



# THE IHS PRIMARY CARE PROVIDER

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



May 2011

Volume 36 Number 5

## A New Age for Elder Care

*Bruce Finke, MD, Eldercare Initiative, Northampton, Massachusetts*

As of the first of this year, Medicare Part B now includes coverage for an annual visit focusing on remaining well rather than treating illness. The Affordable Care Act provides for the Annual Wellness Visit (AWV), including Personalized Prevention Plan Services (PPPS), effective January 1, 2011.<sup>1,2</sup>

It wasn't so very long ago that Medicare only paid for visits associated with illness, and only covered a small handful of preventive care services. That changed with the Medicare Prescription Drug, Improvement, and Modernization Act 2003 (MMA), effective January 1, 2005, which authorized the Initial Preventive Physical Exam (IPPE). This "Welcome to Medicare Visit" is a one time only wellness visit for Medicare Part B beneficiaries, within six months of Medicare eligibility.<sup>3</sup> The MMA also provided coverage for appropriate lipid and diabetes screening tests.<sup>4,5</sup>

The Affordable Care Act takes the next step toward coverage of preventive care services for Medicare beneficiaries with the Annual Wellness Visit as well as 100 percent reimbursement for the Initial Preventive Physical Examination and for those preventive services that are rated with a grade of A or B by the United States Preventive Services Task Force (USPSTF). The list of Medicare-covered preventive care services is now quite extensive, and most of these services require no copayment or deductible.<sup>6</sup>

### *In this Issue...*

- 93 A New Age for Elder Care
- 93 Annual Elders Issue
- 96 HIV Clinical Training Announcement
- 97 GEC Outreach to Tribal Communities in Michigan
- 99 Management of Acute Head Trauma in Rural Locations: University of New Mexico Teleradiology Initiative for Mild Traumatic Brain Injury
- 105 IHS Child Health Notes
- 106 Grants for Health Food Outlets
- 107 Meetings of Interest
- 108 Position Vacancies

## Annual Elders Issue

This May 2011 issue of *The IHS Provider*, published on the occasion of National Older Americans Month, is the sixteenth annual issue dedicated to our elders. We are grateful for the opportunity to honor our elders with a collection of articles devoted to their health and health care. Indian Health Service, tribal, and urban program professionals are encouraged to submit articles for the May 2012 issue on elders. We are also interested in articles written by Indian elders themselves giving their perspective on health care issues. Inquiries can be addressed to the attention of the editor at the address on the back page of this issue.

We wish to express our gratitude for the hard work done by Kay Branch, Elder Care Program Coordinator, Alaska Native Tribal Health Consortium, Anchorage, Alaska, in coordinating the assembly of the fine articles we have included in this issue.

---

The Annual Wellness Visit can be provided by a physician, nurse-practitioner, physician assistant, clinical nurse specialist, or by a team of medical professionals working under the direct supervision of a physician. This is a prevention-oriented visit, and all of the elements of the Annual Wellness Visit will be covered, including the following:

- Vitals with BMI
- Functional status, including basic and advanced activities of daily living
- Assistive devices, support services and suppliers, including family caregivers
- Medical history
  - Hospitalizations
  - Surgeries
  - Injuries
  - Rehabilitation or nursing home stays
- Relevant family history
- Allergies
- Medication review and reconciliation
- Screening
  - Depression (PHQ 2 and PHQ 9)
  - Alcohol and Drug Use
  - Hearing impairment (with a whisper test or questions)
  - Fall risk
  - Home safety (either through a referral for a home visit or with counseling and educational material)
  - Assessment for cognitive impairment, by testing, observation, and report of patient, family, and caregiver
- Plan of Care (Problem List), including:
  - Preventive care screening plan: a written screening schedule tailored to the health and needs of the individual, with a checklist of appropriate preventive services for the next 5 to 10 years
  - Health risks identified and a plan for action
  - Chronic conditions
  - Discussion of any advance directives or preferences for care that the elder may have
- Education, counseling, and referrals as appropriate.

This is a visit designed for the era of the electronic health record. IHS and tribal sites have already begun to design templates to assist in completion of the Annual Wellness Visit. The EHR also supports a team approach to this visit, with clerical staff and nursing taking on much of the visit content and pharmacy managing the medication review and reconciliation.

It is true that not all IHS or tribal programs bill Medicare B (hospital-based clinics usually bill using the all-inclusive rate under Medicare A). It is also true that many patients over 65 do not have Medicare Part B. Nonetheless, many of the elders we serve will have Medicare Part B coverage, and all of

the elders we care for will benefit from an annual comprehensive visit aimed at maintaining their health and wellness. A Clinical Reporting System (CRS) measure being prepared for CRS v.11.1 will allow you to identify how many of your patients age 65 and older have received an Annual Wellness Visit.

The HCPCS billing codes for the Annual Wellness Visit are:

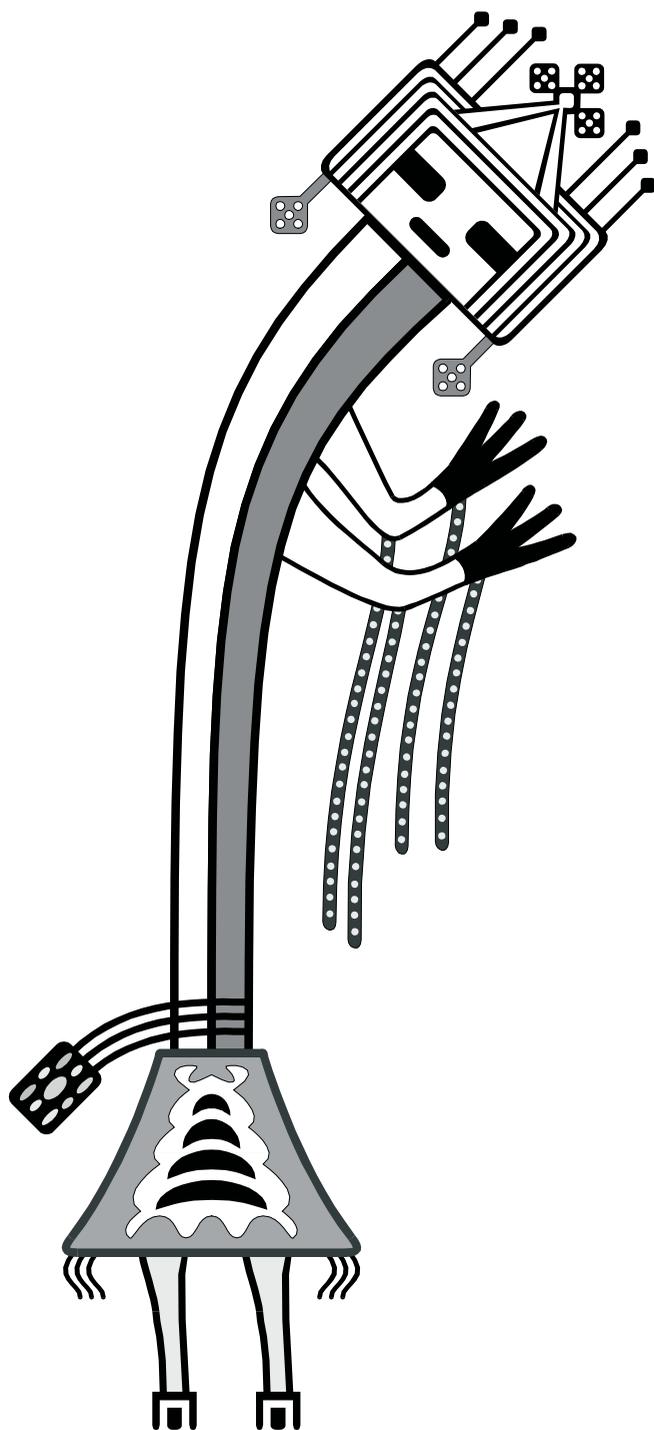
- G0438—Annual wellness visit, includes a personalized prevention plan of service (PPPS), first visit. Short descriptor—Annual wellness first.
- G0439—Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit. Short descriptor—Annual wellness subseq

Review these billing codes with your business office and make use of Medicare guidance and the guidance of your Medicare fiscal intermediary.<sup>2</sup>

In our care for older adults we aim to help them maintain health, function, and the ability to play a vital role in the life of their family, community, tribe, and culture. An annual comprehensive, wellness-oriented visit is central to that aim. With the new Annual Wellness Visit, Medicare now recognizes this and reimburses it. It's our job to make it happen. It's a new age for elder care.

## References

1. MLN Matters® Number: MM7079. Annual Wellness Visit (AWV), Including Personalized Prevention Plan Services (PPPS). <http://www4.cms.gov/MLNMattersArticles/downloads/MM7079.pdf>
2. Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services. 280.5 – Annual Wellness Visit (AWV) Including Personalized Prevention Plan Services (PPPS) (Rev. 134, Issued: 12-03-10, Effective: 01-01-11, Implementation: 04-04-11). <http://www.cms.gov/Transmittals/downloads/R134BP.pdf>
3. [https://www.cms.gov/MLNProducts/downloads/MPS\\_QRI\\_IPPE001a.pdf](https://www.cms.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf)
4. MLN Matters® Number: MM3411. MMA-Cardiovascular Screening Blood Tests. <http://www4.cms.gov/MLNMattersArticles/downloads/MM3411.pdf>
5. MLN Matters® Number: MM3637. MMA-Diabetes Screening Test. <http://www4.cms.gov/MLNMattersArticles/downloads/MM3637.pdf>
6. MLN Matters® Number: MM7012. Waiver of Coinsurance and Deductible for Preventive Services, Section 4104 of The Affordable Care Act, Removal of Barriers to Preventive Services in Medicare. <http://www4.cms.gov/MLNMattersArticles/downloads/MM7012.pdf>



**The following preventive services are covered by Medicare when clinically appropriate:<sup>1</sup>**

- Pneumococcal, influenza, and hepatitis B vaccine and administration
- Screening mammography
- Screening pap smear and screening pelvic examination
- Prostate cancer screening tests
- Colorectal cancer screening tests
- Diabetes Outpatient Self-Management Training (DSMT)
- Bone mass measurement
- Screening for glaucoma
- Medical Nutrition Therapy (MNT) services
- Cardiovascular screening blood test
- Diabetes screening tests
- Ultrasound screening for abdominal aortic aneurysm (AAA) for men age 65 - 75 who have ever smoked
- Additional preventive services (identified for coverage through the National Coverage Determination (NCD) process. Currently, these are limited to Human Immunodeficiency Virus (HIV) testing).

**Additional notes:**

1. The deductible and coinsurance/copayment are waived for those preventive services listed above that have a recommendation grade of A or B by the United States Preventive Services Task Force (USPSTF). Digital rectal examinations provided as prostate screening tests, glaucoma screening, DSMT services, and barium enemas provided as colorectal cancer screening tests are covered Preventive Services but do not carry a USPSTF grade A or B recommendation.<sup>2</sup>
2. The USPSTF recommends against prostate cancer screening in men age 75 and older.<sup>3</sup>

**References**

1. MLN Matters® Number: MM7012. Waiver of Coinsurance and Deductible for Preventive Services, Section 4104 of The Affordable Care Act, Removal of Barriers to Preventive Services in Medicare. <http://www4.cms.gov/MLNMattersArticles/downloads/MM7012.pdf>
2. USPSTF A and B Recommendations are found at <http://www.uspreventiveservicestaskforce.org/uspstf/uspabrecs.htm>
3. USPSTF Prostate Cancer Screening Recommendations are found at: <http://www.uspreventiveservicestaskforce.org/uspstf/uspSprca.htm>

# HIV CLINICAL TRAINING

A three-day intensive training  
designed for individuals working with  
American Indians/Alaskan Natives

*www.mpaetc.org*

Training is individualized to meet your professional learning goals, practice needs, and interests!

## WHO CAN COME?

Community Health Workers, RNs, Social Workers, ANPs, MDs, Dentists, Dental Hygienists, Pharmacists, and PAs

## DATES and LOCATION:

June 7-10, Denver, CO

## OBJECTIVES:

- Learn how to perform HIV risk assessments and provide information on risk reduction and recommendations regarding HIV testing
- Conduct risk assessment, initial evaluation and follow-up of patients in early stages of HIV infection
- Recognize and treat early symptoms and common manifestations of HIV infection

## REGISTRATION:

Applications can be downloaded at *http://www.mpaetc.org*

## QUESTIONS?

E-mail Whitney at *whitney.starr@ucdenver.edu*



---

# GEC Outreach to Tribal Communities in Michigan

---

*Emily Proctor, MSW, Tribal Extension Educator, Improving Health and Nutrition Institute, Greening Michigan Institute, Emmet County-Michigan State University Extension, Harbor Springs, Michigan*

---

The Northern Lower Michigan Geriatric Education Team began with many members in a large geographic area of Northern Michigan, and included the following organizations: The Alzheimer's Association, Michigan State University Extension Educators, county workers, Commission on Aging, Area Agency on Aging, Grand Traverse Band of Ottawa and Chippewa Indians tribal members and leadership, independent business owners who provide and train direct care workers, a primary care nurse, a tribal nurse, and a Michigan State University faculty physician. This large group met for many months discussing connections, common program development, needs for education in the area, and the needs of geriatric clients.

The team evolved into a core group that has been dedicated to the project for nearly three years now. These professionals have donated their time for the most part. The core team is now comprised of a family physician, a family nurse practitioner, a master's level social worker who serves as a MSU Extension tribal educator (and who is a member of a northern Michigan tribal community), and two Extension educators in northern Michigan counties who are gerontologists who deliver and evaluate health programs.

The Geriatric Education Center of Michigan (GECM) at MSU is a federally funded consortium that includes many of Michigan's universities and colleges, public health institutions, community health entities, local area agencies on aging, and regional health systems and hospitals. The mission of the GECM is to advance geriatric education within Michigan. The GECM initiatives are intended to strengthen geriatric care in medically underserved communities and to improve the organization and delivery of unique services for older adults. The team has a special interest in and commitment to the education of tribal communities regarding elder health and well-being. Initially, the team participated in and completed the "Train the Trainer" curriculum consisting of 24 hours of didactics. A community needs assessment process helped identify a focus.

This core group has continued to receive training in geriatric care from the GECM and has launched educational outreach, and facilitated and provided all of the training sessions relying upon the core group expertise. Previous

members and the extended contacts have opened up a wide, interconnected base of expertise within the focus area. Initially the team decided to focus on the early identification of dementia in the primary care setting, which included objectives for every member of the clinical team. The goal was to train the staff at a primary care clinic on functional assessment, quality improvement strategies, and some pertinent electives, so that the whole staff would speak the same language and implement tools to assess a patient's function. By identifying concerns, earlier diagnosis and intervention may help maintain a geriatric patient's abilities to remain independent.

We identified two possible clinics for this project: 1) the Munson Family Practice Residency Clinic comprised of an MSU-affiliated residency program training 18 residents in a combined MD/DO program, and 2) the Grand Traverse Band Medicine Lodge, a tribal health care clinic serving tribal members. Because of the tribal associations of the team's physician and Tribal Extension Educator/MSW, as well as a sharp spike in relatively new diagnoses of dementia in tribal communities, it was decided to develop a working relationship with a tribal community first as a pilot project, which could then expand into other primary care clinics. Meeting with the Munson Geriatric Assessment team confirmed our belief that the need was much greater than they could handle and that education of the professionals regarding geriatric care was imperative.

The process of team formation and evolution entailed about 10 months of three-hour meetings and training sessions. We started the process of relationship building that is necessary in order to be accepted by a tribal community, such as building on past relationships, frequent visits to discuss the project casually as well as at formal meetings, frequent interactions via e-mail or phone, and being present at tribal functions such as the Health Fair. We were able to gain legitimacy in this way, which led to future opportunities to reach more tribal communities.

We provided training internally to gain greater awareness of the local tribal communities' needs, and did self-reflection on our motives for working within the scope of our team goals and focus. We worked with key tribal participants on sharing our experiences, developing relationships and trust, and creating a culturally sensitive curriculum to promote optimal aging.

Cultural issues and values must be understood when working with tribal communities to improve elder health. The initial presentation of the project to tribal health leadership

---

took place almost a full 18 months preceding the initial training session. Even given the previous eight-year relationship with the team member who served as tribal physician, it took over 14 meetings, interactions, and trips to the reservation, and countless hours, phone calls, and e-mails.

We were striving to be a presence but not a bother. We did not go away but kept a low profile at many tribal events, and even elders luncheons. Often it was casual “visiting,” but business would get it done. It helped enormously to have a member of another tribe and a previous GTB tribal physician on the team. It promoted cultural sensitivity and working relationships. The exchange of gifts is also important as a sign of friendship and honor. It is also important to allow time for participants to share their stories.

The results of the evaluation of the 12-hour training confirmed that the content was appropriate and relevant to

scope of practice, educational level, experience, and licensure level. Although many of these presentations did not meet grant requirements, they were integral to the building of relationships and legitimacy over a span of time. As the relationship developed in Michigan tribal communities, the team was asked to participate in many other events, which included GTB health fairs and the National Indian Council on Aging Conference.

One can understand the difficulty of outside agencies gaining access to tribal communities, which requires time, establishment of relationships and trust, and persistence. The team is now in the process of training other northern Michigan tribal communities in the core curriculum of geriatrics in preparation for an intertribal conference on key elder issues such as elder abuse, long term care, and chronic disease self-management programs.

---

## Electronic Subscription Available

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

follow the instruction to click on the link indicated. You will receive a second e-mail from LISTSERV.IHS.GOV confirming you are subscribed to *The Provider* listserv.

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

---

# Management of Acute Head Trauma in Rural Locations: University of New Mexico Teleradiology Initiative for Mild Traumatic Brain Injury

---

*Elizabeth Holguin, MSN, MPH, FNP-BC; Martina Stippler, MD, MSc; and Howard Yonas, MD, all from the University of New Mexico School of Medicine Department of Neurological Surgery, Albuquerque, New Mexico; and David Boyd, MDCM, FACS, Indian Health Service Emergency Services, Rockville, Maryland*

---

## Abstract

**Background:** The University of New Mexico Hospital (UNMH) is the only Level 1 trauma center in the state of New Mexico with dedicated traumatic brain injury (TBI) care. Here we report our experience with triaging acute mild head trauma in rural locations with teleradiology.

**Methods:** Utilization of teleradiology from January 2010 to January 2011 was assessed by reviewing all head CT scans uploaded to the Online Medical Consultant System®.

**Results:** Between January 2010 and January 2011, 87 head CT scans were uploaded on to the Online Medical Consultant System® for review by a neurosurgeon at UNMH. Forty five head CT scans showed pathologies like stroke, tumor, and others. The remaining 42 patients were diagnosed with TBI. Of these, eleven head CT scans were negative. The pathology in the remaining 31 TBI scans was as follows: epidural hematoma, (n = 3), subdural hematoma (n = 14), subarachnoid hemorrhage (n = 14), contusion (n = 5), intraparenchymal bleed (n = 3), intraventricular bleed (n = 1), and skull fracture with pneumocephalus (n = 1). Of these 31 scans described, 48 % (n = 15) of patients were treated locally and 52% (n = 16) were transferred to UNMH or elsewhere.

**Conclusion:** Teleradiology is feasible in rural areas to facilitate triage of patients with mTBI but is currently underutilized.

## Introduction

The University of New Mexico Hospital (UNMH) is the only Level 1 trauma center in the state of New Mexico with dedicated traumatic brain injury (TBI) care. A combination of factors has led to a decrease in availability of neurosurgical coverage in rural community hospital emergency departments.

This has placed an increased burden on neurosurgical departments at academic centers.<sup>1</sup> Since available resources are limited, admissions and transfers to the UNM Neurosurgical unit need to be triaged according to their severity. In an effort to provide safe management and quality care for the mild traumatic brain injury (mTBI) patients at a local level, a teleradiology system has been implemented through collaboration between the Indian Health Service (IHS) and the UNMH.

Transfers of complicated mTBI patients without risk factors to a higher level of care due to unavailability of phone consultation and underutilization of teleradiology, as well as the reluctance to care for complicated mTBI locally, has become evident in the past few years. It has been shown that patients with mTBI, with a lesion on the initial head CT scan that does not require immediate intervention, can safely be observed at a peripheral hospital without neurosurgical coverage.<sup>2</sup> The need for and timing of repeat imaging, as well as the length of the observation period, remains controversial.<sup>3</sup> Because of inexperience in the treatment of patients with TBI, as well as concerns about potential litigation, patients are frequently transferred. These avoidable transfers have been found to be not only very cost-intensive, but also utilize sparse resources, and are often not in the best interest of the patients themselves.<sup>4</sup> Teleradiology can enhance and facilitate medical collaboration and should be encouraged.<sup>5</sup> Teleradiology consultation with a neurosurgeon has been demonstrated to be a safe way to manage complicated mTBI patients locally<sup>6-7</sup> and can help to avoid unnecessary transfers or delays of transport for critically ill patients.<sup>5</sup> In addition, the reliability and completeness of information received from referral hospitals with teleradiology can aid in the effective triage of patients.<sup>6</sup>

Here we report our experience with the implementation of a teleradiology system in cooperation with the IHS and UNMH in order to improve TBI care in rural New Mexico.

## Methods

The technology that is used for the transfer of images is Online Medical Consultant System® (IMedCon). It is a secure,

HIPAA compliant, web-based solution used to enhance the quality of neurosurgery, trauma, cardiology, general surgery, and pediatric referrals, transports, and consultations.<sup>8</sup> IMedCon is structured to be compatible with PACS systems. IMedCon is designed to allow referring hospitals from remote areas to transmit medical brain and spine images (CT, MRI, Ultrasounds, X-ray, etc.) to be reviewed for potential transport to a trauma center.<sup>8</sup> Using these images, along with critical patient information, neurosurgery specialists can make appropriate decisions regarding patient transfer, stabilization, and other management recommendations.

### Results

Between January 2010 and January 2011, 87 head CT scans were transmitted using the Online Medical Consultant System® for review by a neurosurgeon at the UNMH. Forty-five head CT scans showed pathologies such as stroke, tumor, and others. Forty two patients had a diagnosis pertaining to TBI at the local hospital, and telephone neurosurgery consultation supplemented by teleradiology was obtained. Eleven of these 42 head CT scans were negative. The remaining 31 patients had pathologies that included epidural hematoma, (n = 3), subdural hematoma (n = 14), subarachnoid hemorrhage (n = 14), contusion (n = 5), intraparenchymal bleed (n = 3), intraventricular bleed (n = 1), and skull fracture with pneumocephalus (n = 1). It should be noted that some patients had more than one type of TBI. Of the 31 scans reviewed, 48% (n = 15) patients were treated locally and 52% (n = 16) were transferred to the UNMH or elsewhere (see Figure 1).

### Discussion

A recent article published by the University of New Mexico found that the need for surgical intervention in all patients transferred for mTBI was very low (1.4%; see Figure

2).<sup>9</sup> Although 5 - 13% of patients with a Glasgow Coma Scale (GCS) score of 15 will have a traumatic lesion on their head CT,<sup>10-12</sup> fewer than 1% will require neurosurgical intervention.<sup>13-14</sup> The need for routine repeat head CT,<sup>15-16</sup> or even the need for neurosurgical consultation<sup>17</sup> is questionable for patients with mTBI, as emphasis is increasingly placed on cost efficiency in medicine.

The Alaska Trauma Systems Review Committee met in 2003 to develop recommendations pertaining to the evaluation of head injured patients in remote and rural locations.<sup>18</sup> Due to the similarity in circumstances of centralized neurosurgical care with non-trauma centers in rural areas in New Mexico, we have adapted an algorithm based on the Alaska Guidelines for management of acute mTBI (Figure 3).

Similar guidelines have been efficacious elsewhere. Regional guidelines that were adopted in Italy stipulate care of comatose and non-comatose patients, patients with clinical deterioration, patients with open head injury, and mild head injuries. Teleradiology is an integral part of this triage algorithm, and for patient evaluation for possible transfer. Image transfer systems are in widespread use, in Europe especially, and have been successful in other conditions, for example in stroke.<sup>19</sup> Teleradiology helps to address the shortage of neurosurgical coverage and the need to triage patients because of limited resources.<sup>4,20-22</sup> One group in Italy found that only 23% of patients (with a mean GCS score of 11) who had images sent on a teleradiology system required transfer after the initial CT images were sent, and only 5% after follow-up CT.<sup>23</sup> A Level 2 trauma center in Israel found that with the implementation of teleradiology, 40% of patients with TBI were successfully treated at their facility, with only two patients requiring delayed transfer to a Level 1 center.<sup>24</sup> A recent evaluation of transfers in Germany showed that after image transfer, patient transfer was deemed unnecessary in 67% of potential neurosurgical cases, and the cost of the

**Figure 1. TBI pathology reviewed with teleradiology**

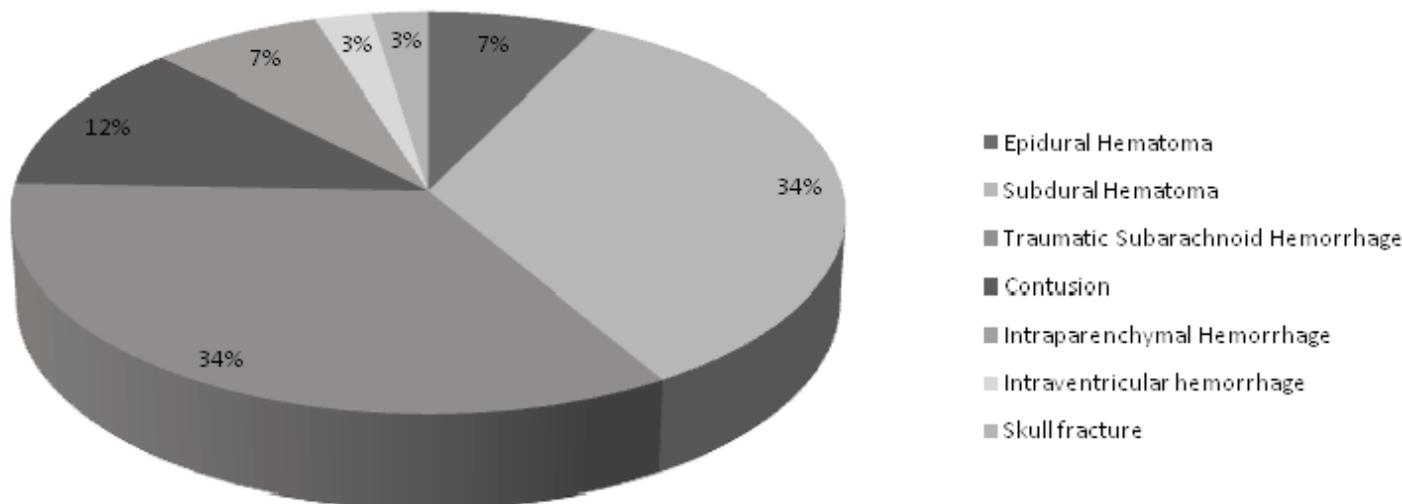
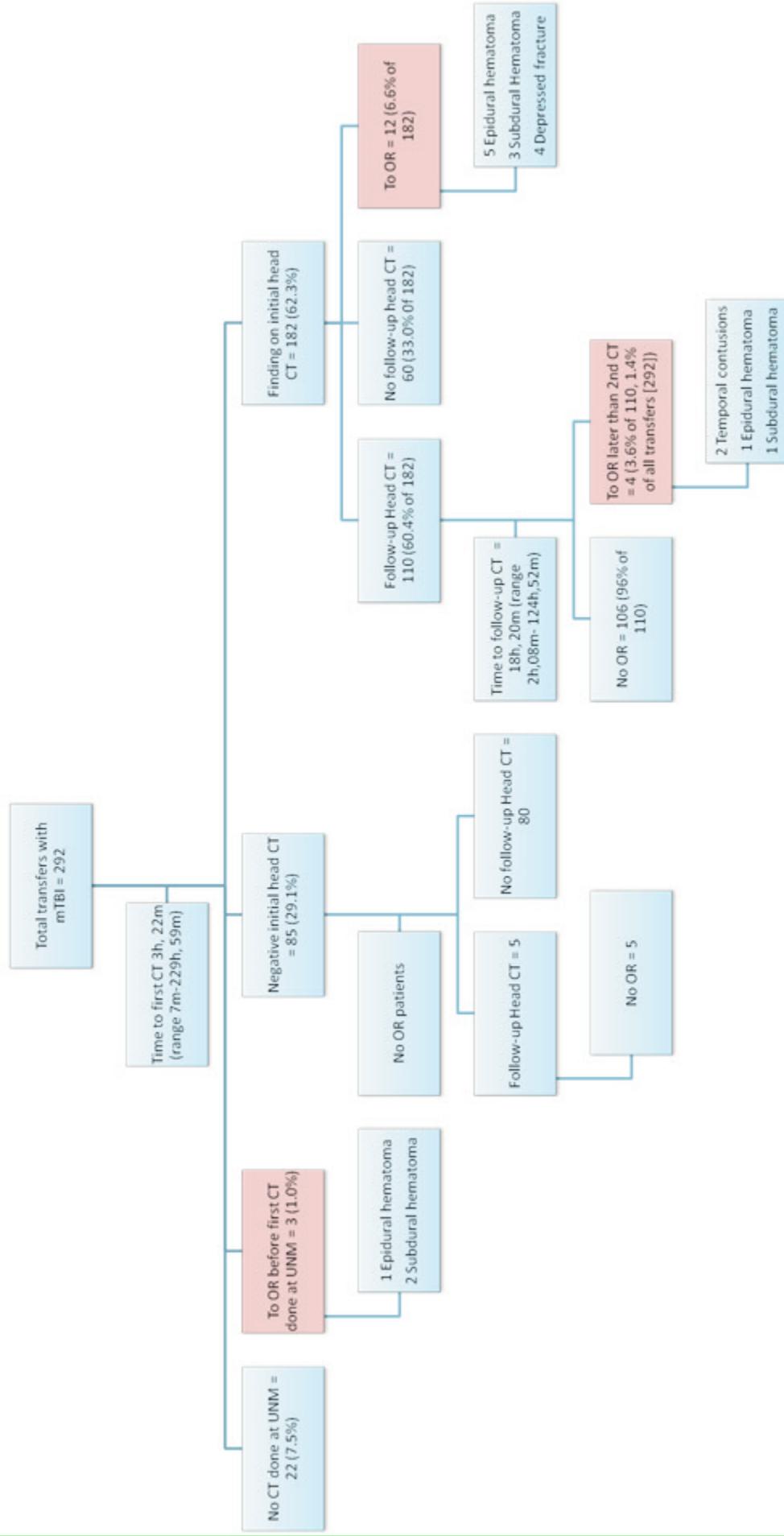
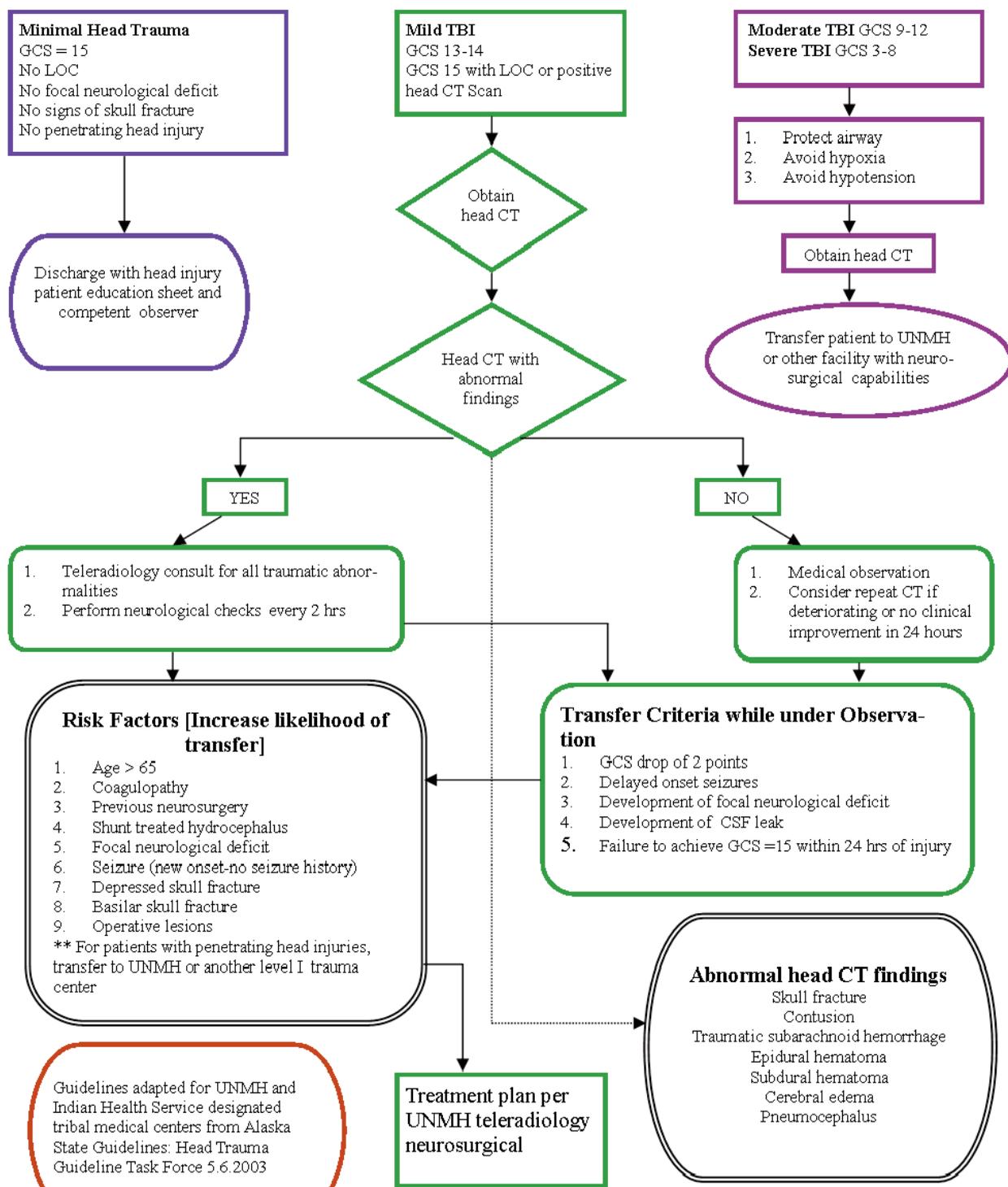


Figure 2. Summary and hospital course of mTBI patients transferred to UNMH



**Figure 3. Algorithm for Management of Acute Head Trauma in Remote and Rural Areas of New Mexico**

Management of Acute Head Trauma in Remote and Rural Locations  
University of New Mexico  
Teleradiology Initiative for Mild Traumatic Brain Injury



teleradiology system was amortized in 15 months of use due to the cost savings.<sup>25</sup>

A study performed in Israel by Klein et al compared three decision making models regarding patient transfer to a neurological center. Patients with intracranial bleeding and a GCS score > 12 were included. The three models were 1) mandatory transfer, 2) telemedicine-based consultation with a remote neurosurgeon, and 3) clinical-radiologic algorithm-based guidelines. All patients from group 1 were transferred to a neurosurgical center while 58% of patients from group 2 and 26% of patients from group 3 were treated in the primary center despite a positive head CT. None of the patients required delayed neurosurgical intervention.<sup>26</sup>

There are several reasons for the underutilization of telemedicine, such as training requirements of staff, possible legal implications, slow Internet connections, ongoing costs, and reimbursement limitations.<sup>27</sup> The Northwest Regional Telehealth Resource Center reasons that expanding existing telehealth network infrastructures will improve care, particularly in remote and rural areas.<sup>27</sup>

The underutilization of teleradiology in IHS facilities in New Mexico is multifactorial. There is a need for CT installation in two locations; IMedCon software installation is needed in five out of seven locations, and there is a pressing need for an educational curriculum for all staff involved in caring for mTBI patients. Byrnes et al found that an outreach program to rural hospitals can provide continuing education in the care of patients and foster process improvements at referring hospitals.<sup>28</sup>

In an effort to improve quality of care for complicated mTBI patients in rural areas, a teleradiology system has been implemented in the IHS health care system in cooperation with UNMH. We have presented our preliminary data to demonstrate that teleradiology is feasible in New Mexico for complicated mTBI. We hope to prove in the near future that mTBI can be safely and effectively managed at local health care facilities in New Mexico.

### Acknowledgements

We wish to recognize Elizabeth Holguin and Martina Stippler for their data collection, research, manuscript preparation, and editing; and David Boyd and Howard Yonas for creating the overall concept for this project. No competing financial interests exist.

### References

1. Byrne RW BB, Slavin KV, Curry D, et al. Neurosurgical emergency transfers to academic centers in Cook County: a prospective multicenter study. *Neurosurgery*. 2008;62(3):709-716.
2. Fabbri A SF, Marchesini G, Stein SC, Vandelli A. Observational approach to subjects with mild-to-moderate head injury and initial non-neurosurgical lesions. *J Neurol Neurosurg Psychiatry*. 2008;79(10):1180-1185.
3. Jagoda AS BJ, Bruns JJ, Jr., Cantrill SV, et al. Clinical policy: neuroimaging and decisionmaking in adult mild traumatic brain injury in the acute setting. *Ann Emerg Med*. 2008;35(2):e5-40.
4. Schulmeyer FJ BA. Telemedicine in neurosurgical daily practice. *Stud Health Technol Inform*. 1999;64:115-118.
5. Bruder N. Transfer of emergency neurosurgical patients: when and how? *Ann. Fr. Anesth. Reanim*. 2007;26:873-877.
6. Iaccarino C RA, Compagnone C, Tagliaferri F, Servadei F. Teleradiology for traumatic brain injury management. *Teleradiology*. 2008:181-202.
7. Fainardi E CA, Antonelli V, Fagioli L, Servadei F. Time course of CT evolution in traumatic subarachnoid hemorrhage: a study of 141 patients. *Acta Neurochir (Wien)*. 2004;146:257-263; discussion 263.
8. Govaltski R. IMedCon. 2008; New Mexico Software. Available at: [www.nmxs.com](http://www.nmxs.com). Accessed November 18, 2010.
9. Carlson AP RP, Kennedy G, McLean AR, et al. Low rate of delayed deterioration requiring surgical treatment in patients transferred to a tertiary care center for mild traumatic brain injury. *Neurosurg Focus*. 2010;29(5:E3).
10. Harad FT KM. Inadequacy of bedside clinical indicators in indentifying significant intracranial injury in trauma patients. *J Trauma*. 1992;32(359-363).
11. Hofman PA NP, Kemerink GJ, Wilmlink JT. Value of radiological diagnosis of skull fracture in the management of mild head injury: meta-analysis. *J Neurol Neurosurg Psychiatry*. 2000;68:416-422.
12. Nagy KK JK, Krosner SM, Roberts RR, et al. The utility of head computed tomography after minimal head injury. *J Trauma*. 1999;46:268-270.
13. Jeret JS MM, Anziska B, Lipitz M, et al. Clinical predictors of abnormality disclosed by computed tomography after mild head trauma. *Neurosurgery*. 1993 1993;32:9-16.
14. Miller EC DR, Kinser D. Minor head trauma: is computed tomography always necessary? *Ann Emerg Med*. 1996;27:290-294.
15. βVelmahos GC GA, Petrovick L, Dorer DJ, et al. . Routine repeat head CT for minimal head injury is unnecessary. *J Trauma*. 2006;60:494-501.
16. Wang MC LK, Tirschwell DL, Hollingworth W. Utility of repeat head computed tomography after blunt head trauma: a systematic review. *J Trauma*. 2006;61:226-233.
17. Huynh T, Jacobs D, Dix S, et al. Utility of

- Neurosurgical consultation for mild traumatic brain injury. *The American Surgeon*. 2006;72(12):1162-1165.
18. Sacco F, Zafren K, Brown K, et al. Guidelines for the management of head injuries in remote and rural Alaska. February 2003.
  19. Smith EE DP, Prvu-Bettger J, Abdullah AR, et al. Stroke center designation can be achieved by small hospitals: the Massachusetts experience. *Crit Pathw Cardiol*. 2008;7:173-177.
  20. Urban V BC, Huwel N, Perneczky A. Teleconsultation: a new neurosurgical image transfer system for daily routine and emergency cases- a four-year study. *Eur J Emerg Med*. 1996;3:5-8.
  21. Gray WP SJ, Buckley TF. Report of a national neurosurgical emergency teleconsulting system. *Neurosurgery*. 1998;42:103-108.
  22. Houkin K FS, Selladurai BM, Zurin AA, et al. Telemedicine in neurosurgery using international digital telephone services between Japan and Malaysia - technical note. *Neurol Med Chir (Tokyo)*. 1999;39:773-778.
  23. Servadei VA, Mastrilli F, Cultrera M, et al. Integration of image transmission into a protocol for head injury management: a preliminary report. *British Journal of Neurosurgery*. 2002;16(1):36-42.
  24. Ashkenazi I HJ, Alfici R, Kessel B, et al. Effect of teleradiology upon pattern of transfer of head injured patients from a rural general hospital to a neurosurgical referral centre. *Emerg Med J*. 2007;24:550-552.
  25. Kreutzer J AH, Fahlbusch R, Buchfelder M, Nimsky C. Teleradiology in neurosurgery: experience in 1024 cases. *J Telemed Telecare*. 2008;14:67-70.
  26. Klein Y DV, Jaffe D, Simon D, et al. Management of patients with traumatic intracranial injury in hospitals without neurosurgical service. *Journal of Trauma Injury Infection and Critical Care*. 2010;69(3):544-548.
  27. Thielst CB. *The Crossroads of Telehealth, Electronic Health Records & Health Information Exchange: Planning for Rural Communities: The Northwest Regional Telehealth Resource Center*;2010.
  28. Byrnes MC IE, Becker L, Thorson M, et al. A trauma outreach program provided by a level I trauma center is an effective way to initiate peer review at referring hospitals and foster process improvements. *Journal of Trauma Injury Infection and Critical Care*. 2010;68(4):778-782.



---

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](mailto:sholve@tcimc.ihs.gov).

## IHS Child Health Notes

### Something of Interest – Free Money

I want to use this month’s space to make you aware of a unique and time-limited funding opportunity for federal/tribal/urban programs that serve AI/AN children. The American Academy of Pediatrics (AAP) is accepting submissions for its 18th annual Community Access to Child Health (CATCH) Planning. The grant cycle began on May 2, 2011, and the deadline is July 29 of this year.

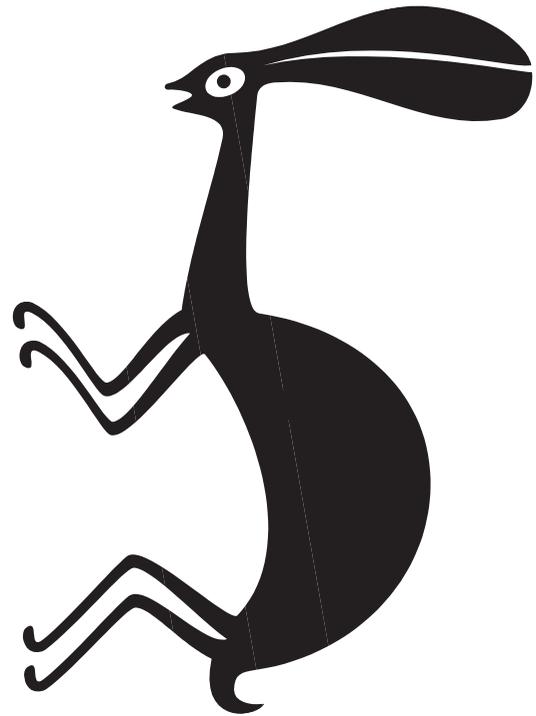
Grants of up to \$12,000 will be awarded on a competitive basis to pediatricians to plan innovative community-based child health initiatives that will ensure all children, especially underserved children, have medical homes and access to health care services. Priority is given to projects that will be serving communities with the greatest health disparities. A pediatrician must be involved in proposal development and project activities.

This grant cycle includes a special call for projects that focus on American Indian/Alaska Native children. The AAP Committee on Native American Child Health has provided funding to guarantee that at least one AI/AN project will be awarded a grant each year for the next five years. This special funding significantly increases the odds that your AI/AN project will be selected.

Family and community physicians who serve AI/AN children may apply but they must have a partnership with a pediatrician. It is also important to note that the Indian Health Service manual specifies that local clinics and hospitals may accept grants of this size with the approval of their local CEO. No approval by the Area Office or national headquarters is required.

Applicants are strongly encouraged to contact the CATCH staff with questions about proposal development. Application and budget review are also available from CATCH staff at [catch@aap.org](mailto:catch@aap.org), or call (800) 433-9016, ext 4916 or (847) 434-4916. Technical assistance publications, including *A Pediatrician’s Guide to Proposal Writing* are available at [www.aap.org/commpeds/resources/grant\\_writing.html](http://www.aap.org/commpeds/resources/grant_writing.html). To view descriptions of previously awarded CATCH grants, visit [www.aap.org/commpeds/grantsdatabase](http://www.aap.org/commpeds/grantsdatabase). Please note that selection criteria may change from year to year.

For more information or to apply for a grant, visit [www.aap.org/catch/planninggrants.htm](http://www.aap.org/catch/planninggrants.htm) or e-mail [catch@aap.org](mailto:catch@aap.org), or call (800) 433-9016, ext 4916. Applications will be available online only.



---

---

# Grants for Health Food Outlets

---

*The following notice was relayed to us by Marybeth Martin, Administrative Assistant, Northern Plains Health Promotion Programs, Great Plains Tribal Chairmen's Health Board, Rapid City, South Dakota. We are grateful to her for sharing this.*

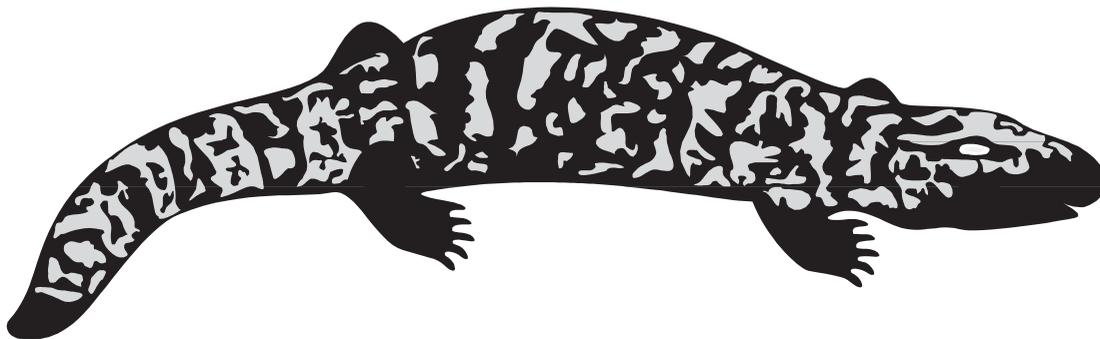
---

The US federal government is requesting proposals for Healthy Food Financing Initiative (HFFI) grants and loans to help open new fresh food outlets—supermarkets, farmers' markets, and expanded convenience stores—in low-income and underserved communities. Ten million dollars will be available from the Department of Health and Human Services for the program.

This exciting development was also made possible through years of policy work and advocacy from equity advocates nationwide, starting with community leaders who have pushed for decades for access to healthy food in low-income communities and communities of color. The federal effort is modeled on a successful and proven program in

Pennsylvania that has already helped create or expand 88 fresh food outlets, create or retain more than 5,000 jobs, and bring healthy food access to 400,000 residents who didn't have access before. Leaders in Congress and the Obama administration clearly listened to the voices of residents, grocers, health experts, economists, and other community leaders forging a chorus in support of HFFI.

The funding announcement is available here: <http://1.usa.gov/12pNvn>. A webinar for prospective applicants will be available beginning on May 27, 2011 at 2 pm EST. Note, the webinar will be available until the closing of the announcement and can be accessed anytime after May 27. Applicants interested in accessing the webinar should register at the following website: <http://bit.ly/jyGFar>, exit disclaimer and follow links to the "Registration" tab on the upper right hand corner of the website. A confirmation e-mail, which will include the instructions on accessing the webinar, will be sent to applicants to confirm their registration.



---

## MEETINGS OF INTEREST

### Advancements in Diabetes Seminars

#### Monthly; WebEx

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

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

#### Available EHR Courses

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

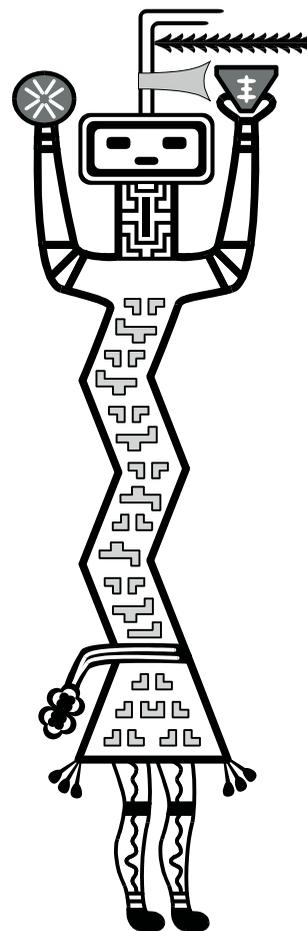
### 2011 Native Fitness Training and 14th Annual Native Diabetes Prevention Conference June 12 – 17, 2011; Santa Fe, New Mexico

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

Falling just before the conference, the Native Fitness Training will be held June 12 – 14, 2011, offering 1.6 CEUs

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

Please visit our conference webpage for more information or to register online: <http://aii.ou.edu/conferencetrainings/>.



---

## POSITION VACANCIES

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

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

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

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

Yellowhawk Tribal Health Center houses a fully accredited, primary care medical facility located on the Confederated Tribes of the Umatilla Indian Reservation. We are looking for a highly motivated, dedicated clinical director to join our already established two-provider practice. We offer excellent hours in a team environment, a well-funded and well-equipped clinic, a competitive salary, and an outstanding

benefits package with relocation assistance, and signing bonus. Yellowhawk is located 10 minutes from Pendleton, Oregon, in the foothills of the beautiful Blue Mountains. Come and experience our culture and a rewarding practice where the focus is on quality patient care. Please contact Janyce Quaempts at YTHC, PO Box 160, Pendleton, Oregon 97801; telephone (541) 278-7549; e-mail [janycequaempts@yellowhawk.org](mailto:janycequaempts@yellowhawk.org); or see our website at [Yellowhawk.org](http://Yellowhawk.org). (5/11)

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

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

- Performance Improvement Director: a new position responsible for management of all aspects of the program including customer service, accreditation, infection prevention and control, and patient safety. Position reports directly to the COO and works closely with other division directors in managing and directing the health programs of SEARHC.
- Hospital Quality Manager: responsible for infection control, patient safety activities, patient satisfaction, risk management, hospital accreditation through the Joint Commission, and data management.
- Community Health Services Quality Manager: responsible for infection control, patient safety activities, patient satisfaction, risk management, accreditation through AAAHC, and data management.
- Safety and Infection Control Officer: responsible for infection control, emergency preparedness, risk assessments, and safety surveys
- Data Specialist: part-time position responsible for data management, analysis, and reporting used to improved quality of care and customer satisfaction.

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

---

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

The Ft. Thompson Health Center in Ft. Thompson, South Dakota is seeking board eligible/board certified physicians and mid-levels with at least 1 - 2 years post-residency experience. We are also in need of family practice physician assistants and family nurse practitioners. Ft. Thompson is located in rural south central South Dakota, east of the Missouri River on the Crow Creek Indian Reservation, and is approximately 80 miles from the Nebraska border. We are a busy clinic that offers the following services: family practice, ob/gyn, pediatrics, optometry, dentistry, dietary counseling, and behavioral health. Our staff is dedicated and devoted to providing quality patient care. The beautiful Black Hills, Badlands, Custer State Park, Mount Rushmore, and Crazy Horse Memorial are just 2 - 3 hours away. South Dakota is an outdoorsman's paradise with plenty of sites for skiing, hiking, hunting, fishing, boating, and horseback riding. Steeped in western folklore, Sioux cultural history, and land of such famous movies as "Dances with Wolves" and "Into the West," there is plenty for the history buff to explore. If you are interested in applying for a position, please contact Mr. Robert Douville, Clinical Services Administrator at (605)245-1514; e-mail him at [robert.douville@ihs.gov](mailto:robert.douville@ihs.gov); or Diana Rodriguez, MD, Medical Director at (605) 245-1516; e-mail her at [diana.rodriguez@ihs.gov](mailto:diana.rodriguez@ihs.gov). (4/11)

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

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

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

and dental insurance for employee and family. The clinic also pays for licensures, liability insurance, and CME.

The Oklahoma City Indian Clinic is located in the heart of Oklahoma City and offers limitless entertainment, cultural, and recreational opportunities. Enjoy shopping, fine dining, downtown night life, museums, NBA basketball, Division 1 college football, professional baseball, and hockey.

There are also major universities and colleges close by for continuing education opportunities. Oklahoma City's economy continues to grow. As reported in USA Today and Newsweek, Oklahoma City has proven to be one of the most recession-proof places to live in the United States.

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

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

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

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

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

---

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

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

### **Mid-Level Practitioner Pediatrician**

#### **St. Regis Mohawk Health Service; Akwesasne, New York**

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

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

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

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

The Bay Mills Health Center is seeking a family practice physician (MD or DO; board certified). Must have completed

a residency program and have a Michigan license or be able to obtain one. New Graduates are welcome to apply!

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

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

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

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

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

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

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

The Rosebud Comprehensive Health Care Facility in Rosebud, South Dakota is seeking board eligible/board certified physicians and mid-levels with at least 2 - 3 years post-residency experience. We are also in need of ER PA-Cs, family practice PA-Cs, and family nurse practitioners. Rosebud is located in rural south central South Dakota, west of the Missouri River on the Rosebud Indian Reservation and is approximately 30 miles from the Nebraska border. We are a 35-bed facility that has a 24-hour emergency department, and a busy clinic that offers the following services: family practice, internal medicine, ob/gyn, pediatrics, general surgery, optometry, dentistry, physical therapy, dietary counseling, and

---

behavioral health. Our staff is devoted to providing quality patient care, and we have several medical staff members who have been employed here ten or more years. The beautiful Black Hills, Badlands, Custer State Park, Mount Rushmore, and Crazy Horse Memorial are just 2 - 3 hours away. South Dakota is an outdoorsman's paradise with plenty of sites for skiing, hiking, hunting, fishing, boating, and horseback riding. Steeped in western folklore, Lakota cultural history, and the lands of such famous movies as "Dances with Wolves" and "Into the West," there is plenty for the history buff to explore. If you are interested in applying for a position, please contact Kevin Stiffarm, Chief Executive Officer, at (605) 747-3111, (605) 517-1283; or e-mail him at [kevin.stiffarm@ihs.gov](mailto:kevin.stiffarm@ihs.gov). (11/10)

**Family Practice Physician  
Menominee Tribal Clinic; Keshena, Wisconsin**

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

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

SEARHC invites registered dietitians to apply for a community dietitian opening on the SEARHC Health Promotion Team. The baseline qualifications are a BS in community nutrition/dietetics or a nutrition-related field. Two years clinical nutrition and/or community nutrition work experience are required, with specific experience in

management and prevention of diabetes, heart disease, and other chronic diseases. Must be a registered dietitian and eligible for dietetic licensure in the State of Alaska.

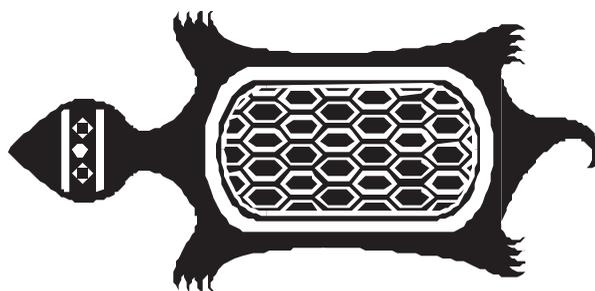
The dietitian will assess, plan, implement, and evaluate community nutrition programming focused on diabetes prevention. Additionally, the community dietitian offers medical nutrition therapy to clients living with diabetes and pre-diabetes on an on-site, outpatient basis as well as using distance delivery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

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

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

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

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



Dept. of Health and Human Services  
Indian Health Service  
Clinical Support Center  
Two Renaissance Square, Suite 780  
40 North Central Avenue  
Phoenix, Arizona 85004

**PRESORTED STANDARD**  
POSTAGE AND FEES PAID  
U.S. DEPT. OF HEALTH & HUMAN  
SERVICES  
PHOENIX, AZ  
**PERMIT NO. 5691**

CHANGE SERVICE REQUESTED

\_\_\_\_\_

OFFICIAL BUSINESS  
PENALTY FOR PRIVATE USE \$300



### Change of Address or Request for New Subscription Form

Name \_\_\_\_\_ Job Title \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Worksite:  IHS  Tribal  Urban Indian  Other

Service Unit (if applicable) \_\_\_\_\_ Last Four Digits of SSN \_\_\_\_\_

Check one:  New Subscription  Change of address

If change of address, please include old address, below, or attach address label.

Old Address \_\_\_\_\_



## THE IHS PRIMARY CARE PROVIDER

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



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

- Wesley J. Picciotti, MPA .....Director, CSC
- John F. Saari, MD .....Editor
- Cheryl Begay .....Production Assistant
- Theodora R. Bradley, RN, MPH .....Director, OCE
- Linda Trujillo, RN, MSN .....Nursing Consultant
- Erma J. Casuse, CDA .....Dental Assisting Training Coordinator
- Edward J. Stein, PharmD .....Pharmacy Consultant

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

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

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

Authors should submit at least one hard copy with each electronic copy. References should be included. All manuscripts are subject to editorial and peer review. Responsibility for obtaining permission from appropriate tribal authorities and Area Publications Committees to publish manuscripts rests with the author. For those who would like more information, a packet entitled "Information for Authors" is available by contacting the CSC at the address above or on our website at [www.csc.ihs.gov](http://www.csc.ihs.gov).