressing, to dispensing the supplies to the patient. The nurse can perform debridement of ulcers, including the use of mechanical, autolytic, enzymatic, and biologic methods. For frequent dressing changes, the nurse can be the primary provider at those visits, providing there are no complications. The podiatrist is available for any unforeseen changes in wound status.

## **Palliative Care**

The Certified Foot and Nail Care Nurse can provide primary palliative treatment of uncomplicated nails and calluses. This frees up the podiatrist to perform in-office procedures and also helps to forestall the development of complications.

## **Vascular Studies**

The nurse can be trained to perform non-invasive vascular studies, including the ankle brachial index, toe brachial recordings, and pulse volume recording on all patients with diabetes. This can result in early detection of vascular compromise, and earlier intervention. The patient would be referred to a vascular specialist for applicable interventions such as angioplasty, stent placement, or bypass to re-establish vascular flow. Early intervention will be a huge step in the prevention of amputations.

## **Triage**

Our nurse manages walk-in triage. By assessing neurological, vascular, and infection status, patients are fast-tracked to earlier treatment and wound prevention.

## **Education**

Education has always been the best method of wound prevention and better foot care. The more information patients are given, the more likely they are to follow guidelines. Our nurse can educate the patient on topics from wound care to plantar fasciitis.

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In conclusion, the utilization of a multi-discipline approach to diabetic foot care can decrease the likelihood of amputations and improve patient care. The utilization of a nurse certified foot and wound care in the podiatry setting can

- Relieve the busy practitioner from palliative care issues
- Decrease clinic waiting time
- Increase patient satisfaction due to more frequent care and less waiting
- Increase revenue by billing for a nurse grade facility fee instead of for a podiatry technician.

Having a Certified Foot Care Nurse who is credentialed through a nationally recognized credentialing board such as Wound Ostomy Continence Nursing Certification Board (WOCNCB) in the clinic raises the standard of care for our patients. The cost of diabetes care in the US in 2002 was \$132 billion for both direct medical and indirect costs.<sup>4</sup> Given the current statistics on diabetes and associated risks in the US, we need to focus on early detection and early intervention in order to decrease the diabetic sequelae.

#### References

1. American Diabetes Association. *Diabetes Statistics*. [www.diabetes.org](http://www.diabetes.org)
2. Wound Ostomy Continence Nurses Society. (2004). *Guideline for management of wounds in patients with lower-extremity neuropathic disease: WOCN clinical practice guideline series (3)*
3. Baranoski, Sharon, & Ayello, Elizabeth . (2004). *Wound care essentials: practice principles*. Pennsylvania. Lippincott, Williams & Wilkins.
4. National Diabetes Information Clearinghouse (NDIC). <http://diabetes.niddk.nih.gov>





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# New NIH Continuing Education Program on SIDS Risk Reduction

The National Institutes of Health is releasing a continuing education program for nursing professionals designed to help reduce the risk of SIDS. This program, titled *Continuing Education Program on SIDS Risk Reduction*, helps nurses communicate the risk factors for SIDS to parents and child caregivers. The most current research about SIDS can be found in this program, in addition to practical approaches to communication about SIDS in a multi-cultural environment.

Nursing professionals who complete the program will earn 1.1 contact hours. *Continuing Education Program on SIDS Risk Reduction: Curriculum for Nurses* is a learner-directed program available from the National Institute of Child Health and Human Development (NICHD) of the National Institutes of Health (NIH).

Although SIDS deaths have declined by 50 percent in recent years, it is still the leading cause of death in infants between one month and one year of age. In addition, the rate of SIDS in American Indian/Alaska Native populations is almost three times higher than the rate of SIDS in white populations. Research shows that nurses are in a unique

position to educate parents and caregivers about SIDS and ways to reduce the risk of SIDS.

This newly-available CE is designed to inform nurses about the latest research and risk-reduction strategies for SIDS, and to provide nurses with concrete tools and strategies for communicating this information to parents and caregivers both in the clinical and community settings. Topics include the etiology, epidemiology, and risk factors for SIDS (including prenatal, developmental, and environmental risk factors). It also covers critical SIDS risk-reduction messages for parents and caregivers, challenges to SIDS risk reduction, the role for nurses in educating parents and caregivers about SIDS risk reduction, and specific approaches for communicating effectively about SIDS risk reduction with parents and caregivers.

Nursing professionals can order a free copy of the curriculum by visiting <http://www.nichd.nih.gov/sidsnursesce/> or by calling 1-800-370-2943. An interactive, online version of the program will be available toward the end of 2007.

## Important facts about Sudden Infant Death Syndrome (SIDS)

- SIDS is the sudden, unexplained death of an infant younger than one year of age. It is a sudden and silent medical disorder that can happen to a seemingly healthy infant.
- More than 2,000 babies in the United States succumb to SIDS every year.
- Although the overall number of SIDS deaths have declined by 50 percent in recent years, SIDS is still the leading cause of death in infants from one month to one year of age.
- African American families are twice as likely to be affected by SIDS as are white families.
- The rate of SIDS in American Indian/Alaska Native populations is almost three times higher than the rate of SIDS in white populations.
- Research shows that side sleeping is not as safe as back sleeping; therefore the American Academy of Pediatrics began recommending that infants be placed *wholly on their backs* to sleep for naps and at night in 1996.
- The single most effective action that parents and caregivers can take to reduce the risk of SIDS is to place infants on their backs to sleep for naps and at night.
- Other major modifiable factors which may put infants at higher risk of SIDS are soft sleeping surfaces and loose, fluffy bedding; overheating during sleep; maternal smoking during pregnancy and smoke in the infant's environment; and bed sharing with an adult or with other children, regardless of age.
- Every sleep time counts—infants who are usually placed on their backs to sleep and who are then placed on their stomachs to sleep are at significantly higher risk of SIDS.
- Research shows that parents are more likely to follow safe sleep practices—such as placing infants on their backs to sleep—if staff at nurseries, hospitals, clinics, birthing centers, and other venues consistently model these behaviors. Nurses can be role models for parents and families simply by knowing the risk-reduction strategies and putting them into action.
- Because nurses often spend the most time with families in the hospital following the birth of a child, they are a key information resource for new parents. By knowing the risk-reduction strategies for SIDS and modeling them in the postpartum environment, nursing professionals are in a unique position to make a significant difference in alerting parents and families about reducing the risk of SIDS.
- Nurses can order hard copies or download electronic versions of the CE through NICHD's Web site, at <http://www.nichd.nih.gov/sidsnursesce/>, or by calling 1-800-370-2943. An interactive, online version of the program will be available toward the end of 2007.

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# Pharmaceutical Care for American Indian Elders

*Joni Buffalohead, PhD, Administrator, Planner, Fond du Lac Human Services, Mashkiki waakaigan (Medicine Lodge) Pharmacy, Minneapolis, Minnesota*

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## Abstract

The literature about the health of American Indian populations contains much information about the incidence of chronic diseases such as diabetes and hypertension. Many programs have been established to address the epidemic numbers of patients with, for example, diabetes. However, one obvious pattern is the absence of medication management services. Researchers working with American Indian populations have made recommendations for the need to research the area of medication use for American Indian people of all ages.

The practice of pharmaceutical care served as the framework to identify the drug therapy problems and experiences among urban American Indian elders. This study, which is a descriptive, secondary data sample, is the first step to look at the drug therapy problems and their associated medical conditions.

This study involved a practice-based intervention called pharmaceutical care provided by a pharmacist to American Indian residents at an independent living facility located in a midwestern metropolitan area. The convenience sample selected was 36 American Indian elders with 337 encounters with a pharmaceutical care practitioner. The participants received documented pharmaceutical care using the Assurance™ software program. The process for secondary clinical data™ analysis looked at the number of drug therapy problems identified and the medical conditions associated with drug therapy for American Indian elders studied.

The purpose of the study was to identify American Indian elders' drug-related needs, and the types and causes of their drug therapy problems. Drug therapy problems are defined by Cipolle, Strand, and Morley (1998) "as any aspect of a patient's drug therapy that is interfering with a desired positive patient outcome."

## Background

The definition of pharmaceutical care is as follows: a patient-centered practice in which the practitioner assumes responsibility for a patient's drug-related needs and is held accountable for this commitment (Cipolle, Strand, Morley, 1998). The pharmaceutical care practitioner assumes the responsibility to ensure that all of the patient's medication-related therapies are working in the most effective and safe manner. This enhances the patient's quality of care and quality of life. The pharmaceutical care practitioner serves as the patient's advocate by

communicating with other health care providers and educating the patient. The pharmaceutical care practitioner and patient set goals for the patient to meet. If the pharmaceutical care practitioner identifies a drug therapy problem, he or she will make recommendations to the patient and to the appropriate health care provider (Cipolle et al., 1998).

This study was accomplished with volunteer open enrollment and was non-blinded. The services were provided without a control or comparison group. Patient records were selected from the Assurance Pharmaceutical Care™ database.

Assurance Pharmaceutical Care™ is an electronic therapeutic record (ETR) system specifically designed to help provide and document pharmaceutical care. It collects patient demographics; checks for drug interaction; and does patient-specific care planning, medication documentation, drug therapy problem identification, follow-up evaluations, physician and patient reporting, billing, workload tracking, clinical outcome tracking, and data consolidation among numerous practitioners. Assurance Pharmaceutical Care™ supports practitioners providing pharmaceutical care to patients on a continuous basis, over repeated patient encounters, at multiple practice sites, by multiple practitioners.

A comprehensive electronic therapeutic record is generated and stored for each patient and includes complete patient demographic information, drug therapy problems identified, and an individualized care plan to manage the drug therapy of every medical condition. Best practices care plans for medical conditions are available using the most widely accepted system in use today (ICD-9-CM classification). Medical conditions are associated with the specific drug therapies, including product (coded with both NDC and GPI codes), dose, route, schedule, and duration. This medication management system allows the practitioner to document cost savings resulting from the identification, resolution, and prevention of drug therapy problems at the point of service. A unique classification system was developed for drug therapy problems, including adverse drug reactions and their most common causes. This system tracks what actions were taken to resolve drug therapy problems, who was involved in the resolution of the problem, and the economic impact in terms of health care costs and savings.

For this study, patient records were selected, retrospectively, from the Assurance Pharmaceutical Care database. A retrospective data analysis about the prevalence of drug therapy problems was conducted with a convenient sample of 36 American Indian elders 55 and older whom received pharmaceutical care for eighteen months. The patients had had at least two encounters with the pharmaceutical care practitioner.

The data include seven categories of drug-therapy problems.

The categories are needing additional pharmacotherapy, but not receiving it (drug indication); taking /receiving an ineffective drug; taking /receiving too little of the correct drug; taking/receiving too much of the correct drug; experiencing an adverse drug reaction; not taking/receiving the drug prescribed; and taking/receiving a drug for which there are no valid medical indications identified.

This was accomplished by conducting a retrospective data analysis from patients who identified themselves as American Indian. The data came from original records that were created by the pharmaceutical care practitioner providing pharmaceutical care services to ambulatory patients in their normal course of practice. The data were electronically stripped of the patients' identifiers and consolidated into the Assurance Pharmaceutical Care Database system developed by the faculty at the College of Pharmacy at the University of Minnesota.

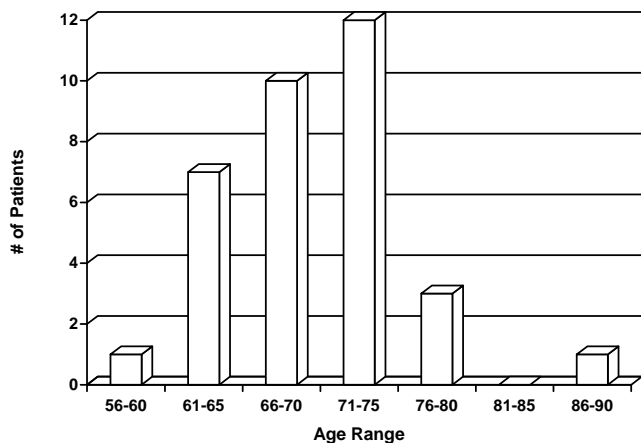
Each visit between the pharmacy practitioner and the patient is considered an encounter. The independent living facility housed 50 American Indian elders; 36 of the 50 enrolled elders chose to participate. The total number of encounters was 337. Patients were 16 (44%) females and 20 (55%) males between the ages of 60 and 90 years old (Figure 1).

The first of two encounters is the assessment, and the second is the follow-up. These encounters, along with the care plan, constitute the pharmaceutical care process. In the process, the practitioner conducts an assessment, which identifies the patient's medication-related needs and medication therapy problems, designs the care plan, and conducts the follow-up evaluation based on the individual patient's needs. This process enables the pharmaceutical care practitioner to ensure that their patient's medication therapies are working in the best, most effective, and safest way possible (Strand et al, 2004).

### Analysis

The age group for the American Indian elders group is summarized in Figure 1. The ages range from 56 to 90 years. The largest age group was from 66-70 years representing 35%, and the smallest age group was between the ages of 86 and 90, representing approximately 2%.

**Figure 1. Age distribution of patients**

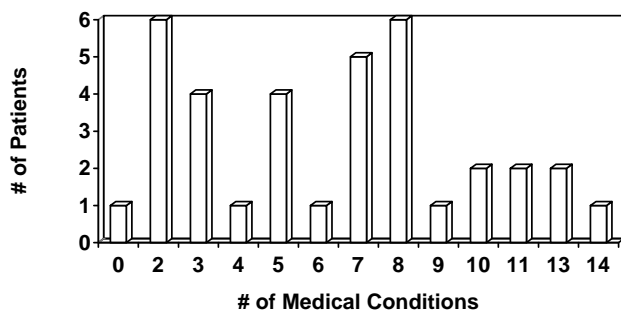


**Table 1. Distribution of medical conditions**

Medical condition	Number of Pts.
1. Hypertension	24
2. Family history cardiovascular disease	21
3. Nutritional deficiencies	16
4. Diabetes	14
5. Hyperlipidemia	14
6. General symptoms (pain-generalized)	14
7. Esophagitis	12
8. Osteoporosis	11
9. Allergic Rhinitis	6
10. Other joint disorders (arthritis pain)	6
11. Hypothyroidism	5
12. Constipation	5
13. Back pain	5
14. Obesity	4
15. Angina Pectoris	4
16. Stroke CVA	4
17. COPD/Emphysema	4
18. Gout	3
19. Anxiety	3
20. Depression	3

Listed in Table 1 are the 20 most common indications for drug therapy identified in this sample. These represent 78% of indications for drug therapy. The number of medical conditions per patient ranged from 0 to 14; the average number of medical conditions was six per patient (see Figure 2). Indications for drug therapy were to treat medical conditions ranging from hypertension to anxiety, while preventive therapies were indicated as primary prevention of osteoporosis or secondary prevention of a stroke or myocardial infarction. Out of the 36 Indian elders, 24 were being treated for hypertension, 16 had nutritional deficiencies requiring chronic medication use, and 14 had diabetes treated with a variety of oral agents and insulin products.

**Figure 2. Number of medical conditions per patient**



The most frequent medical conditions for drug therapy in the 337 encounters were hypertension (24 patients), diabetes (14 patients), and hyperlipidemia (14 patients) (see Table 2).

**Table 2. Most frequent indications for drug therapy (N=228 indications)**

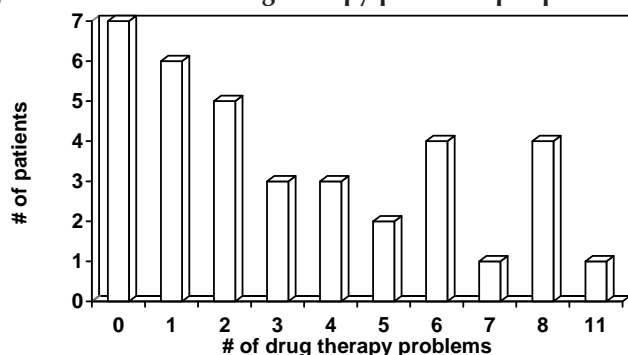
1. Hypertension	6. General symptoms (pain-generalized)
2. Family history cardiovascular disease	7. Esophagitis
3. Nutritional deficiency	8. Osteoporosis
4. Diabetes	9. Allergic Rhinitis
5. Hyperlipidemia	10. Other joint disorders (arthritis pain)
These 10 conditions represent 61% of all indications for drug therapy	

It is important to identify the most common indications for drug therapies and the average number of medical conditions per patient. This will show that an individual's medical condition can be complex and explain why a disease-specific approach may not be the best way to address his/her drug-related needs. It is also important to approach the whole patient rather than taking a disease-specific approach because the average number of medical conditions in this sample was high (six).

In general, these American Indian elders would be considered to have complex medical situations due to their multiple co-morbidities. The median number of medical indications for drug therapy was six. Seven of these individuals (19%) had 10 or more active medical conditions requiring an involved, comprehensive assessment to ensure that all of their medications were achieving the desired goals of therapy and not causing drug therapy problems.

Over the course of this study, patients took 357 medications, or an average of ten medications per patient. In addition to these prescription medications, 29 patients (81%) were also using 132 different over-the-counter medications to manage or prevent medical conditions. Additionally, four patients were using 13 different medications obtained as free physician samples in an attempt to manage their chronic conditions.

**Figure 3. Number of drug therapy problems per patient**



Drug therapy problems are defined as “any aspect of a patient’s drug therapy that is interfering with a desired, positive patient therapeutic outcome (Cipolle, et al, 1998).” Within mainstream society, approximately half of all patients are found to have at least one drug therapy problem during the initial encounter (Cipolle, et al, 2004). The number of drug therapy problems identified, resolved, and prevented by the practitioner specific to this sample was 121 (see Figure 3). The average number of drug therapy problems identified for each patient was 3.4. Twelve patients (33%) had five or more drug therapy problems, while one had 11 drug therapy problems. The majority (80%) of drug therapy problems involved over-the-counter medications, including sample drugs provided by their physician (4%) and medications provided by friends and family members (1%).

**Figure 4. Distribution of drug therapy problems**



There are four categories in which the seven types of drug therapy problems occur (Figure 4): 1) indication; 2) effectiveness; 3) safety; and, 4) compliance (Strand, et al, 1998). The most commonly occurring category of drug therapy problem is “needs additional drug therapy,” or indication. For example, a patient may not know that he or she has a medical condition requiring medication prior to the initial encounter. Another common category is “unnecessary drug,” perhaps due to duplication of a drug. For instance, the pharmaceutical care practitioner identifies that the diabetic patient is taking two types of insulin when only one is required. The second category is effectiveness, or how well the drug therapy is working. For instance, is the current dosage appropriate? Is there a new drug on the market that could be more beneficial to the patient? Is the dosage too low? Or is there a better administration form for the patient? The third category is safety; it addresses whether or not a medication is causing adverse drug reactions or interactions that could be harmful or toxic to the patient. The fourth category is compliance. Access is often a barrier to compliance; the patient cannot afford the medication or the co-pays, or cannot access a pharmacy due to transportation or an unsafe neighborhood. Other examples include a patient’s lack of understanding of the instructions for self-administration of medication, lack of trust, or unwillingness to take the medication.

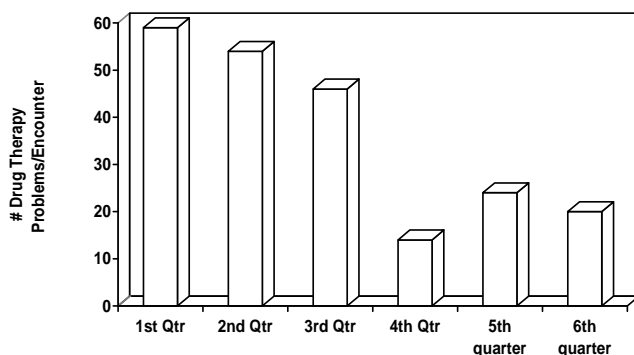
**Table 3. Number of drug therapy problems (N=36 Patients)**

		# of DTP	Percent
Indication	Needs additional drug therapy	48	40
	Unnecessary drug therapy	1	1
Effectiveness	Ineffective drug	6	5
	Dosage too low	28	23
Safety	Adverse drug reaction	10	8
	Dosage too high	8	7
Compliance	Inappropriate compliance	20	16
	Total	121	100

As Table 3 shows, the most frequent drug therapy problem patients experienced is “needs additional drug therapy” (23) to either treat or prevent previously unidentified medical conditions, followed by the category “dosage too low” (19) to provide effective therapy. In these cases, the dose or the frequency of administration needed to be increased to achieve goals of therapy. Both of these situations occurred more frequently than the category of “noncompliance.” Thirteen patients were found to be noncompliant with their medications at some point during this 18 month project. The most frequent cause of noncompliance was because the patient did not understand the instructions about how to administer the medication.

The data are categorized by six quarters (three months in each quarter) to identify the number of drug therapy problems, number of encounters, and number of prescriptions (see Figure 5). This was necessary to determine if pharmaceutical care had an impact on improving health by decreasing the number of drug therapy problems over a period of time.

**Figure 5. Drug therapy problems identified per quarter**



**Table 4. Most frequent drug therapy problems and associated medical conditions**

Medical Condition	Drug Therapy Problem Category	#
Diabetes	Needed additional drug therapy	9
Hypertension	Needed additional drug therapy	8
Diabetes	Dosage too low	6
Diabetes	Noncompliance	4
Angina Pectoris	Dosage too low	3
Hypertension	Noncompliance	3
Back Pain	Dosage too low	2
Osteoporosis	Needed additional drug therapy	2
Constipation	Dosage too low	2
Hypertension	Dosage too low	2

**Table 5. Drugs most frequently involved in drug therapy problems**

Drugs	Drug Therapy Problem Category	#
Salicylates	Needed additional drug therapy	8
NSAIDs	Adverse drug reaction	4
Calcium supplements	Needed additional drug therapy	4
ACE inhibitors	Noncompliance	3
Calcium	Dosage too low	3
Insulin	Dosage too low	2
Insulin	Dosage too high	2
Beta blockers	Noncompliance	2
ACE inhibitors	Dosage too low	2
Loop diuretics	Dosage too high	2

The drug therapy problems most often needing to be resolved involved common medical conditions including diabetes, hypertension, angina pectoris, and back pain. These are listed in Table 4 in order of frequency. These data demonstrate that drug therapy problems are a common occurrence and they are associated with common medical conditions.

The drug products most frequently involved in drug therapy problems in this sample include products commonly used throughout our health care systems. These medications were commonly assessed as being used in subtherapeutic or supratherapeutic dosages, causing either treatment failure or toxicity. The addition of preventive medications, including aspirin and calcium supplements, were often required despite the ample evidence of their efficacy in preventing heart attacks, strokes, and osteoporosis respectively. These are listed in Table 5 in order of frequency.

In the sample of 36 American Indian elders, the provision of pharmaceutical care services over an 18 month period had a positive impact on clinical outcomes. Over 50% of the medical conditions evaluated on at least two occasions improved with the provision of pharmaceutical care. One third remained the same throughout the 18 months of this study, while the status of 19 conditions declined despite the resolution of drug therapy problems.

The clinical impact of these services was also measured by the change in the number of medical conditions that were stable before and after receiving pharmaceutical care. The clinical outcome status of “stable” was defined as “the goals of therapy that have been achieved and no drug therapy problems exist requiring changes in medication or dosage” (Cipolle, et al, 2004).

One hundred and fifteen of the medical conditions were evaluated on at least two occasions. At the first evaluation, 82% of these medical conditions being treated with drug therapies were not stable. Of those, 62% improved with the provision of pharmaceutical care services by their last follow-up evaluation. This clinical improvement in achieving desired goals was the result of the pharmaceutical care practitioner identifying and resolving drug therapy problems.

This outcome shows that American Indians can benefit from pharmaceutical care. The data from this study generate hypotheses for future research affecting this population and provide a basis to begin looking at the drug-related needs of American Indian people residing on and off-reservation.

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# Faculty Development Programs in Geriatrics at UCLA

Those interested in any of these opportunities should contact Anne Hu at telephone (310) 312-0531; e-mail [annehu@mednet.ucla.edu](mailto:annehu@mednet.ucla.edu); or visit the website at <http://www.geronet.ucla.edu/centers/reynolds>.

## **Reynolds Mini-Fellowship in Geriatrics February 20-22 and June 25-27, 2008**

The UCLA Mini-Fellowship in Geriatrics is a three-day intensive course focusing on integrating geriatric content into the role of clinician-educator. Free enrollment for eligible participants. Must have a valid US medical license (MD, DO, etc.), faculty appointment, and limited geriatric training.

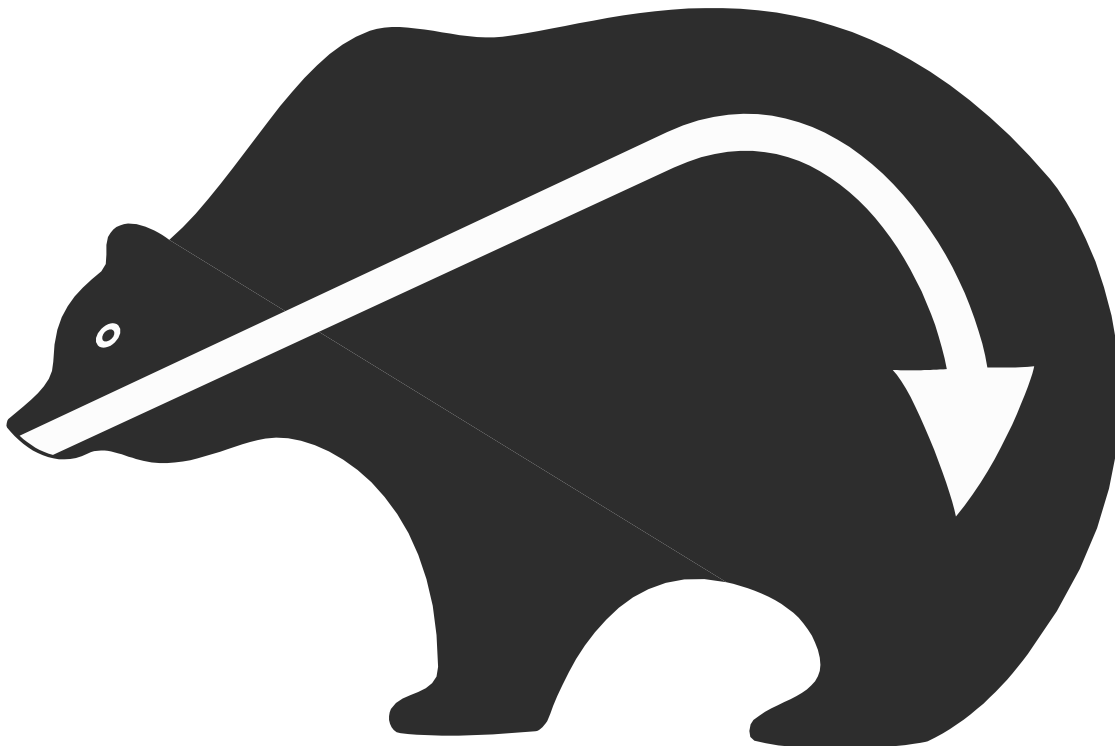
- Four tailored tracks to choose from: Generalist, Hospitalist, Palliative Care, and Skilled Nursing Facility.
- Topics include: Pain Management for the Elderly, Advanced Care Planning, Breaking Bad News, Delirium and Dementia, and much more.
- Interactive sessions include: standardized patient assessment, standardized student simulation, developing platform skills, and problem based learning.
- CME units available

## **Leadership and Management in Geriatrics March 14-15, 2008**

If you have ever felt challenged by a lack of leadership/management training, then Leadership and Management in Geriatrics 2008 is for you. LMG is an intensive and interactive program where you will be encouraged to consider novel business strategies for geriatric care.

## **Intensive Course in Geriatric Medicine September 17-20, 2008**

This intensive course in geriatric medicine emphasizes a functional assessment approach to comprehensive care of older adults and is directed toward health care professionals who care for older persons, and toward faculty in teaching programs in geriatrics and gerontology.



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# How to Create Scopus™ Alerts

*Diane Cooper, Biomedical Librarian/Informationist, Health Services Research Library, National Institutes of Health Library, Bethesda, Maryland*

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Do you need to receive automatic alerts on a specific topic or author? The *Scopus*™ database has an alert service and includes scientific, technical, medical, and social sciences literature from more than 14,000 peer-reviewed journals. It is large, interdisciplinary, and includes cited references for articles published after 1995.

## Scopus Alert Types

Four types of alerts can be created in Scopus:

- Subject,
- Table of Contents,
- Author, and
- Citation Alerts (tracks new citations to a particular article).

With these alerts, you can stay current on a particular topic, browse a journal's latest issue, see the latest publications of a particular author, or identify new articles that cite a particular article.

## Steps to Creating Scopus Alerts

1. Develop your search strategy.
2. Click Alert Me from the Document Display page. The Add a Document Citation Alert page will display. 1.
3. Choose a name for your alert and enter it in the Name of Alert field.
4. Enter in the E-mail Address field the e-mail address to which you want your alerts to be sent.
5. Select how often you wish to receive the Alert: Daily, Weekly, Monthly from the Frequency List. You can also select Inactive for times you do not wish to receive alerts.
6. Select either HTML or Text Format from the E-mail Format section.
7. Click Submit to save the Document Citation Alert or click Cancel to discontinue creating the Document.

## Differences between Scopus and MEDLINE/PubMed

Scopus has a much broader scope, including the 5,000 plus journals in MEDLINE®/ PubMed® as well as more than 9,000 journal titles from other disciplines. This can be good or not so good, depending on your situation. There is an advantage to getting articles from many different disciplines, but it is common to get more results that are non-relevant in Scopus.

For subject-based alerts, Scopus works best with very specific, non-ambiguous topics. For authors, it is more effective than MEDLINE/PubMed because Scopus will find your author's works in journals not indexed in MEDLINE.

Scopus includes cited references for articles published after 1995. This allows searching to identify subjects or authors for your citation alert from 1995 forward in time. Scopus does not include a single subject vocabulary (thesaurus) such as Medical Subject Headings® (MeSH®) in MEDLINE. It is, therefore, more challenging to construct an authoritative search in Scopus. It is advisable to try various synonyms of terms and/or consult with a librarian to develop the most effective and efficient search strategy for a subject-based alert.

To access *Scopus*, mouse-over Research Tools on the green menu bar of the HSR Library website and click on *Databases* from the drop-down options. *Scopus* is listed alphabetically, near the bottom of the page. You can also access it on the left panel of each web page of the HSR Library.

For more information about using *Scopus*, contact Diane Cooper, Informationist and Biomedical Librarian to the Indian Health Service, HSR Library, a branch of the NIH Library, [cooperd@mail.nih.gov](mailto:cooperd@mail.nih.gov); telephone (301) 594-2449.



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# IHS Child Health Notes

*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.*

## Quote of the month

*“Nothing significant will ever be accomplished if all possible objections must be dealt with beforehand.”*

Winston Churchill

## Article of Interest

A randomized, controlled trial of a removable brace versus casting in children with low-risk ankle fractures. *Pediatrics*. 2007 Jun;119(6):e1256-63

<http://pediatrics.aappublications.org/cgi/content/abstract/119/6/e1256>

Recent studies have shown that casting may not be necessary for some common childhood fractures such as buckle fractures of the wrist. A recent double blinded, randomized, controlled study in Canada looked at treatment of low risk distal fibular fractures. They compared the standard treatment of four weeks in a fiberglass walking cast with a removable air stirrup ankle brace. At four weeks post-injury, the children with the ankle brace were more likely to have returned to regular activities. These children were more likely to have been “very happy” with their treatment and had fewer unscheduled return visits for complications. The cost of ankle bracing was also lower.

## Editorial Comment

This study is particularly helpful for IHS and tribal sites that are often rural, remote, and without ready access to orthopedic specialty care. These low risk fibular fractures, like low risk wrist fractures, can be treated with bracing in a primary care clinic. Patients get better faster, with fewer complications of casting, and costs are minimized.

## Article of Interest

Superhero-related injuries in paediatrics: a case series. Davies P, Surridge J, Hole L, Munro-Davies L. *Arch Dis Child*. 2007;92:242-243.doi:10.1136/adc.2006.109793.

The authors describe five patients between the ages of 3 and 8 years of age who sustained serious injuries while dressed up as superheroes (4 Spiderman, 1 Superman). They speculate that the wearing of full costumes may have led children to believe their own powers had been given a super boost. The authors, all British, describe, how “all were injured after initiating flight without having planned for landing strategies.” The authors also point out that all of the injured were boys. Commercial role models for girls are less likely to show risk taking behaviors: there are no known instances of “My Little Pony” related injuries.

## Infectious Disease Updates

Rosalyn Singleton, MD, MPH

### Influenza Vaccination for 2007-8

- **Influenza disease Predictions for 2007-8**

- Some experts are predicting that the 2007-8 Flu season could be the worst in years. Australia is facing its worst influenza season since 2003, and it’s possible the US may expect the similar pattern after two mild seasons.

- **IHS Childhood Influenza Immunization Rates, 2006-7**

- In the IHS 3rd Quarter Immunization Report, among nine reporting IHS Areas, 55% (range 14% to 65%) of 6-23 month old children received at least 1 influenza vaccine during the 2006-7 season.

- **Influenza vaccine Recommendations 2007-8**

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5606a1.htm>

- Routine vaccination of 6-59 month olds.
- Importance of 2 doses for children 6 mo-8 yrs being vaccinated the first time.
- NEW! Children 6 mo-8 yrs who received only 1 dose in their first year of vaccination should receive 2 doses the 2nd year they are vaccinated.
- Vaccination of household contacts and caregivers of children birth-59 months old.
- Timing of Influenza vaccine: Early October through March.
- National Influenza Vaccination week is November 26 – December 2.



## Inactivated Influenza (TIV) Vaccine Products

Vaccine	Package	Dose	Age	Thimerosal
Fluzone (Sanofi)	Multidose	Age-dependent	>6 mos	Yes
	Single dose syringe	0.25 mL	6-35 mos	No
	Single dose syringe	0.5 mL	>36 mos	No
	Single dose vial	0.5 mL	>36 mos	No
Fluvirin (Novartis)	Multidose vial	0.5 mL	>4 yrs	Yes
Fluarix (GSK)	Single dose syringe	0.5 mL	>18 yrs	Trace
Flulaval (GSK)	Multidose vial	0.5 mL	>18 yrs	Yes

- **Live attenuated Influenza Vaccine (LAIV)**
  - New refrigerated (NOT FROZEN) formulation this season.
  - Approved only for 5-49 year old healthy persons – Medimmune is applying for expansion of the licensure down to 1-2 years of age. Should hear soon!
- **Flu Vaccine Supply predictions:**
  - So far there are no predictions of vaccine shortages or delays.
  - National Foundation of Infectious Disease press conference Sept 19

## Recent literature on American Indian/Alaskan Native Health Doug Esposito, MD

### Article

Barry M. The tail end of guinea worm - global eradication without a drug or vaccine. *NewEngl J Med.* 2007;365(25):2561-4. [http://www.ncbi.nlm.nih.gov/sites/entrez?Db=pubmed&Cmd=ShowDetailView&TermToSearch=17582064&ordinalpos=1&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed\\_ResultsPanel.Pubmed\\_RVDocSum](http://www.ncbi.nlm.nih.gov/sites/entrez?Db=pubmed&Cmd=ShowDetailView&TermToSearch=17582064&ordinalpos=1&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_RVDocSum)

### Editorial Comment

So, how does an article on the global eradication of dracunculiasis, or guinea worm, relate to American Indian/Alaska Native Child Health? Please read on to find out! As most of you are aware, dracunculiasis is likely to become only the second human disease in history to be eradicated from the face of the planet through human intervention, the first, of course, being small pox. From an estimated 3.5 million cases in 1986 to a few over 25,000 cases in 2006, and from 20 countries with endemic disease down to just nine in the same period (five of which reported fewer than 30 cases each), guinea worm is taking its last gasp. What is so remarkable about this achievement, though, is that this progress has been made without drugs or vaccines, and for a total estimated cost of around \$250 million. The progress made to date has almost entirely been accomplished through a grass-roots public health movement and generalized changes in behavior of populations. "Its demise will be proof that people can be persuaded to change their behavior through innovative health education."

I will refer the reader to the article itself to review the

specific details of the dracunculiasis eradication effort and not repeat them here. The point that I would like to make is that it really is possible to change behavior on a population level, as evidenced by this incredible achievement. So why then is greater progress on such issues as obesity, diabetes, and motor vehicle related morbidity and mortality so elusive? I suppose we just haven't yet managed to get it right! The medical and public health communities have not been able to make sufficient inroads into the consciousness of the population as a whole or to counter the significant social, political, and corporate forces that stand in opposition to positive change. As such, a sufficient societal response to these problems in the form of broad behavioral change has not yet been achieved.

One might argue that the afflictions of the developed world are somehow just a little more complex than a simple endemic helminthic infestation of the developing world, that the interplay between health behaviors and societal, political, and corporate forces are somehow more intricate in the US (please see the article in "Additional Reading" below for a fascinating example of just one aspect of that complexity in our own society). Yes, obesity is a difficult issue, with complex and powerful modulating forces at work. But no matter how simple the process of collecting clean water in the developing world might seem, it is an incredibly complex process that is subject in my opinion to many of the same forces that have led to overeating, poor physical activity, and low passenger restraint use rates in our world.

As overwhelming as health problems like obesity, diabetes, and injury are, I, for one, take heart in knowing that successes like the impending guinea worm eradication are possible, without drugs, immunizations, complex technologies, or mega-bucks! Population-level behaviors that result in disease and illness CAN be changed. The impossible really is possible! I guess the bottom line is that we will just have to keep trying until we get it right. We will get there, hopefully sooner rather than later.

### Additional Reading

Jones MM, Bayer R. Paternalism and its discontents: motorcycle helmet laws, libertarian values, and public health. *Am J Public Health.* 2007 Feb;97(2):208-17 [http://www.ncbi.nlm.nih.gov/sites/entrez?Db=pubmed&Cmd=ShowDetailView&TermToSearch=17194856&ordinalpos=2&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed\\_ResultsPanel.Pubmed\\_RVDocSum](http://www.ncbi.nlm.nih.gov/sites/entrez?Db=pubmed&Cmd=ShowDetailView&TermToSearch=17194856&ordinalpos=2&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_RVDocSum)

### Article

Brugge D, Delemos JL, Bui C. The Sequoyah Corporation fuels incident and the Church Rock spill: unpublicized nuclear releases in American Indian Communities. *Am J Public Health.* 2007;97(9): 30-5 [http://ncbi.nlm.nih.gov/sites/entrez?Db=pubmed&Cmd=ShowDetailView&TermToSearch=17666688&ordinalpos=3&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed\\_ResultsPanel.Pubmed\\_RVDocSum](http://ncbi.nlm.nih.gov/sites/entrez?Db=pubmed&Cmd=ShowDetailView&TermToSearch=17666688&ordinalpos=3&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_RVDocSum)

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## Editorial Comment

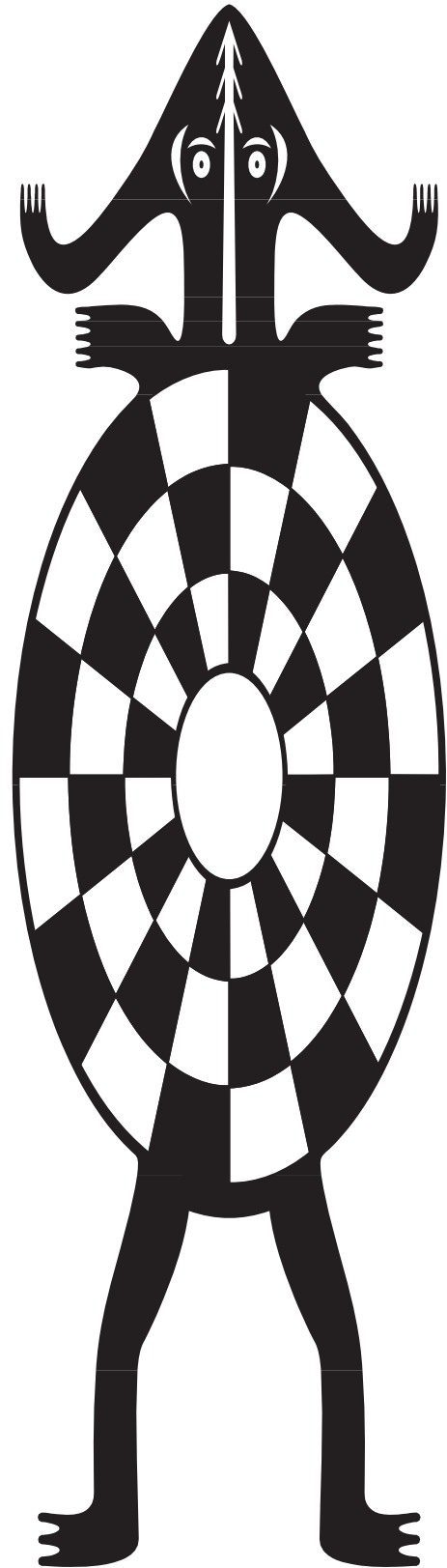
This is an interesting article about two significant accidental nuclear releases into the environment that occurred in two American Indian communities and the possible reasons why these events never really received much interest or mention in the press or the scientific literature. In fact, I had never really heard of either, despite the fact that the largest of the two incidents (the Church Rock, New Mexico incident was more than three times larger in terms of estimated curies of radiation release than the infamous Three Mile Island incident) occurred less than 45 miles from where I now reside! The authors contend that the reason so little interest has been paid to these two incidents might have something to do with their having occurred in rural, low-income, American Indian communities. I would suggest reading this interesting article and deciding for yourself.

## Announcements from the AAP Indian Health Special Interest Group

Sunnah Kim, MS

### Locums Tenens and Job Opportunities

If you have a short- or long-term opportunity in an IHS, tribal or urban facility that you'd like for us to publicize (i.e., AAP Web site or complimentary ad on Ped Jobs, the official AAP on-line job board), please forward the information to [indianhealth@aap.org](mailto:indianhealth@aap.org) or complete the online locum tenens form at <http://www.aap.org/nach/locumtenens.htm>.



# SAVE THE DATE



- \* Challenges in Indian Health Care \*
- \* Health Care Budgets & Financing \*
- \* Data and Information Technology \*
- \* Law \*
- \* Integrity and Ethics \*
- \* Negotiation \*

**May 2008-Session One**  
**June 2008- Session Two**  
**July 2008- Session Three**

You can be a part of the 2008 Class  
of the Executive Leadership Development Program (ELDP)!

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.

Look for the registration material in January on  
<http://www.ihs.gov/nonmedicalprograms/eldp/> .

ELDP Coordinators:  
*Gigi.Holmes@ihs.gov* and *Wesley.Picciotti@ihs.gov*

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## MEETINGS OF INTEREST □

### Available EHR Courses

EHR is the Indian Health Service's Electronic Health Record software that is based on the Resource and Patient Management System (RPMS) clinical information system. For more information about any of these courses described below, please visit the EHR website at [http://www.ihs.gov/CIO/EHR/index.cfm?module=rpms\\_ehr\\_training](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>.

### Making Data Count: Measuring Diabetes and Obesity in the Indian Health System

**December 18 - 20, 2007; Tucson, Arizona**

This conference, supported by the IHS Division of Diabetes Treatment and Prevention (DDTP), will offer plenary sessions and concurrent workshops focusing on both clinical and technical applications. It will be beneficial to all new and experienced data users addressing diabetes and obesity in Indian health care systems.

The program objectives are as follows:

- Identify current status of diabetes and obesity data-related issues
- Learn the impact of cost and quality issues
- Network and share common issues and best practices for capturing, reporting, using, and improving data to help improve the lives of American Indian and Alaska Native people
- Review currently available and advanced diabetes and obesity related data systems and analysis tools in IHS, tribal, and urban program (I/T/U) health care settings
- Explore opportunities for education, training, and career development in data management and program analysis in I/T/U systems

The meeting will be held at the Westin La Paloma. For more information, go to [www.ihs.gov/MedicalPrograms/Diabetes/training.asp](http://www.ihs.gov/MedicalPrograms/Diabetes/training.asp). Registration is now available at <http://conferences.thehillgroup.com/conferences/makingdatacount/registration.html>.

### Indian Health Midwinter Conference on Women's and Children's Healthcare

**February 8 - 10, 2008, Telluride, Colorado**

Mark your calendar! Ask for leave! Think snow! It's time to make plans to attend the annual Indian Health Midwinter Conference on Women's and Children's Healthcare. This conference will bring together health care providers and nurses from Navajo Area and throughout Indian country for three days

of continuing education, networking, and winter recreation. Topics will include a wide range of timely issues important for ob/gyns, pediatricians, family physicians, NPs, CNMs, PAs, and RNs who care for Native American women and children.

It will be a fun and educational weekend if you ski, snowboard, or like to sit by the fire. As always, no advance registration is needed. Details regarding times and location will be mailed later in the fall. If you need additional information in the meantime, please contact Alan Waxman, MD at [awaxman@salud.unm.edu](mailto:awaxman@salud.unm.edu).

Share this announcement with a friend. See you there!

### Clinical Update on Substance Abuse and Dependency (CUSAD)

**(Formerly known as the Primary Care Provider Training on Chemical Dependency)**

**March 11 - 13, 2008; Phoenix, Arizona**

This three-day intensive workshop includes both didactic and experiential training. The curriculum is updated annually with the most current nursing, addiction medicine, and prevention information. This training is available to Indian health providers (physicians, physician assistants, nurses, and advanced practice nurses). Enrollment is limited to 30 providers (preferably 2 - 3 person teams from the same facility representing the various disciplines targeted). The conference site expected to be announced in January; it will be in downtown Phoenix. Be sure to ask for the "Indian Health Service" group rate when the venue is confirmed. For more information or to register, contact Cheryl Begay at (602) 364-7777 or e-mail [Cheryl.Begay@ihs.gov](mailto:Cheryl.Begay@ihs.gov). To register on-line, go to the CSC website at <http://www.ihs.gov/MedicalPrograms/ClinicalSupportCenter/>.

### Office Based Opioid Treatment Course

**March 14, 2008; Phoenix, Arizona**

The IHS invites all physicians and nurses to register for its upcoming Office Based Opioid Treatment (OBOT) Course to be held Friday, March 14, 2008 at the CUSAD venue in Phoenix. The course faculty features the top clinicians and researchers in the field. This new treatment modality reduces the regulatory burden on physicians who choose to practice opioid addiction therapy. It is open to all physicians and nurses, including federal, state, and military. For more information, contact Dr. Anthony Dekker at (602) 762-1908 or [anthony.dekker@ihs.gov](mailto:anthony.dekker@ihs.gov).

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## POSITION VACANCIES □

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

### **Family Practice Physician Sonoma County Indian Health Project; Santa Rosa, California**

The Sonoma County Indian Health Project (SCIHP) in Santa Rosa, California is seeking a full-time BC/BE Family Practice Physician to join our team. SCIHP is a comprehensive community care clinic located in the northern Californian wine country. Candidates must currently hold a California Physician/Surgeon license. Inpatient care at the hospital is required. For the right candidate, we offer a competitive salary, excellent benefits, and an opportunity for loan repayment. For more information, please contact Bob Orr at (707) 521-4654; or by e-mail at [Bob.Orr@crihb.net](mailto:Bob.Orr@crihb.net).

### **Family Practice Physician/Medical Director American Indian Health and Family Services of Southeastern Michigan; Dearborn, Michigan**

American Indian Health and Family Services of Southeastern Michigan (*Minobinmaadziwin*) (AIHFS) is a non-profit ambulatory health center, founded 1978. AIHFS provides quality, culturally integrated, medical and preventative dental care in addition to comprehensive diabetes prevention and treatment. All of AIHFS programs integrate traditional Native American healing and spiritual practices with contemporary western medicine in both treatment and prevention.

AIHFS is seeking a full time primary care and family practice physician/medical director. This involves the delivery of family oriented medical care services as well as general professional guidance of primary care staff. The incumbent will also function as the Medical Director, who will collaborate with fellow physicians and the Executive Director on administrative operations of the medical, dental, and behavioral health services.

Please send a cover letter (include the position that you are applying for, a summary of your interests and qualifications for position), minimum salary requirement, resume, and a list of

three professional references with contact information to American Indian Health and Family Services of Southeastern Michigan, Inc., Attn: Jerilyn Church, Executive Director, P.O. Box 810, Dearborn, Michigan; fax: (313) 846-0150 or e-mail [humanresources@aihfs.org](mailto:humanresources@aihfs.org).

### **Pediatrician Nooksack Community Clinic; Everson, Washington**

The Nooksack Community Clinic in Everson, Washington is seeking an experienced pediatrician to take over the successful practice of a retiring physician. The clinic provides outpatient care to approximately 2,000 members of the Nooksack Indian Tribe and their families. The position includes some administrative/supervisory duties as well as part-time direct patient care. We are seeking a dedicated, experienced pediatrician with a special interest in child advocacy and complex psychosocial issues. This is a full time position with a competitive salary and benefits. There are no on-call, no inpatient duties, and no obstetrics. We currently are staffed with one family practitioner, one internist, one pediatrician, and one nurse practitioner. Additionally we have three mental health counselors, a state-of-the-art four-chair dental clinic, a nutritionist, a diabetic nurse educator, and an exercise counselor. We provide high quality care in an environment that prides itself on treating our patients like family.

The clinic is located in a very desirable semi-rural area of Northwest Washington, renown for its scenic beauty, quality of life, and year 'round outdoor recreation. The beautiful city of Bellingham is 20 minutes away. Vancouver, Canada is less than 90 minutes away, and Seattle is approximately a two-hour drive away. St. Joseph Hospital in nearby Bellingham offers a wide range of specialist and inpatient services, an excellent hospitalist program, as well as emergency care, lab, and imaging services, all easily accessible for our patients.

For further information, please send your CV or contact Dr. MaryEllen Shields at [nooksackclinic@gmail.com](mailto:nooksackclinic@gmail.com), or write c/o Nooksack Community Health Center, PO Box 647, Everson, Washington 98247; telephone (360) 966-2106; fax (360) 966-2304.

### **Nurse Executive Santa Fe Indian Health Hospital; Santa Fe, New Mexico**

The Santa Fe Indian Hospital is recruiting for a quality, experienced nurse executive. The 39-bed Santa Fe Indian Hospital is part of the Santa Fe Service Unit providing services in the clinical areas of general medical and surgical care, operating room, urgent care, progressive care, and preventive health. The purpose of this position is to serve as the top level

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nurse executive for all aspects of the nursing care delivery. As Director of Nursing (DON) services, manages costs, productivity, responsibility of subordinate staff, and programs, as well as providing leadership and vision for nursing development and advancement within the organizational goals and Agency mission.

The Nurse Executive is a key member of the SFSU Executive Leadership Team and has the opportunity to coordinate clinical services with an outstanding, stable, and experienced Clinical Director and Medical Staff. The SFSU includes the hospital and four ambulatory field clinics primarily serving nine tribes. The SFSU earned 2006 Roadrunner Recognition from Quality New Mexico. The hospital is located in beautiful Santa Fe, New Mexico, filled with cultural and artistic opportunities.

Contact CAPT Jim Lyon, CEO at (505) 946-9204 for additional information.

### **Director of Nursing Acoma-Canoncito Laguna Hospital; San Fidel, New Mexico**

Acoma-Canoncito Laguna Hospital has an opening for a director of nursing. The Acoma-Canoncito Laguna Service Unit (ACL) serves three tribal groups in the immediate area: the Acoma Pueblo (population 3,500), the Laguna Pueblo (5,500) and the Canoncito Navajos (1,100). The ACL Hospital is located approximately 60 miles west of Albuquerque, New Mexico. The hospital provides general medical, pediatric, and obstetric care with 25 beds. The director of nursing is responsible for planning, organizing, managing, and evaluating all nursing services at ACL. This includes both the inpatient and outpatient areas of the service unit. The director of nursing participates in executive level decision making regarding nursing services and serves as the chief advisor to the chief executive officer (CEO) on nursing issues. Other responsibilities include management of the budget for nursing services. For more information about the area and community, go to <http://home.Abuquerque.ihs.gov/serviceunit/ACLSU.html>. For details regarding this great employment opportunity, please contact Dr. Martin Kileen at (505) 552-5300; or e-mail [martin.kileen@ihs.gov](mailto:martin.kileen@ihs.gov).

### **Primary Care Physician (Family Practice Physician/General Internist) Family Practice Physician Assistant/Nurse Practitioner Kyle Health Center; Kyle South, Dakota**

Kyle Health Center, a PHS/IHS outpatient clinic, is recruiting for the position of general internal medicine/family practice physician and a position of family practice physician assistant/nurse practitioner. The clinic is south of Rapid City, South Dakota, and is located in the heart of the Badlands and the Black Hills – an area that is a favorite tourist destination. It is currently staffed with physicians and mid-level practitioners. It provides comprehensive chronic and acute primary and

preventive care. In-house services include radiology, laboratory, pharmacy, optometry, podiatry, primary obstetrics/gynecology, diabetic program, and dentistry. There is no call duty for practitioners. We offer competitive salary, federal employee benefits package, CME leave and allowance, and loan repayment. For further information, please contact K.T Tran, MD, MHA, at (605) 455-8244 or 455-8211.

### **Internist Northern Navajo Medical Center; Shiprock, New Mexico**

The Department of Internal Medicine at Northern Navajo Medical Center (NNMC) invites board-certified or board-eligible internists to interview for an opening in our eight-member department. NNMC is a 75-bed hospital in Shiprock, New Mexico serving Native American patients from the northeastern part of the Navajo Nation and the greater Four Corners area. Clinical services include anesthesia, dentistry, emergency medicine, family practice, general surgery, internal medicine, neurology, OB/Gyn, optometry, orthopedics, ENT, pediatrics, physical therapy, and psychiatry. Vigorous programs in health promotion and disease prevention, as well as public health nursing, complement the inpatient services.

The staff here is very collegial and unusually well trained. A vigorous CME program, interdepartmental rounds, and journal clubs lend a decidedly academic atmosphere to NNMC. Every six weeks, the departments of internal medicine and pediatrics host two medical students from Columbia University's College of Physicians and Surgeons on a primary care rotation. In addition, we have occasional rotating residents to provide further opportunities for teaching.

There are currently eight internists on staff, with call being about one in every seven weeknights and one in every seven weekends. We typically work four 10-hour days each week. The daily schedule is divided into half-days of continuity clinic, walk-in clinic for established patients, exercise treadmill testing, float for our patients on the ward or new admissions, and administrative time. On call, there are typically between 1 and 4 admissions per night. We also run a very active five-bed intensive care unit, where there is the capability for managing patients in need of mechanical ventilation, invasive cardiopulmonary monitoring, and transvenous pacing. The radiology department provides 24-hour plain film and CT radiography, with MRI available weekly.

The Navajo people suffer a large amount of diabetes, hypertension, and coronary artery disease. There is also a high incidence of rheumatologic disease, tuberculosis, restrictive lung disease from uranium mining, and biliary tract and gastric disorders. There is very little smoking or IVDU among the Navajo population, and HIV is quite rare.

Permanent staff usually live next to the hospital in government-subsidized housing or in the nearby communities of Farmington, New Mexico or Cortez, Colorado, each about 40 minutes from the hospital. Major airlines service airports in Farmington, Cortez, or nearby Durango, Colorado.

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Albuquerque is approximately 3? hours away by car.

The great Four Corners area encompasses an unparalleled variety of landscapes and unlimited outdoor recreational activities, including mountain biking, hiking, downhill and cross-country skiing, whitewater rafting, rock climbing, and fly fishing. Mesa Verde, Arches, and Canyonlands National Parks are within a 2 - 3 hour drive of Shiprock, as are Telluride, Durango, and Moab. The Grand Canyon, Capitol Reef National Park, Flagstaff, Taos, and Santa Fe are 4 - 5 hours away.

If interested, please contact Thomas Kelly, MD, by e-mail at [Thomas.Kelly@ihs.gov](mailto:Thomas.Kelly@ihs.gov) or call (505) 368-7037.

**Physician Assistant  
Native American Community Health Center, Inc.;  
Phoenix, Arizona**

The Native American Community Health Center, Inc. (dba Native Health) is a non-profit, community focused health care center centrally located in the heart of Phoenix, Arizona. Native Health has been providing health care services to the urban Indian community in metro Phoenix, since it was incorporated in 1978. Native Health is currently seeking a physician assistant (PA). The PA is a key element in providing quality health care services to patients of all ages. Native Health offers competitive and excellent benefits. For more information, contact the HR Coordinator, Matilda Duran, at (602) 279-5262 or [mduran@nachi.com](mailto:mduran@nachi.com).

**Family Practice Physicians  
Medical Clinic Manager  
North Olympic Peninsula, Washington State**

The Jamestown Family Health Clinic is seeking two BC/BE full spectrum family practice physicians with or without obstetrical skills. The clinic group consists of five FP physicians, two OB/GYN physicians, and five mid-level providers. The clinic is owned by the Jamestown S'Klallam Tribe and serves tribal members and approximately 9,000 residents of the north Olympic Peninsula. The practice includes four days per week in the clinic and inpatient care at Olympic Medical Center. OMC is family medicine friendly with hospitalists who cover nighttime call and are available to assist with most hospital rounding. Our practice fully utilizes an electronic medical record system (Practice Partner) and participates in the PPRI net research affiliated with Medical University of South Carolina. The clinic serves as a rural training site for the University of Washington Family Medicine residency.

The Jamestown S'Klallam Tribe provides a competitive salary and unbeatable benefit package including fully paid medical, dental, and vision coverage of the physician and family. The north Olympic Peninsula provides boating opportunities on the Strait of San Juan de Fuca, and hiking, fishing, and skiing opportunities in the Olympic Mountains and Olympic National Park. Our communities are a short

distance from Pacific Ocean beaches, a short ferry ride away from Victoria, BC, and two hours from Seattle.

Send CV to Bill Riley, Jamestown S'Klallam Tribe, 1033 Old Blyn Highway, Sequim, Washington 98382, or e-mail [briley@jamestowntribe.org](mailto:briley@jamestowntribe.org).

The Medical Clinic Manager is responsible for management and staff supervision of the multiple provider clinic in Sequim, Washington. Clinic services include primary care and OB/GYN. Send cover letter and resume to Jamestown S'Klallam Tribe, 1033 Old Blyn Highway; Sequim Washington 98382, Attn: Bill Riley; or fax to (360) 681-3402; or e-mail [briley@jamestowntribe.org](mailto:briley@jamestowntribe.org). Job description available at (360) 681-4627.

**Chief Pharmacist  
Deputy Chief Pharmacist  
Staff Pharmacists (2)  
Hopi Health Center; Polacca, Arizona**

The Hopi Health Care Center, PHS Indian Health Service, is located on the Hopi Indian Reservation in beautiful northeastern Arizona. HHCC is a critical access hospital with an inpatient unit consisting of four patient beds plus two labor and delivery suites, emergency room, and a large outpatient clinic. The HHCC serves the Hopi, Navajo and Kiabab/Paiute Tribes. Housing, sign-on bonus and/or moving expenses are available for eligible applicants. The Hopi people are rich in culture, customs, and traditions and live atop the peaceful mesas. Applications are available on-line at [www.ihs.gov](http://www.ihs.gov), or contact Ms. April Tree at the Phoenix Area Office at (602) 364-5227.

**Nurse Practitioners  
Physician Assistant  
Aleutian Pribilof Islands Association (APIA), St. Paul and  
Unalaska, Alaska**

Renown bird watcher's paradise! Provide health care services to whole generations of families. We are recruiting for mid-level providers for both sites, and a Medical Director for St. Paul and a Clinical Director for Unalaska, Alaska.

Duties include primary care, walk-in urgent care, and emergency services; treatment and management of diabetes a plus. Must have the ability to make independent clinical decisions and work in a team setting in collaboration with referral physicians and onsite Community Health Aide/Practitioners. Sub-regional travel to other APIA clinics based on need or request. Graduate of an accredited ANP or 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. 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

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37.5 hours per week.

Salary DOE + benefits. Contractual two year commitment with relocation and housing allowance. Job description available upon request. Please send resumes with at least three professional references to Nancy Bonin, Personnel Director, via email at [nancyb@apiai.org](mailto:nancyb@apiai.org).

### **Family Practice Physician Dentist**

#### **Northeastern Tribal Health Center; Miami, Oklahoma**

The Northeastern Tribal Health Center is seeking a full-time Family Practice Dentist and a Family Practice Physician to provide ambulatory health care to eligible Native American beneficiaries. The Health Care Center is located in close proximity to the Grand Lake area, also with thirty minute interstate access to Joplin, Missouri. The facility offers expanded salaries, excellent benefits, loan repayment options, no weekends, and no call. To apply please submit a current resume, certifications, and current state license. Applicants claiming Indian preference must submit proof with their resume. Applicants will be required to pass a pre-employment drug screen and complete a background check. To apply, send requested documents to Northeastern Tribal Health Center, P.O. Box 1498, Miami, Oklahoma 74355, attention: Personnel. The phone number is (918) 542-1655; or fax (918) 540-1685.

### **Internal Medicine and Family Practice Physicians Yakama Indian Health Center; Toppenish, Washington**

Yakama Indian Health Center in Toppenish, WA will soon have openings for internal medicine and family practice physicians. The current staff includes four family physicians, two pediatricians, one internist, five nurse practitioners, and a physician assistant. The clinic serves the 14,000 American Indians living in the Yakima Valley of south central Washington. Night call is taken at a local private hospital with 24/7 ER coverage. The on-call frequency is about 1 out of 7 nights/weekends. The area is a rural, agricultural one with close proximity to mountains, lakes, and streams that provide an abundance of recreational opportunities. The weather offers considerable sunshine, resulting in the nearest city, Yakima, being dubbed the "Palm Springs of Washington." Yakima is about 16 miles from Toppenish, with a population of 80,000 people. There you can find cultural activities and a college. For further information, please call or clinical director, Danial Hocson, at (509) 865-2102, ext. 240.

### **Family Practice Physician Ilanka Community Health Center; Cordova, Alaska**

The Ilanka Community Health Center has an immediate opening for a board certified/eligible family practice physician. Position is full-time or part-time with flexible hours.

Ilanka is a tribally-owned clinic that also receives federal Community Health Center funding. We serve all members of the community. Cordova also has a 10-bed Critical Access

Hospital with on-site long-term care beds. Physicians and physician assistants provide services in the clinic and in the hospital emergency department, as well as inpatient and long-term care.

This is a very satisfying practice with a nice mix of outpatient, ER, and inpatient medicine. Sicker patients tend to be transferred to Anchorage. The clinic provides prenatal care to about 20 patients a year, but the hospital is currently not doing deliveries.

Cordova is a small, beautiful community situated in southeast Prince William Sound. It is a very friendly town. The population of Cordova is 2,500 in the winter and around 5,000 in the summer. The population is 70% Caucasian, 15% Alaska Native, and 10% Filipino, with an influx of Hispanic patients in the summer.

Most of the town is within easy walking distance to the clinic/hospital. The community is off the road system, but connects to roads by ferry and has daily flights to Anchorage and Juneau. This offers the advantages of remoteness with the benefits of connectivity.

We have tremendous access to outdoor sports and activities including excellent hiking, cross country skiing, alpine skiing, ice skating, boating, world class kayaking, heli-skiing, fishing, and hunting. This is the source of Copper River Salmon!

We offer flexible schedules, competitive salary and benefits, and loan repayment options. We would like to hear from you if you are excited about being an old style, small-town, family doctor.

Get more information about Cordova at [www.cordovaalaska.com](http://www.cordovaalaska.com), [www.cordovachamber.com](http://www.cordovachamber.com), and [www.cordovaalaska.net/cordovarealty/](http://www.cordovaalaska.net/cordovarealty/). For more information, please contact Gale Taylor, at (907) 424-3622; or [gale@ilanka.org](mailto:gale@ilanka.org)

### **Emergency Department Physician/Director Kayenta Health Center; Kayenta, Arizona**

Kayenta is unique in many ways. We are located in the Four Corners area on the Navajo Indian Reservation as part of the Indian Health Service/DHHS. We have challenging assignments, beautiful rock formations, movie nostalgia, ancient ruins, and wonderful clientele to care for. We are within one hundred and fifty miles from the Grand Canyon and one hundred miles from Lake Powell, which offers boating, fishing, water skiing, and camping. World class skiing resorts and winter sports are just a few hours away in Colorado and Utah. Kayenta is a great place to raise a family with stress free living in a small hometown setting.

Working for Kayenta Health Center provides a unique opportunity. Because of our remote location and underserved population, you may be eligible for loan repayment and can be making a real difference in the world.

We are currently recruiting for a BC/BE emergency department physician and director to work in our 24-hour, eight



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bed facility. This is a great opportunity to join our multi-specialty ten member medical staff and nursing team. This position will be supported by dynamic outpatient clinical services, including dental, optometry, mental health, public health nursing, pharmacy, radiology, environmental health services, and nutrition.

If interested in this exciting employment opportunity, please contact Stellar Anonye Achampong, MD, Clinical Director, at (928) 697-4001; e-mail [stellar.anonye@ihs.gov](mailto:stellar.anonye@ihs.gov); or send CV to Human Resources/Melissa Stanley, PO Box 368, Kayenta, Arizona 86033; telephone (928) 697-4236.

### **Multiple Positions**

#### **Riverside-San Bernardino County Indian Health Inc.; Banning, California**

Internal medicine physician: two years experience in an ambulatory care patient setting. MD degree, current California medical license, current DEA license, board certified.

Public health nurse: bachelor of science degree in nursing from an accredited school of nursing. Must possess a current California nursing license and public health nurse certificate; valid California driver's license and safe driving record.

RN charge nurse: current California RN license, current CPR certification, current California driver's license. Experience with computerized medical management system desirable. Two years experience in ambulatory care, urgent care, or similar setting.

Registered Dietitian & Public Health Nutritionist: bachelor of science degree in foods and nutrition, applicable master's degree in nutrition or masters in public health or RD. At least two years professional experience required. A California driver's license and a current DMV printout are required.

Quality management/credentialing assistant: applicant must possess a high school diploma or equivalent. Must have two years experience in the coordination of quality management and credentialing services for the professional staff. Must have strong written and oral communications skills.

All applicants must be able to work with the Indian community and be sensitive to the Indian culture and its needs. Please fax resumes to Human Resource Department at (951) 849-3581; or e-mail [msouvenir@rsbcihi.org](mailto:msouvenir@rsbcihi.org).

### **Multiple Professions**

#### **Pit River Health Service, Inc.; Burney, California**

Pit River Health Service is an IHS funded rural health clinic under P.L.93-638 in northern California that provides medical, dental, outreach, and behavioral health. We are seeking several professional positions to be filled. We are looking for a Health Director to administer and direct the program to fulfill the Pit River Health Service, Inc.'s primary mission of delivering the highest possible quality of preventative, curative and rehabilitative health care to the

Indian people served; a Dental Director to plan and implement the dental program and supervise dental staff; a Public Health Nurse or Registered nurse seeking a PHN license to provide public health nursing and to coordinate and supervise Community Health Services program; a Behavioral Health Director/LCSW as an active member of an interdisciplinary team providing prevention, intervention, and mental health treatment services to clients; and a Registered Dental Assistant.

Burney is located about 50 miles northeast of Redding, California in the Intermountain Area. The Intermountain Area offers plenty of recreational opportunities such as fishing, hiking, camping, boating, and hunting, with a beautiful landscape. Snow skiing is within an hour's drive away. The Intermountain Area is a buyers market for homes, as well. All available positions require a California license and/or certification. To apply for employment opportunities and for more information, please contact John Cunningham; e-mail [johnc@pitriverhealthservice.org](mailto:johnc@pitriverhealthservice.org); or telephone (530) 335-5090, ext. 132.

#### **Family Practice Physician Internal Medicine Physician Psychiatrist**

#### **Winslow Indian Health Care Center; Winslow, Arizona**

The Winslow Indian Health Care Center (WIHCC) in northern Arizona is currently looking for primary care physicians in family practice, internal medicine, and psychiatry. We have a staff of 12 physicians, including a surgeon, and nine family nurse practitioners and physician assistants. We offer comprehensive ambulatory and urgent/emergent care to patients at our health center in Winslow, which includes a state-of-the-art, seven-bed Urgent Care Center completed in 2006. WIHCC also operates two field clinics five days a week on the Navajo Reservation, at Leupp and Dilkon. Our FPs and internist also provide inpatient care at the local community hospital, the Little Colorado Medical Center, where the FPs provide obstetrical deliveries with excellent back-up from the local OB-Gyn group. The psychiatrist works as part of a team consisting of one full-time psychiatric nurse practitioner, another (part-time) psychiatrist, and five Navajo counselors, providing primarily outpatient services with occasional hospital consults.

WIHCC offers an awesome mix of professional, cultural, and recreational opportunities. It is located just seven miles from the breathtaking beauty of Navajoland and its people, and 50 miles from Flagstaff – a university town with extensive downhill and cross-country skiing, where several of our employees choose to live. Attractive salary and benefits, as well as a team oriented, supportive work environment are key to our mission to recruit and retain high quality professional staff.

WIHCC became an ISDA 638 contracted site in 2002, and has experienced steady growth and enhancement of programs and opportunities since the transition from a direct IHS

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program. Please contact Frank Armao, MD, Clinical Director, if you are interested in pursuing an opportunity here, at [frank.armao@wihcc.org](mailto:frank.armao@wihcc.org); telephone (928) 289-6233.

### **Family Practice Physician**

#### **Peter Christensen Health Center; Lac du Flambeau, Wisconsin**

The Peter Christensen Health Center has an immediate opening for a board certified family practice physician; obstetrics is optional, and call will be 1/6. The facility offers competitive salaries, excellent benefits, and loan repayment options; all within a family oriented work atmosphere.

The Lac du Flambeau Indian Reservation is located in the heart of beautiful northern Wisconsin. The area's lakes, rivers, and woodlands teem with abundant wildlife, making it one of the most popular recreational areas in northern Wisconsin. The area boasts fabulous fishing, excellent snowmobiling, skiing, hunting, golf, and much more. Four seasons of family fun will attract you; a great practice will keep you.

For specific questions pertaining to the job description, call Randy Samuelson, Clinic Director, at (715) 588-4272. Applications can be obtained by writing to William Wildcat Community Center, Human Resource Department, P.O. Box 67, Lac du Flambeau, Wisconsin 54538, Attn: Tara La Barge, or by calling (715) 588-3303. Applications may also be obtained at [www.lacduflambeautribe.com](http://www.lacduflambeautribe.com).

### **Primary Care Physician**

#### **Zuni Comprehensive Community Health Center; Zuni, New Mexico**

The Zuni Comprehensive Community Health Center (Zuni-Ramah Service Unit) has an opening for a full-time primary care physician starting in January 2008. 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 14 physicians, one PA, 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 Native American 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 elevation and surrounded by beautiful sandstone mesas, canyons, and scattered sage, juniper, and pinon pine trees. Half of our medical staff has been with us for more than seven 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](mailto:john.bettler@ihs.gov). CVs can be faxed to (505) 782-4502, attn: John Bettler.

### **Primary Care Physicians (Family Practice, Internal Medicine, Med-Peds, Peds)**

#### **Psychiatrists**

#### **Pharmacists**

#### **Nurses**

#### **Chinle Service Unit; Chinle, Arizona**

Got Hózhó? That's the Navajo word for joy. Here on the Navajo Reservation, there's a great mix of challenging work and quality of life. No rush hour traffic, no long commutes, no stressors of urban life. We walk to work (naanish) and enjoy living in our small, collegial community. Our 60-bed acute care hospital is located in Chinle, Arizona, the heart of the Navajo Nation. At work we see unique pathology, practice evidence-based medicine, and are able to utilize the full scope of our medical training. Together, we enjoy learning in an atmosphere of interdepartmental collaboration, supported by an established network of consulting specialists across the southwest. A comprehensive system of preventive programs and ancillary services allows us to provide the best possible care for our patients. During our time off, many of us explore the beautiful southwest, bike on amazing slick rock, and ski the slopes of the Rocky Mountains. It's a great life — combining challenging and interesting work with the peaceful culture of the Navajo people and the beautiful land of the southwest.

We're looking for highly qualified health care professionals to join our team. If you're interested in learning more about a place where "naanish baa hózhó" (work is joyful), contact Heidi Arnholm, Medical Staff Recruiter, Chinle Service Unit, telephone (970) 882-1550 or (928) 674-7607; e-mail [heidi.arnholm@ihs.gov](mailto:heidi.arnholm@ihs.gov).

### **Family Practice Physician**

#### **Family Practice Medical Director**

#### **Tanana Chiefs Conference, Chief Andrew Isaac Health Center; Fairbanks, Alaska**

We are seeking a board certified family practice physician, preferably with obstetrics skills for a full-time position. We will have openings in the summers of 2007 and 2008.

The facility is a multispecialty clinic providing services in obstetric/gynecology, internal medicine, and family practice. It also includes dental, optometry, pharmacy, behavioral health, community health aides, and other services. Our referral region includes 43 villages in interior Alaska covering an area the size of Texas. Fairbanks has an outstanding school system and university. We offer a very competitive salary with a great benefits package and a loan repayment plan. Commissioned Corps positions are also available. Contact Jim Kohler at (907) 459-3806 or [james.kohler@tananachiefs.org](mailto:james.kohler@tananachiefs.org).

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**Family Practice Physician  
Seattle Indian Health Board; Seattle, Washington**

Full Time, Fantastic Benefits! We are recruiting for a family practice physician to join our team at the Seattle Indian Health Board in Seattle, Washington. We are a multiservice community health center for medical, dental, mental health, substance abuse, and community education services. We are looking for a physician who is familiar with health and social issues facing American Indians/Alaska Natives and a desire to promote the delivery of appropriate health services to this population.

Seattle Indian Health Board (SIHB) physicians are responsible for the delivery of quality, culturally sensitive primary medical care to the SIHB's patient population. This position provides general medical care (including diagnosis, treatment, management, and referral) to SIHB patients with acute, chronic, and maintenance health care needs. The physician chosen will also participate in the medical on-call rotation schedule and other responsibilities such as consulting and coordinating care with other practitioners, nursing, pharmacy, laboratory, and outside referral sites. He or she will provide clinic preceptorship of mid-level practitioners and patient care instruction to nurses, pharmacists, and other SIHB clinical staff. The incumbent will precept for residents for the outpatient continuity family practice clinics. In addition to supervising patient care, preceptors engage in didactic activity to enhance resident learning. The physician will also participate in quality assurance, program development, community health education/screening, and related activities. He or she will document all patient care information/treatment in problem-oriented format in the patient's medical records, as well as complete and submit encounter forms and related materials according to established procedure. Finally, the person selected will comply with SIHB policies and procedures, and the AAAHC Standards of Care.

Qualifications include board certification in family medicine and a Washington State medical license. All applicants will be required to complete a background check. Please visit our website at [www.sihb.org](http://www.sihb.org) for more information, or you can call Human Resources at (206) 324-9360, ext. 1123.

**Primary Care Physicians  
USPHS Claremore Comprehensive Indian Health Facility;  
Claremore, Oklahoma**

The USPHS Claremore Comprehensive Indian Health Facility has openings for full-time positions for an emergency medicine physician, a surgeon, an anesthesiologist (or nurse anesthetist), an OB/GYN physician, and an internal medicine physician.

The Claremore hospital is a 50-bed specialty based comprehensive care facility, providing care through nine organized clinical services: community health, dentistry, optometry, emergency medical services, general surgery, internal medicine, obstetrics and gynecology, pediatrics, and

radiology. In addition, the hospital has a six-bed intensive and coronary care unit and CAT scan equipment with 24 hour teleradiology support. The facility maintains several academic affiliations, and has a professional staff consisting of 36 staff physicians, approximately 60 contract physicians, five dentists, three nurse practitioners, a physician assistant, an optometrist, and an audiologist.

Claremore is a town of 18,000 just 21 miles northeast of the very metropolitan city of Tulsa, with a US Census county population of 560,431. Tulsa has a major airport with international flights and destinations in most major US cities, and was ranked in the top 10 southern cities in Southern Living magazine and Fodor's Travel Publications as one of its outstanding travel destinations. Tulsa's cost of living is 8 percent below the national average and has a county per capita income 11 percent above the national average. If you prefer rural living, there are many opportunities nearby. The facility is located 10 minutes from a major lake, and only one hour from a lake with over 1,100 miles of shoreline.

For more information, contact Paul Mobley, DO at (918)342-6433, or by e-mail at [paul.mobley@ihs.hhs.gov](mailto:paul.mobley@ihs.hhs.gov). CVs may be faxed to (918) 342-6517, Attn: Paul Mobley, DO.

**Family Practice Physician  
Hopi Health Care Center; Polacca, Arizona**

The Hopi Health Care Center currently has openings for family practice physicians and family nurse practitioner or physician assistants. The Hopi Health Care Center is a small, rural IHS hospital providing full spectrum family practice medical services including ambulatory care, adult/peds inpatient care, low risk obstetrics, and ER care. We currently staff for 12 full time physicians, and four full time FNP/PA positions. Our facility is located in northern Arizona, 90 miles northeast of Flagstaff and 70 miles north of Winslow, on the Hopi Indian Reservation. Services are provided to both Hopi and Navajo reservation communities. The reservation is located in the heart of the southwest; within a 90 mile radius are abundant mountain areas, lakes, forests, and archeological sites. The Hopi Health Care Center is a new facility established in 2000 with a full ambulatory care center environment including a dental clinic, physical therapy, optometry, and behavioral health services. We are a designated NHSC site, and qualify for the IHS Loan Repayment Program.

For more information, please contact Darren Vicenti, MD, Clinical Director at (928) 737-6141 or [darren.vicenti@ihs.gov](mailto:darren.vicenti@ihs.gov). CVs can be faxed to (928) 737-6001.

**Family Practice Physician  
Chief Redstone Health Clinic, Fort Peck Service Unit,  
Wolf Point, Montana**

We are announcing a job opportunity for a family practice physician at the Chief Redstone Clinic, Indian Health Service,

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Fort Peck Service Unit in Wolf Point, Montana. This is a unique opportunity for a physician to care for individuals and families, including newborns, their parents, grandparents, and extended family. Applicants must be culturally conscious and work well within a team environment. The Fort Peck Service Unit is located in the northeast corner of Montana along the Missouri river. Fort Peck Service Unit has two primary care clinics, one in the town of Poplar and one in the town of Wolf Point.

Our Medical Staff is composed of five family practice physicians, two internal medicine physicians, one pediatrician, one podiatrist, and four family nurse practitioners/physician assistants. We have a full complement of support services, which include dental, optometry, audiology, psychology, social work, radiology, lab, public health nursing, and a very active Diabetes Department. These are ambulatory clinics; however our providers have privileges in the local community hospital. We have approximately 80,000 patient contacts per year. We work very closely with the private sector. IHS and the private hospital have a cardiac rehabilitation center. By cooperating with IHS, the hospital has been able to get a CT scanner and a mammography unit. Tribal Health has a dialysis unit attached to the Poplar IHS clinic. Customer service is our priority. The IHS has excellent benefits for Civil Service and Commissioned Corps employees. There are loan repayment options, and we are a designated NHSC site. We strive to provide quality care through a strong multidisciplinary team approach; we believe in being closely involved in our population to encourage a "Healthier Community."

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

**Pediatrician  
Family Practice Physician  
Pharmacist  
Obstetrician/Gynecologist  
PHS Indian Hospital; Browning, Montana**

The Blackfeet Service Unit is recruiting for health practitioners who want to join the staff at the PHS Indian Hospital, Browning, Montana. The Blackfeet Service Unit is

home to the Blackfeet Community Hospital, a 27-bed hospital, active outpatient clinic, and well-equipped emergency department. Inpatient care includes obstetrics and elective general surgery. We also offer community health nursing, an active diabetes program, optometry, laboratory, dental, and ENT services along with behavioral and social services and women's health. We are seeking candidates who are committed to improving the health of the local community and being part of a team approach to medicine. The hospital is located 13 miles from Glacier National Park. This area offers spectacular mountains and incredible outdoor activities year round. There are loan repayment options, excellent benefits, and we are a designated NHSC site. If you are interested in joining our medical team, contact Dr. Peter Reuman at [peter.reuman@ihs.gov](mailto:peter.reuman@ihs.gov) or telephone (406) 338-6150; or contact the Physician Recruiter, Audrey Jones, at [audrey.jones@ihs.gov](mailto:audrey.jones@ihs.gov) or telephone (406) 247-7126. We look forward to hearing from interested candidates.

**Family Practice Physician  
Pharmacists  
PHS Indian Hospital, Harlem, Montana**

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

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

There are loan repayment options, excellent benefits, and we are a designated NHSC site. The area is primarily rural, and a friendly small-town atmosphere prevails here. The reservation communities promote various local activities such as rodeos, church socials, and basketball. The tribe also manages its own buffalo herd. Bigger events fill in the calendar as well, such as the Milk River Indian Days, Hays Powwow, and the Chief Joseph Memorial Days, featuring cultural activities and traditional dancing. The Fort Belknap

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Tribe has hunting and fishing available both on and off the reservation. The Little Rocky Mountains and the Missouri River provides scenic and enjoyable areas for the outdoor-minded. If you are interested in joining our medical team, contact Dr. Robert Andrews at [robert.andrews@ihs.gov](mailto:robert.andrews@ihs.gov) or telephone (406) 353-3195; or contact the Physician Recruiter, Audrey Jones, at [audrev.jones@ihs.gov](mailto:audrev.jones@ihs.gov); telephone (406) 247-7126.

### **Family Nurse Practitioner or Physician Assistant Fort Peck Service Unit; Poplar, Montana**

We are announcing a job opportunity for a family nurse practitioner and/or physician assistant at the Verne E Gibbs Health Center in Poplar, Montana and the Chief Redstone Health Clinic, Indian Health Service, Fort Peck Service Unit in Wolf Point, Montana. The Fort Peck Service Unit is located in the northeast corner of Montana along the Missouri river. Fort Peck Service Unit has two primary care clinics, one in the town of Poplar and one in the town of Wolf Point. The Medical Staff is composed of five family practice physicians, two internal medicine physicians, one pediatrician, one podiatrist, and four family nurse practitioners/physician assistants. We have a full complement of support services, which include dental, optometry, audiology, psychology, social work, radiology, lab, public health nursing, and a very active Diabetes Department that includes one nurse educator, one FNP, and one nutritionist. We strive to provide quality care through a strong multidisciplinary team approach; we believe in being involved in the community to encourage a "Healthier Community."

There are many opportunities for recreation, as we are a short distance from the Fort Peck Dam and Reservoir. For more information about our area and community please go to the [website](http://www.ihs.gov/FacilitiesServices/AreaOffices/Billings/FtPeck/index.asp) at <http://www.ihs.gov/FacilitiesServices/AreaOffices/Billings/FtPeck/index.asp>. We are looking for an applicant with well rounded clinical skills. Two years experience is preferred but new graduates are welcome to apply. Northeast Montana offers many amenities one might not expect this far off the beaten path. If you are interested please contact our provider recruiter, CDR Karen Kajiwara-Nelson, MS, CCC-A at (406) 768-3491 or by e-mail at [karen.kajiwara@ihs.gov](mailto:karen.kajiwara@ihs.gov).

### **Family Practice Physicians**

#### **Dentists**

#### **Pharmacists**

### **Crownpoint Comprehensive Healthcare Facility; Crownpoint, New Mexico**

The Crownpoint IHS facility has openings for two family practitioners with low risk obstetric skills (we will consider candidates without OB skills), two pharmacists, and two general dentists. Our service unit follows a family medicine model for providing full-spectrum care to our patients, with a dynamic medical staff that finds the work here quite rewarding. With a high HPSA rating, we are a NHSC-eligible site for

payback and loan repayment.

Crownpoint is a town of about 2,500 people in the Four Corners region of New Mexico. We serve a traditional community of 25,000 Navajo people, many of whom speak only Navajo and live in traditional homes with no running water, electricity, or phone service. Our hospital has a six bed ER, a 17 bed med/peds unit, a labor and delivery/post-partum unit, and a large outpatient clinic. We have a total of 16 dental chairs, optometry, and mental health services, as well as on-site pharmacy, laboratory, radiology, and ultrasonography. Our medical/dental staff is a collegial and supportive group including ten family physicians, two pediatricians, an obstetrician/gynecologist, a psychiatrist, three PAs, three FNPs, four dentists, and a podiatrist. We have a very exciting, full-spectrum medical practice that includes high-risk prenatal care, low-risk labor and delivery, emergency room care with management of trauma and orthopedics, and an interesting inpatient medicine and pediatric service.

As primary care physicians in a rural setting, we manage a wide variety of medical problems. We care for many patients with diabetes and hypertension, but we also see some unusual illnesses such as plague, Hantavirus, and snake bites. There are many opportunities for outpatient and ER procedures including suturing, therapeutic injections, closed reductions of fractures and dislocations, para/thoracentesis, chest tubes, LPs, colposcopy, sigmoidoscopy, and OB ultrasound.

While Crownpoint is small, there is a lot to do in the surrounding area. There are two junior colleges in town where many of us have taken Navajo language, weaving, and history classes. Some have gotten involved with local churches and children's activities. Outdoor activities are plentiful, with downhill and cross-country skiing, camping, and fishing all nearby. There are several excellent mountain biking and hiking trails, as well as Anasazi ruins that are right in Crownpoint. Albuquerque is two hours away and is our nearest large city with an international airport. Other destinations that are within an afternoon's drive include Santa Fe (three hours), Durango and the Rocky Mountains (two hours), Taos (four hours), Southern Utah's Moab and Arches/Canyonlands National Parks (four hours), Flagstaff (three hours) and the Grand Canyon (five hours).

For more information, contact Harry Goldenberg, MD, Clinical Director, at (505)786-5291, ext.46354; e-mail [harry.goldenberg@ihs.gov](mailto:harry.goldenberg@ihs.gov); or Lex Vujan at (505) 786-6241; e-mail [Alexander.vujan@ihs.gov](mailto:Alexander.vujan@ihs.gov).

### **Family Practice Physician Pediatrician**

### **Bristol Bay Area Health Corporation, Dillingham, Alaska**

Bristol Bay Area Health Corporation (BBAHC) is a mature tribal compact located in scenic southwestern Alaska. The Bristol Bay Area Service Unit encompasses 44,000 square miles of Alaska country bordering the Bristol Bay region of the state. Over 400 employees provide primary care to 28 villages

including two sub-regional villages, and a primary care hospital, Kanakanak, located in Dillingham, Alaska. The Medical Staff consists of nine family physicians, a pediatrician, a nurse midwife, four dentists, a physical therapist and an optometrist, all providing primary care. The patient population consists of Yupik Eskimo, Aleut, and Athabascans who have been residents of the area for hundreds of years. Family physicians provide a broad spectrum of practice including obstetrics, inpatient medicine, emergency care and procedures such as colonoscopy, EGD, flexible sigmoidoscopy, colposcopy, and treadmill services in a very collegial and supportive atmosphere. Our solo pediatrician is allowed to practice full spectrum pediatrics with an extremely interesting patient mix and some very high risk and rare genetic disorders unique to this area. The pediatrician works in a collegial manner with family physicians and is not required to perform any adult medicine or obstetrics, but solely pediatrics.

BBAHC was the first hospital in the country to establish a 638 contract and has an extremely good working relationship with their Board of Directors. Of note, the practice here in Alaska is unique, and air travel to outlying villages is required, since continuity care to the villages is very important to our care here and is uniquely rewarding. BBAHC has an extremely competitive salary and benefits package.

If interested, please contact Arnie Loera, MD, Corporate Medical Director, at (907) 842-9218, Kanakanak Hospital/Bristol Bay Area Health Corporation, PO Box 130, Dillingham, Alaska 99576. You may also contact him by e-mail at [aloera@bbahc.org](mailto:aloera@bbahc.org). CVs can be faxed to (907) 842-9250, attn: Arnie Loera, MD. You may also view our website for information about our corporation at [www.bbahc.org](http://www.bbahc.org).

#### **Family Practice Physician Santa Clara Indian Health Service Health Center; Española, New Mexico**

The Santa Clara Indian Health Service Health Center is recruiting for a family practice physician for a full-time position. The medical department is staffed with three providers: one full-time family practice physician, one half-time family practice physician, one half-time internal medicine physician, and one full-time nurse practitioner or one full-time physician assistant position. This ambulatory care clinic is primary care-oriented with outpatient, dental, behavioral health, laboratory, radiology, optometry, psychiatry, podiatry, pediatrics, women's health, and other services. The referral facility is Santa Fe Indian Hospital in Santa Fe, New Mexico, located 30 miles away, from where many of the staff commute.

The Santa Clara Health Center is located in the Pueblo of Santa Clara in Northern New Mexico. This area is renowned for its famous black pottery and Puye cliff dwellings and has outdoor activities including their very own Big Rock Casino and Golf Course, skiing nearby at Santa Fe, Taos, or Angelfire, fishing, river rafting, biking, hiking, rock climbing, feasts, pow-wows, and many others. We are located approximately 80

miles northwest from Albuquerque, the largest city in New Mexico. The University of New Mexico is also located in Albuquerque.

The position is available as either Commissioned Corps or Civil Service (US citizens and Status Candidates). For more information, please contact Bindu Smelser, MD or Chico Livingston MD at Santa Clara Health Center, (505) 753-9421, or apply on the open continuous announcement number AAO-OC-602 to Albuquerque Area Indian Health Service, Division of Human Resources, 5300 Homestead Road, NE, Albuquerque, NM 87110; telephone (505) 248-4510. Contact Raelyn Pecos at (505) 248-4106 or [raelyn.pecos@ihs.gov](mailto:raelyn.pecos@ihs.gov) for a copy of the job announcement, or go to [www.usajobs.gov](http://www.usajobs.gov), USAJOBS control number 806649.

#### **Medical Technologist Tuba City Regional Health Care Corporation; Tuba City, Arizona**

The Tuba City Regional Health Care Corporation, a 73-bed hospital with outpatient clinics serving 70,000 residents of northern Arizona, is recruiting for full-time generalist medical technologists. The laboratory has state-of-the-art equipment. We offer competitive salary, based on experience. Relocation benefits are available. New graduates are encouraged to apply for this position. Tuba City is located on the western part of the Navajo reservation approximately 75 miles north of Flagstaff, Arizona, with opportunities for outdoor recreation and cultural experiences with interesting and adventurous people.

For more information, please contact Minnie Tsingine, Laboratory Supervisor, at (928) 283-2716 or [minnie.tsingine@tcimc.ihs.gov](mailto:minnie.tsingine@tcimc.ihs.gov). For an application, please contact Human Resources at (928) 283-2041/2432 or [mfrancis@tcimc.ihs.gov](mailto:mfrancis@tcimc.ihs.gov).

#### **Family Medicine Physicians Phoenix Indian Medical Center, Phoenix Arizona**

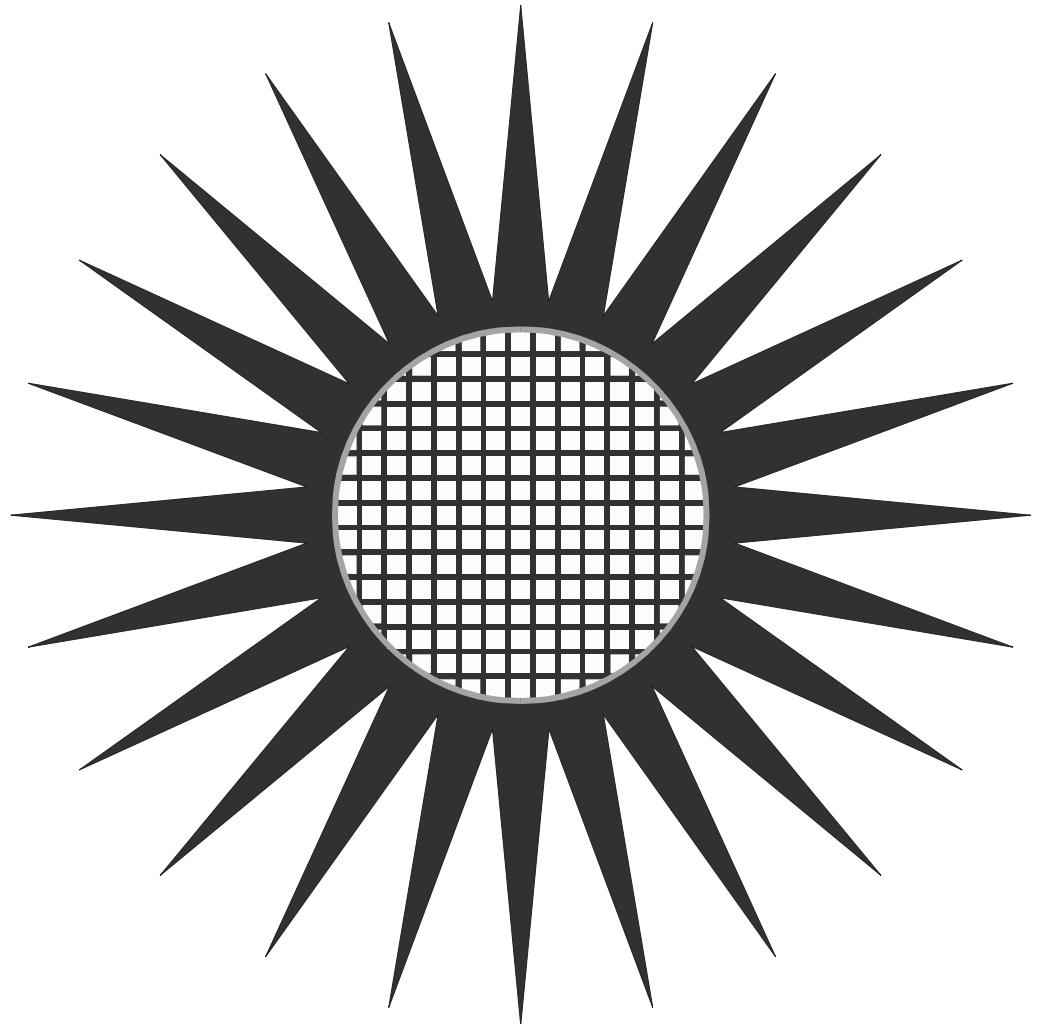
The Family Medicine Department is recruiting for BC/BE family physicians at the Phoenix Indian Medical Center and the satellite clinic at Salt River. The positions are predominantly outpatient with limited hospital inpatient activity; OB optional. Join eight physicians, one nurse practitioner, one physician's assistant, and a number of part-time providers. PIMC is one of the largest IHS sites, with over 100 providers and 70 active beds. We have been using PCC+ and in part EMR. There are great opportunities socially, culturally, professionally, and educationally living in the Phoenix metropolitan area. The IHS has a great benefits package for Civil Service and Commissioned Corps. Loan payback is an option. For more information, please contact/send CV to Eric Ossowski MD, Family Medicine Department, Phoenix Indian Medical Center, 4212 N. 16<sup>th</sup> Street, Phoenix Indian Medical Center, Phoenix, Arizona 85016. Telephone (602) 263-1537; fax (602) 263-1593; or e-mail [eric.ossowski@ihs.gov](mailto:eric.ossowski@ihs.gov).

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

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

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





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

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