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Meeting the Needs of Individuals with Alzheimer's and Related Dementias

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An article in the May 2013 *Provider* reviewed the national impact of Alzheimer's disease and related dementias and outlined a set of steps we can take in IHS, Tribal, and Urban Indian health programs to improve care for persons with dementia and their families.[1] That article explored the changes we need to make in the system of care to improve quality of care, a system perspective. What would this care look like from the perspective of the person with dementia? What might an individual with dementia tell us about their care?

Here are four statements that every individual with dementia receiving care through the Indian Health System should be able to make:

- "I was diagnosed in a timely way."
- "I know what I can do to help myself and who else can help me."
- "Those helping to look after me feel well supported."
- "My wishes for care are supported."

I was diagnosed in a timely way.
Individuals and families need help recognizing cognitive impairment at its earliest presentation and expect a timely and accurate diagnosis so that they understand what is going on and what to expect.

I know what I can do to help myself and who can help me.
Often persons with dementia and their families struggle in isolation to adapt and cope with the inevitable changes that Alzheimer's disease and related dementias bring to their lives. They need reliable access to information and to resources available in the community to help them – both formal long-term services and support and less formal support through caregiver support groups, the Alzheimer's Association, and other similar groups.

Those helping to look after me feel well supported.
Persons with dementia should know that their caregivers will receive the help and support they need.

My wishes for care are supported.
Individuals with dementia may not be able to express their wishes for care as the condition progresses. Those who have specific wishes or advance directives should have confidence that these wishes will be honored.

In this Issue…

In the **2014 update to the National Plan to Address Alzheimer's Disease**, the Department of Health and Human Services (DHHS) committed to improve coordination between IHS, Tribal, and Urban Indian health programs and the Tribal Aging Network around these four person-centered goals.[2]

Work has already begun on one of these goals. In the past year, with the support of the IHS Division of Nursing and the collaboration of the veterans, there was a successful pilot of the REACH VA program of caregiver support[3] by Public Health and Community Health nurses in three Tribal communities. In all three communities the program fit well within the usual scope of practice of the Public Health and Community Health Nurses and was well received by caregivers and individuals with dementia. The initial pilot was limited to veterans with dementia or veterans caring for someone with dementia; in all three communities there is interest in offering the services more broadly to the entire community. Efforts to make that possible are now underway.

Later this summer the REACH VA program of caregiver support will be introduced to the Aging Network at the 2014 National Title VI Training & Technical Assistance Conference sponsored by the Administration on Aging Native American Programs in the Administration of Community Living (ACL).

These are the first steps toward the clear goal that in every Tribal community, whether through the Indian Health system (public and community health nursing) or through the Aging Network (Tribal Senior Centers and Title VI programs) every person living with Alzheimer's or other dementia can say, "*Those helping to look after me feel well supported*."

With the needs of individuals with Alzheimer's disease and other forms of dementia clearly in mind, we can create a system of care that meets those needs.

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The following data, obtained using a comprehensive set of ICD-9 CM dementia diagnoses adapted from the Veterans Health Administration (VHA), clearly demonstrates that in every IHS Area dementia is a significant health problem. This data very likely under-represents the impact of dementia given low rates of diagnosis of dementia and incomplete reporting to the IHS National Data Warehouse.

Figure 1. IHS Annual Unduplicated Dementia Patients for Calendar Years 2009 through 2013-to-Date

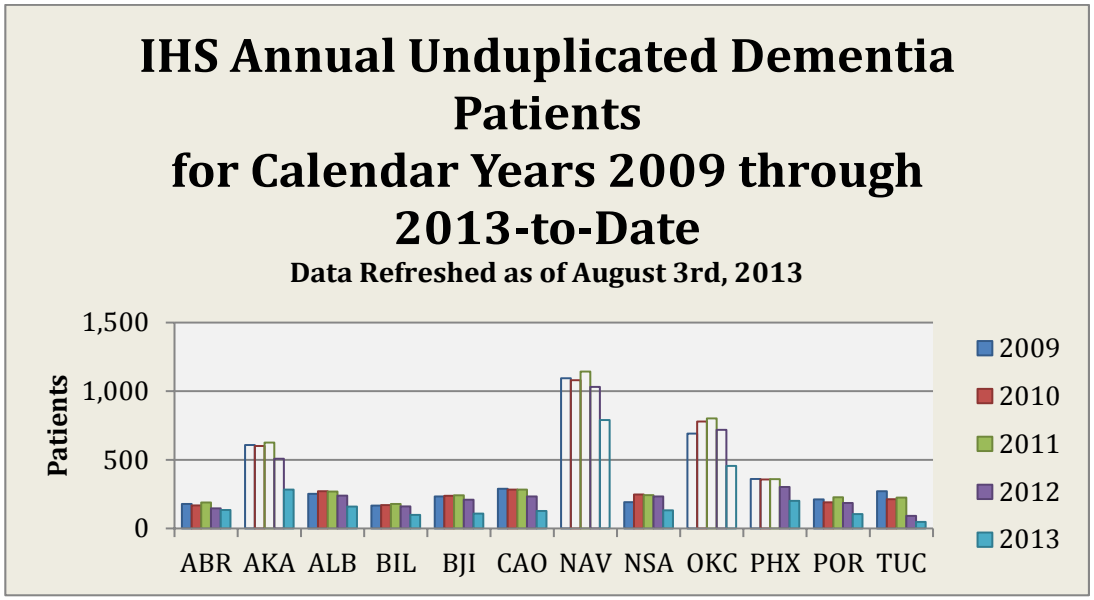
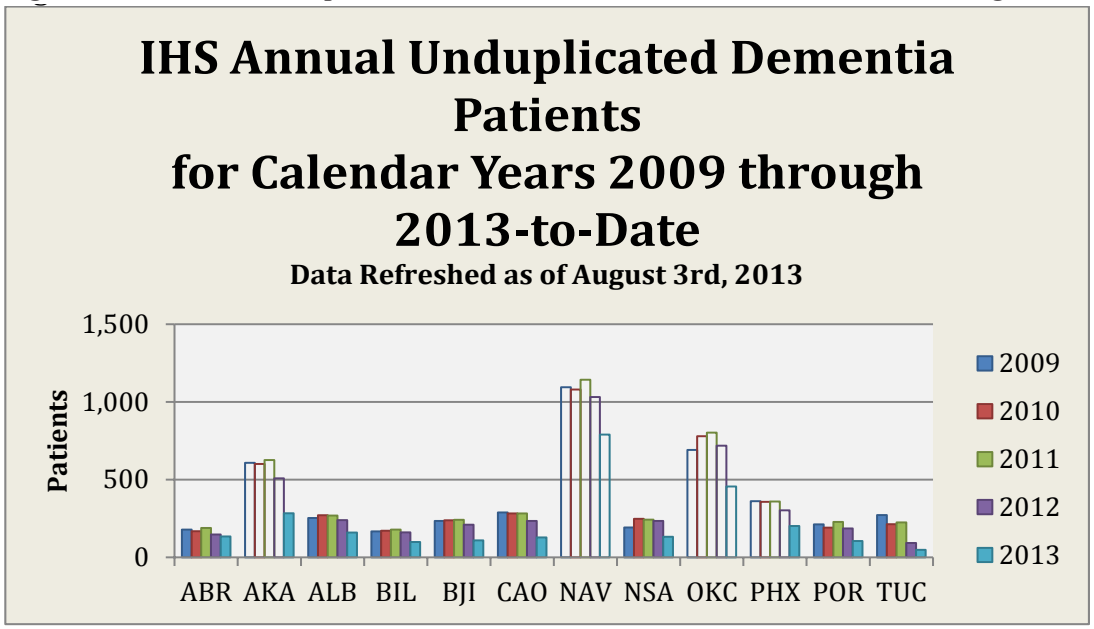


Figure 2. IHS Annual Unduplicated Dementia Patients for Calendar Years 2009 through 2013-to-Date



Workload obtained from the National Data Warehouse, courtesy of the IHS Division of Nursing.

The following code list was used to obtain the workload statistics in Figure 1 and 2 that give a picture of the care of persons with Alzheimer's and Related Dementia from 2009 – August 2013. This list has also been used at in queries at local sites to identify individuals with dementia who might benefit from services. It can be used to obtain an estimate of the prevalence of diagnosed dementia within a local user population.

Dementia Diagnostic Codes

ICD9 Code	Diagnosis
046.1	Jakob-creutzfeldt disease
046.11	Variant creutzfeldt-jakob disease
046.19	Other and unspecified creutzfeldt-jakob disease
046.3	Progressive multifocal leukoencephalopathy
290.0	Senile dementia uncomplicated
290.10	Presenile dementia uncomplicated
290.11	Presenile dementia with delirium
290.12	Presenile dementia with delusional features
290.13	Presenile dementia with depressive features
290.20	Senile dementia with delusional features
290.21	Senile dementia with depressive features
290.3	Senile dementia with delirium
290.40	Vascular dementia uncomplicated
290.41	Vascular dementia with delirium
290.42	Vascular dementia with delusions
290.43	Vascular dementia with depressed mood
291.2	Alcohol-induced persisting dementia
292.82	Drug-induced persisting dementia
294.10	Dementia in conditions classified elsewhere without behavioral disturbance
294.11	Dementia in conditions classified elsewhere with behavioral disturbance
294.8	Other persistent mental disorders due to conditions classified elsewhere ["DEMENTIA NOS"]
331.0	Alzheimer's disease
331.11	Pick's disease
331.19	Other frontotemporal dementia
331.2	Senile degeneration of brain
331.7	Cerebral degeneration in diseases classified elsewhere
331.82	Dementia with lewy bodies
331.89	Other cerebral degeneration
331.9	Cerebral degeneration unspecified
333.0	Other degenerative diseases of the basal ganglia
333.4	Huntington's chorea

Adapted from the Veterans Health Administration (VHA) Dementia Registry code list, August 2013.

The Wisdom of Bad Butch

Blythe S. Winchester, MD, MPH, Cherokee Indian Hospital

As a tribal member and Geriatrician in my community, the best thing I can do is listen to the voices of the elders. I listen to the stories, the concerns, the complaints, the compliments, and no matter how long that may take the answer is always there.

My father is a tribal elder in the community I serve. He and my grandmother are the main reasons and inspirations for why I dedicate my life's work to taking care of tribal elders. I watched him sacrifice years of his life to being an excellent caregiver to his parents. He has a long career as a tribal social worker and is a grandfather known as "Bad Butch". Though I do not see him as a patient for obvious reasons, I am an informal "consultant" on a regular basis at the dinner table. I have helped to diagnose him with sleep apnea, encouraged him to discuss stopping some medications that were adversely affecting him with his physician, encouraged him to get acupuncture on a regular basis which is benefitting him greatly, and helped diagnose his spinal stenosis (with which he is living and thriving quite well right now). I also tell my male patients on a regular basis about how my dad has gone through more than one colonoscopy, and knowing that someone they are familiar with has had that same procedure helps them to have it done. I firmly believe my dad allowing me to divulge that information has helped to diagnose colon cancer on at least one occasion.

I sat down with him to get an elder's perspective.

What is most important to you as you age?

To stay happy and healthy.

What does happiness mean to you? When you say you want to be happy and healthy, what does that include?

Well number one, I guess like everybody else, is getting all my bills paid and having enough left over to enjoy a night out with dinner, or go play golf. And also to be with my family, whom I am blessed to have living all around me, and to entertain my grandsons.

What does happiness mean to you? When you say you want to be happy and healthy, what does that include?

How about the health part? For you, as you get older, what does being healthy mean to you?

Well, with age comes wisdom. A funny thing about that was, prior to my first retirement, which was 9 years ago, I was more directed toward my work and earning an income and really didn't pay attention or take as good of care of myself as I should have. Only later in life, I guess as my systems started breaking down and I found out I was taking medication I probably shouldn't that would affect my memory and other capabilities and quality of life, then I began to do what I should have done.

Doing more homeopathic methods in order to take better care of my health and also I have to put in there now sleep was a big part of that. I never slept up until—I guess it's been about a year now, and I'm 67. Now that I sleep I notice that everything has improved. And I'm much happier with life in general after sleeping and after not taking certain medications.

What do you think is different in being a tribal elder than being an elder anywhere else?

It is still a part of the culture to respect elders. They do have more impact, more ability to speak and be heard, or pass on learning and important things-just with education or cultural things like beadwork and pottery but learning experiences that are extremely important to the young people.

Even though a lot of times they don't absorb or learn from the experience of hearing what could prevent harm or pain, they will still usually go through the process and then a light bulb goes on. They realize that they could have prevented that if they had listened to "so and so." Of course, I didn't listen to "so and so" when I was young, so I find it kind of ironic that now that I am the elder. I have talked to, trained, and influenced a lot of young

people. It is more or less like fire; you don't learn the true lesson of fire until you stick your finger in and get burned.

So you talk about what you are doing now as you age, but as you think about yourself in your 80s and 90s what is it that is most important that you hope you can still do and function well doing?

I guess my number 1 priority is to be able to think, express myself and to learn. I have always thought and still do believe that we are blessed with the capability of learning, and I'm still learning even into my 60s.

You were talking about learning and expressing yourself and still being able to think, so those are things that are most important to you.

I should put in there too that, like the quality of sleep, I have also learned that one can amplify the qualities of other things like food and exercise. I have learned that I can shoot better golf now than when I was younger. Because even though when I was younger I could drive the ball a lot further, I think psychologically that was a powerful thing for me to be involved in the thoughts of actually knocking a golf ball as far as I could or hitting a tennis ball as hard as I could. The sound of the racket or a driver hitting a golf ball was pleasant and you can't control a ball that is hit hard as well as you can one that is hit not as hard and you have more control over it.

I guess my number one priority is to be able to think, express myself, and learn.

I have learned that has a context that goes deeper than just with golf. It applies to just about everything in life as well as the concept that old dogs can learn new tricks.

Have you ever thought about having to live in a long-term care facility or anything like that?

Yeah, yeah I do. It was largely to do with my ideas as a professional and my experience of having to go in on an almost daily basis to hospitals or long-term facilities. The idea of wasting away is not opportune in my mind. I would like to contribute as long as I could. And then the best results would be my wife and I would enjoy traveling for a while, or just peacefully going out on the porch and sitting, watching TV inside, taking care of each other, maybe having the grandchildren and children assist us as long as possible. And then, when the time came, if there was, nearby, a nice, extended care facility that accommodated a co-existence with your spouse as long as possible in a family-oriented, open, energetic, going to various activities at the festival grounds, movie theater and other physical activities that are appropriate, like corn hole, horse shoes, things that could be incorporated without a lot of physical exertion or exhausting physical effort.

You were a caregiver for older parents you had to make the decisions to place grandpa in a memory care unit. After he was there, what do you remember most about him being there?

That he really didn't like it. Like most elders faced with the same situation (especially those with Alzheimer's), that is extremely painful not just for the individual but for the family members. I'm just speaking personally. I know it happens quite frequently because, from the professional standpoint, I've dealt with it for a long time. Even when I retired I couldn't get away from it. People constantly asked me questions and I felt that due to my part of the community, i.e., being an elder, to go ahead and respond truthfully about my experiences.

And it was really difficult because, like I said, my father has always been active and energetic, and has gone all over the place, and has friends all over. Everywhere I have ever gone I have run into people that have known him-which is really neat in a way.

And watching him go through this mental deterioration was extremely painful for me. I had been through the same experience with numerous patients of other associated friends or other members of the community that I'd grown up with my whole life and none of that had affected me as personally or traumatically as watching my father go through this experience.

And also he didn't know what was going on.

And it was very demoralizing and painful to watch him question what was happening, what was happening to him and him not knowing and not being able to do anything about it.

I don't know if I would be able to go through that.

Is there something that really sticks out from that time period that really strikes you about what that Alzheimer's picture looks like that you didn't' really know about before?

That's a really good question. I told him one time I would change his Indian name to 4 Hats because he had four hats on that time and he laughed. And this

was another reason it can be so painful. He had one of those moments where he was totally like he had used to be, and he said to me "do you know why I wear all of these hats?"

I said "why?"

He said "cuz if I didn't wear em somebody would steal one of them so I have em all on because I like all of these hats and I don't want anybody to take any of them from me."

And I thought to myself, 'my gosh you know that makes sense'. It was needed because it's a time I was very frustrated with him because of his need for me to assist him with his bathroom things and that was tedious, time-consuming and quite messy and hard and it really was in my opinion is a thing that divides and shows how much your children or family who are close to you love you. Because if they are willing to take care of you and understand at that point that they are doing something for you then it is very much an example of what your life has been and the frustration of it being that you got to the end and members of your family that you raised are taking care of you. It really shows that you have completed the circle of life in a satisfactory and important way, in my opinion.

I talked to my dad about dying and death. He said he saw something on TV when he was young about how members of a tribe went off to a place to die when they were "too old to get on anymore."

Tell me about that—

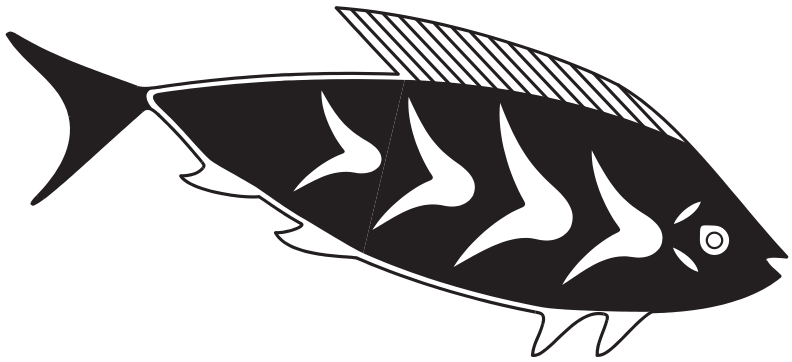
I thought about that an awful lot because I had a dog that was old and I couldn't figure out one time…. one day the dog was gone and we didn't know what happened to the dog. We were concerned because of his age we thought he had fell in the ditch or something. We spent a lot of time trying to find him. It wasn't until much later that I was hunting in the woods, squirrel hunting, and I saw what I took to be the remains of my dog. A thought that came to mind even though I was quite young at the time I thought that was his way that he had gone up to the ridge there where it was nice and pretty. Actually he had to climb bit to get up there. The only thing that I could think of was that him being up there was he knew his time had come and he had gone up there and was in a beautiful place where he could see the mountains and trees and everything.

And so that came to mind.

And so I would ideally like to do something of that nature.

I had a dog that was old and I couldn't figure out one time . . . he knew his time had come and he had gone up there and was in a beautiful place . . .

He brings up a lot of the main issues I address with my elder patients: advance care planning, polypharmacy, older patients as caregivers, the importance of sleep, and maintaining function. I am honored to be able to share this personal information in the hopes that it helps you to learn and better care for the elders in your community.



Indian Health Service
National Pharmacy and Therapeutics Committee
Long Acting Opioids in Chronic Pain
NPTC Formulary Brief
May 2014

Background:
In May 2014, the Indian Health Service National Pharmacy and Therapeutics Committee (NPTC) reviewed the role of long acting opioids (LAOs) as a part of a comprehensive integrated pain management strategy for the IHS service populations

Discussion:
Peer reviewed publications comprising the work product of a variety of well-respected national and international review and guidelines committees were thoroughly reviewed. These included recommendations from the Cochrane Review Committee, British National Institute for Clinical Excellence, World Institute of Pain, Oregon State University Drug Effectiveness Review Project, and American Society of International Pain Physicians Guidelines.

The review focused on the LAOs, Oxycodone ER, Hydrocodone ER, Hydromorphone ER, Morphine SR, Buprenorphine Transdermal, Methadone, Fentanyl Transdermal, Tramadol ER, for which reasonable clinical evidence exists regarding efficacy in the management of pain. Generally, all of these LAOs are effective for the management of chronic pain.

Findings:
Systematic reviews of LAOs for chronic pain management revealed that data was insufficient to determine unequivocal differences in effectiveness or harm. Ten head to head trials identified comparing 2 or more LAOs with no difference. Two trials did find differences, however were flawed by design. They were open labeled, rated as poor quality trials, and had inconsistent findings with higher quality trials evaluating the same comparisons.

The NPTC identified several practical clinical points regarding the use of LAO pharmacotherapy for chronic pain management:

- A Food and Drug Administration Risk Evaluation and Mitigation Strategy (REMS) is required for all LAOs. REMS prescriber education includes drug information on ER/LA opioid analgesics; information on assessing patients for treatment with these drugs; initiating therapy, modifying dosing, and discontinuing use of ER/LA opioid analgesics; managing therapy and monitoring patients; and counseling patients and caregivers about the safe use of these drugs. Additionally, prescribers are required to learn how to recognize evidence of and potential for opioid misuse, abuse, and addiction.
- The ER/LA opioid analgesics REMS also includes a patient counseling document for prescribers to give to patients, helping prescribers to properly counsel patients on their responsibilities for using these medicines safely.
- Patients will receive from their pharmacist an updated one-page Medication Guide along with their prescription that contains information on the safe use and disposal of ER/LA opioid analgesics. Included in the guide are

instructions for patients to consult their health care professional before changing doses, signs of potential overdose and emergency contact instructions, and advice on safe storage to prevent accidental exposure to family members.

- The class associated adverse effects (AE) of abuse, addiction, constipation, nausea and vomiting, somnolence, and hyperalgesia were relevant for all LAOs.
- Break through pain and end of dose pain may be decreased by the use of the LAOs vs. the use of short acting opioids alone in chronic pain.
- Guidelines recommend treating pain in a step wise approach with LAOs being relegated to third line in mild to moderate nociceptive pain. Start with acetaminophen and NSAIDs, then weak opioids, and lastly strong opioids. Opioid selection should be individualized based on any renal or hepatic impairment, adverse effects occurring, and tolerance to previous opioids. Opioid medications should be used on a chronic basis, primarily, only in patients who are assessed to be at low risk for substance abuse, and who have persistent pain despite trials of non-opioid analgesics.
- The initial treatment of neuropathic pain involves either antidepressants (tricyclic antidepressants or dual reuptake inhibitors of serotonin and norepinephrine) or calcium channel alpha 2-delta ligands (gabapentin and pregabalin). Opioids should be considered a later option once non-opioid medications have not achieved proper pain relief.
- Before initiating chronic opioid therapy, an assessment of the risks and benefits of therapy for the individual patient should be based upon the history, physical examination, and assessment of the risk of substance abuse, misuse, or addiction. Chronic opioid therapy should be accompanied by a pain treatment agreement. Treatment of chronic pain should include multiple approaches and medication should not be the single focus of treatment but should be used when needed, in conjunction with other treatment modalities.

The NPTC's review identifies the role of opioid therapy in the more severe forms of acute and chronic pain is established, but opioid therapy in many types of chronic non-cancer pain remains controversial, many times the clinical evidence is equivocal, and health systems policies and procedures vary greatly in the use of opioids in pain management. Due to these variables, no specific modifications were made to the IHS NCF and no long-acting opioid was added to the NCF. Opioid medications should be used on a chronic basis only in patients who have persistent pain despite trials of non-opioid agents. They should be used with extreme caution and very close monitoring in patients with a medium or higher risk for substance misuse and abuse. It should be recognized that the evidence for the effectiveness of long-term opioid therapy in terms of pain relief and improved functional outcomes is limited, and that the risk of opioid overdose increases with increasing dosing.

If you have any questions regarding this document, please contact the NPTC at IHSNPTC1@ihs.gov. For more information about the NPTC, please visit the NPTC website.

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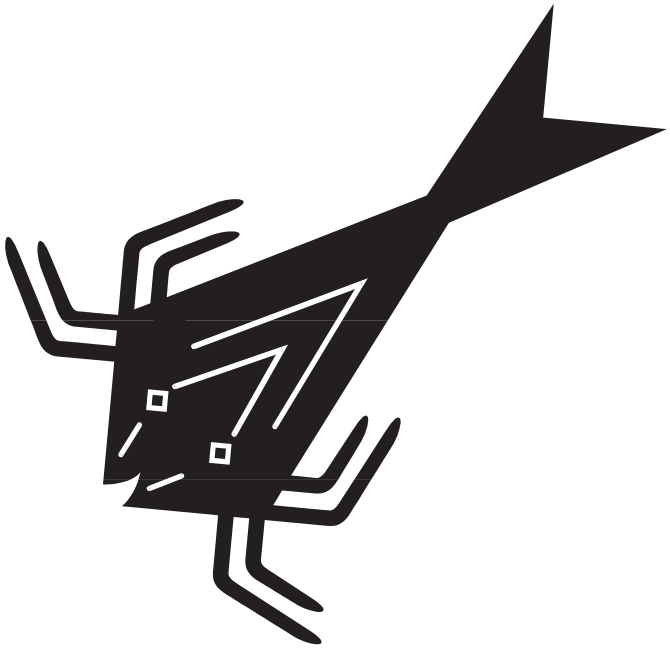

Indian Health Service
National Pharmacy and Therapeutics Committee
Short-Acting Opioids –Formulary Brief
May 2014

Background:
The IHS National Pharmacy and Therapeutics Committee (NPTC) reviewed short-acting opioid medications at the May 2014 meeting. The discussion included clinical, utilization and procurement data for this class of medications. This discussion did not lead to a formulary modification; however, it was felt that a formulary brief would be of benefit to IHS providers.

Discussion:
Clinical data support short-acting opioids as effective for acute pain relief including breakthrough pain in patients on chronic long-acting opioids. Over the past several decades the use of opioids has increased dramatically throughout the United States. As prescribing trends have increased, so has the detrimental effects associated with their use including; adverse drug effects, medication misadventures, overdose, abuse and diversion. Additionally, in the recent years unannounced DEA audits have been seen throughout IHS focusing diversion prevention. This has resulted in a second look at prescribing practices and reassessment of opioids place in therapy for the treatment of nonmalignant pain.

Neuropathic Pain: Data has shown that short-acting opioids are effective at relieving neuropathic pain. However, their support for chronic use in neuropathic pain remains controversial as there are limited studies of their use for greater than 12 weeks in duration. Even though most studies show significant efficacy of opioids over placebo, there has been no shown benefit to quality of life. Therefore, analgesic efficacy of short acting opioids in chronic neuropathic pain is subject to considerable uncertainty. Findings in a Mayo Clinic review article suggest that opioids can be used if first line agents (TCAs, SNRIs, gabapentin, or pregabalin) are not effective. Also, there is little to no evidence showing efficacy of long-acting over short-acting opioids in these conditions. 2013 NICE guidelines recommend initial treatment choice for neuropathic pain of amitriptyline, duloxetine, gabapentin, pregabalin, or carbamazepine (trigeminal neuralgia). If the original first line agent fails, switching to another non-opioid first line agent is recommended. If multiple first line agents fail, the providers should consider combination therapy. If non-opioid chronic therapy fails and the patient experiences breakthrough pain, short term tramadol is recommended for acute rescue therapy. For more severe pain, NICE guidelines also recommend long term treatments with morphine, tramadol, and non-opioid alternatives be managed by a pain specialist.

Nociceptive Pain: In contrast to neuropathic pain, the pharmacologic approach to nociceptive pain largely involves NSAIDs, APAP and opioid analgesia. Medications should be used in conjunction with non-pharmacologic therapies and approaches to relieve the source of the pain.

When pharmacotherapy for nociceptive pain is required, acetaminophen is typically recommended as a first-line therapy for pain related to osteoarthritis and chronic low back pain. However, in clinical trials acetaminophen is less effective than nonsteroidal anti-inflammatory drugs (NSAIDs) and has the potential for hepatic toxicity at doses of >4 g per day.

An alternative first line agent to APAP is an oral NSAID, which is effective for mild-to-moderate chronic low back pain or osteoarthritis. Opioid medications should be used on a chronic basis only in patients who are assessed to

be at low risk for substance abuse, and who have persistent pain despite trials of non-opioid analgesics and antidepressants. Opioids should be initiated with a short-acting drug and then converted to a sustained-release form to be given on a schedule, although evidence is unclear regarding benefits of a specific regimen or whether long-acting or short-acting medications are preferred. It should be recognized that the evidence for the effectiveness of long-term opioid therapy in terms of pain relief and improved functional outcomes is limited, and that the risk of opioid overdose increases with increasing dosing.

First line agents based on efficacy and lower side effect profile remains nonsteroidal anti-inflammatory drugs (NSAIDs), COX-2 selective inhibitors, acetaminophen (APAP), antiepileptic drugs, antidepressants, local anesthetics, and alpha-2 agonists. The American College of Rheumatology recommends opioids if other therapies (APAP, NSAIDs) are not effective/contraindicated and pain continually interferes with quality of life.
For low back pain, opioids are a treatment option for severe, disabling pain not controlled by APAP or NSAIDs and there is little evidence for long term efficacy of opioids with neither long- nor short-acting having greater efficacy. The studies that show that long-acting opioids may have greater efficacy over short-acting are few and these studies are limited by poor design and sample sizes. Since chronic noncancer pain presents in patients from various causes and patients have different pain profiles, therapeutic goals for optimal treatment must be individualized. The drug of choice in NICE guidelines for chronic lower back pain is APAP. If adequate control is not sufficient with APAP, then NSAIDS can be considered and/or weak opioids such as codeine or possibly tramadol. Finally, they recommend only short-term use in severe pain of strong opioids (buprenorphine, fentanyl, oxycodone, higher doses of tramadol).

Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain: In 2010 the Canadian guidelines were published. They give very few recommendations for specific agents, and mostly related to specific indications. This lengthy document can be summarized by the following:

For Mild to moderate pain:

1. first line - codeine, tramadol
2. second line - morphine, oxycodone, or hydromorphone

For Severe pain:

1. first line – morphine, oxycodone, or hydromorphone
2. second line – fentanyl
3. third line – methadone

Additionally, in osteoarthritis, if adverse effects outweigh benefits of non-tramadol opioids then they should be avoided. Tramadol is considered effective for fibromyalgia (2 RCTs) and strong opioids are not recommended. Finally, for severe pain in the elderly, controlled-release products are preferred; also oxycodone and hydromorphone have fewer side effects compared to morphine.

Findings:
No single opioid is preferred for all patients. Therapy must be individualized to the patient and indication. Short-acting opioids are an effective treatment modality for acute moderate to severe pain, but should only be used after other non-opioid medications classes have failed or are not indicated due to the acute severity of the pain condition or not indicated due to misuse, abuse, and tolerance toxicities. Each treatment plan and facility utilize short-acting opioids in a different manner, thus their use is too individualized and the healthcare systems policies and procedures vary too greatly to have any one particular short-acting opioid on the NCF. No specific modifications were made to the IHS NCF in this class. There are currently no short-acting opioids on the NCF.

If you have any questions regarding this document, please contact the NPTC at *IHSNPTC1@ihs.gov*. For more information about the NPTC, please visit the NPTC website.

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MEETINGS OF INTEREST

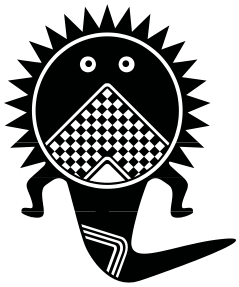
Advancements in Diabetes Seminars
Monthly; WebEx

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

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

Available EHR Courses

EHR is the Indian Health Service's Electronic Health Record software that is based on the Resource and Patient Management System (RPMS) clinical information system. For more information about any of these courses described below, please visit the EHR website at *http://www.ihs.gov/CIO/EHR/index.cfm?module=rpms_ehr_training*. To see registration information for any of these courses, go to *http://www.ihs.gov/Cio/RPMS/index.cfm?module=Training&option=index*.



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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* the.provider@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.*

Psychiatrist
Zuni Comprehensive Community Health Center;
Zuni, New Mexico

The Zuni Comprehensive Community Health Center (Indian Health Service) has an opening for a full-time psychiatrist to see adults and children. We do psychotherapy, crisis work, trauma work, as well as work with families, couples, and groups. You will have the opportunity to impact and design mental health for the community as a whole. We are shielded from managed care. You have an opportunity to provide psychotherapy to your patients and families without worrying about insurance approvals. You are not merely hired as a prescriber, but as a biopsychosocial psychiatrist. In this job, you have a chance to feel good about the care you are providing, in a setting that is personally and professionally stimulating, and in a place where your skills are needed and valued. Additional advantages include market pay, no call, and excellent federal benefits.

We are located on the Zuni reservation. The Zuni Pueblo is one of the oldest continuously inhabited Native American villages in the US, estimated to be at least 800-900 years old. The Zuni are located on their ancestral lands and have one of the most intact Native American cultures in the country. Zuni tradition and the Zuni language are a living and vibrant part of daily life in the community. Zuni is nestled amongst beautiful redrock mesas and canyons. It is considered high desert at 6000 - 7000 feet and is located in the northwestern region of New Mexico, along the Arizona border.

For more information or to apply, contact Michelle Sanchez, Zuni Service Unit Behavioral Health; telephone (505) 782-7312; e-mail *michelle.sanchez2@ihs.gov*. (3/14)

Staff Clinician
Department of Health and Human Services,
National Institutes of Health, National Institute
of Diabetes and Digestive and Kidney Diseases,
Division of Intramural Research
Phoenix, Arizona

The Diabetes Epidemiology and Clinical Research Section (DECRS), Phoenix Epidemiology and Clinical Research Branch (PECRB), National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) conducts research in the epidemiology and prevention of type 2 diabetes, its complications, and related conditions, primarily among American Indians in the southwestern United States. The section is recruiting a staff clinician to take part in clinical research activities. The position is located in Phoenix, Arizona on the campus of the Phoenix Indian Medical Center.

The staff clinician will work in an interdisciplinary, collaborative environment and have the following responsibilities: a) medical director of the DECRS research clinics, supervising nurse practitioners and medical assistants, and overseeing clinic schedules and operations; b) principal or associate investigator of randomized clinical trials in prevention of diabetes or its complications; c) principal or associate investigator of epidemiologic investigations of type 2 diabetes and related conditions; and d) associate investigator in a randomized clinical trial of optimizing weight gain in pregnancy and effects on the mother and child. There are outstanding opportunities to collaborate with experts in epidemiology, clinical research, physiology, genetics, and biostatistics. Ample clinical, laboratory, and computing resources are available.

The position requires licensure to practice medicine in one of the United States or D.C. and board eligibility or certification, preferably in internal medicine, pediatrics, family practice, or preventive medicine. Clinical or epidemiological research training and experience are desirable. Salary and benefits will be commensurate with experience and qualifications. Outside candidates and current federal employees (civilian or commissioned corps) are encouraged to apply.

Interested candidates may contact William C. Knowler, MD, DrPH, Chief, DECRS, c/o Ms. Charlene Gishie. To apply, please send a cover letter; CV with publications list; and names and contacts of three references to Ms. Charlene Gishie, National Institutes of Health, 1550 E. Indian School Rd, Phoenix, AZ 85014; e-mail *charlene.gishie@nih.gov*. The deadline to submit an application is March 7, 2014.

NIDDK is a component of the National Institutes of

Health (NIH) and the Department of Health and Human Services (DHHS). All positions are subject to a background investigation. DHHS and NIH are Equal Opportunity Employers. (1/14)

Family Practice Physicians (2)
Cass Lake IHS Hospital; Cass Lake, Minnesota

Leech Lake Reservation is an open reservation located in Minnesota's Northwoods region. Towering pines fringe many of the lakes found within its boundaries. Wild rice beds, deep forests, and shimmering lakes, two of which are among the largest in the state, abound. There are approximately 1,050 square miles within the reservation, nearly all of which is within the boundaries of the Chippewa National Forest.

When you locate here, you are looking for a quality of life for both your workers and your family. That is why it will be worth your while to find out how much Leech Lake can offer with its natural beauty, friendly communities, good schools, and various civic, cultural, and historical organizations. The area also provides many quality outdoor recreational activities, from fishing and boating in the summer to nordic and alpine skiing in the winter. Though Leech Lake's natural beauty, civic attractions, and recreational activities are things to behold, they pale in comparison to the friendliness of the people of the Leech Lake area.

The population within the reservation boundaries is estimated at 91,800. Nearly fifty-eight percent are between the ages of 16 and 65. The resident American Indian population on the reservation has been estimated at 7,763 by the census. Most of the population is concentrated in eight communities dispersed across the reservation. Adjacent to the reservation, there are three major area economic centers: Bemidji, which is 13 miles to the west of Cass Lake; Grand Rapids, which lays 54 miles to the east of Cass Lake; and Walker, roughly 23 miles to the south of Cass Lake.

The Cass Lake Indian Hospital is owned and operated by the Federal Government as a Public Health Service, Indian Health Service Facility. We have a staff of 120 employees, six of whom are physicians and five nurse practitioners; there is a contracted emergency department service. Additional services include ambulatory clinic, dental, optometry, audiology, laboratory, radiology, physical therapy, and diabetes clinic. Our Facility has 13 beds; we had 223 discharges and 1,398 patient days in FY '05. According to the most recent data, we have 99,503 outpatient visits annually, 5,612 Dental visits, and 2,763 Optometry visits; there are 20,512 registered patients. The Leech Lake Tribe operates mental health, substance abuse, podiatry, and diabetes clinics, as well as seven other clinics staffed by various professionals.

For additional information, contact Antonio Gruimaraes, MD, Clinical Director (family medicine at telephone (218) 335-3200; e-mail *antonio.guimaraes@ihs.gov*, or Tony Buckanaga, Physician Recruiter, at telephone (218) 444-0486; e-mail *tony.buckanaga@ihs.gov*. (1/14)

Family Practice Physician
Pharmacist
Laboratory Supervisor
EMT Basic/Intermediate
First Responder
Environment Health Assistant
Master Social Worker
Alamo Navajo School Board, Inc.; Alamo, New Mexico

Alamo Navajo School Board, Inc., Health Division is seeking health care practitioners to come work with their dedicated staff on the Alamo Navajo Reservation. Our clinic is located 140 miles southwest of Albuquerque and sixty miles west of Socorro. We have a multiservice community health center that include medical, dental, onsite pharmacy and lab, optometry, mental health, emergency medical, aftercare, and community health education services. One focus is on diabetes awareness and prevention of the disease, which affects one in every five people in Alamo. In support of the effort, the Health Division in collaboration with the Board and Administration constructed a community wellness center. The facility has a full-size gymnasium, aerobic and weight room, classrooms, kitchen, game room, day care, and an outdoor fitness path.

Alamo Navajo School Board, Inc., provides a highly negotiable and competitive salary; signing bonus; student loan assistance; housing; and an excellent benefits package that consist of a group health insurance/life insurance at no cost for employees and shared cost for dependents; 403(b) Retirement Plan and 457(b) Deferred Contribution Plan; Relocation reimbursement; 13 major holidays off; personal leave; and community wellness center access. Hiring preference will be given to Navajo and Indian Preference. For more information, please contact Hotona Secatero, Director of Personnel, at (575) 854-2543 extension 1309; or e-mail *hsecatero@ansbi.org*. (12/13)

Clinical Director
Family Medicine Physician
Kodiak Area Native Association; Kodiak, Alaska

The Kodiak Area Native Association (KANA) is searching for an adventurous, highly motivated physician to lead our team that is committed to patient centered care, customer service, quality improvement, and stewardship. KANA is celebrating its 48th year of providing patient and family focused health care and social services to Alaska Natives and other beneficiaries of KANA throughout Kodiak Island. KANA's award winning medical staff is comprised of four physicians who work in conjunction with two midlevel providers, dedicated nurse case managers, and ancillary staff to deliver the highest quality, team-based health care to an active user population of 2,800 patients. Integrated behavioral health and pharmacy services within the primary care setting also facilitate an advanced support system to ensure our patients' needs are met.

The spectacular scenic beauty of Kodiak Island offers a

backdrop for an abundance of outdoor and family activities, including world-class fishing, hunting, wildlife viewing, kayaking, and hiking just minutes from your door. Its sometimes harsh climate is balanced by mild temperatures and unparalleled wilderness splendor that provide Kodiak's residents with a unique lifestyle in a relaxed island paradise.

KANA offers competitive compensation and an excellent employee benefits package, including medical, dental, vision, flexible spending accounts, short term disability insurance, life insurance, accidental death and dismemberment insurance, 401k with employer contribution, fitness membership, and paid time off.

If you're interested in hearing more about how you can start your journey to an adventure of a lifetime, please visit our website at *www.kanaweb.org*, give Lindsey Howell, Human Resources Manager, a call at (907) 486-9880, or contact our HR Department at *hr@kanaweb.org*. Alaska's Emerald Isle awaits you! (12/13)

Clinical Director
Family Practice Physician (2)
Physician Assistant
Family Nurse Practitioner
Clinical Nurse
Tohatchi Health Center; Tohatchi, New Mexico

Tohatchi Health Center is the quality innovation and learning network (QILN) site for Gallup Service Unit. We are located approximately 30 miles north of Gallup, New Mexico, nestled against the Chuska Mountains. Ambulatory services include family medicine, internal medicine, obstetrics and gynecology, optometry, dental, pharmacy (including anticoagulation clinic), podiatry, physical therapy, social services, public health nursing, laboratory, limited radiology, and support services. Our facility provides health care Monday through Friday, 8:00 am to 4:30 pm. Our focus is building our medical home and supporting a patient centered health care system with the patients and communities we serve.

For more information, you can contact CDR Pamela Smiley, RN-SCN, Acting Health Systems Administrator at (505) 733-8100 or e-mail at *pamela.smiley@ihs.gov*. (12/13)

Primary Care Providers
Koosharem Community Health Center; Richfield, Utah
Kanosh Community Health Center; Kanosh, Utah

The Paiute Indian Tribe of Utah (PITU) has job openings for full-time mid-level practitioners at each location. The tribe operates health clinics in four communities, two of which are newly funded Community Health Centers in Richfield and Kanosh, Utah. Our outreach area encompasses 15 cities in Millard and Sevier Counties with an approximate service population of 25,311. Our goal is to provide excellent health care and services to those with economic, geographic, cultural, and language barriers. Clinical services include family medicine, prenatal and women's health care, dental, optometry, nutrition and dietetics education, and social service programs.

Richfield is located in west central Utah and lies in a valley surrounded by beautiful red rock mountains. Richfield is part of Panoramaland, and is a popular thoroughfare to several nearby national parks and forests. Kanosh is a small farming town located in Millard County; it was named in honor of the Paiute Indian Chief Kanosh. These areas have long been known for their outdoor recreational opportunities, such as hiking, fishing and hunting, mountain biking, and all-terrain vehicle events.

We offer an excellent benefits package that consists of a competitive annual salary, no cost health/dental/life insurance for the entire family, a 401(k) retirement plan with tribal match, 14½ paid holidays, annual (vacation) and sick leave accruals that roll over year to year, ability to earn compensatory time for time over 40 hours weekly, plus eligibility for NHSC or IHS loan repayment.

Interested candidates should submit a PITU application; CV/resume; and copies of medical license, driver's license, highest level of education achieved, and CIB (if applicable) to Paiute Indian Tribe of Utah, Attention: Kim Kelsey, 440 N. Paiute Dr., Cedar City, UT 84721. Job posting closes January 17, 2014, although the position will be remain open until filled. Visit www.utahpaiutes.org to download application; call (435) 586-1112, ext. 110; or e-mail *kim.kelsey@ihs.gov* with questions or for more information. (11/13)

Primary Care (Internal Medicine or Family Practice) Physicians
Phoenix Indian Medical Center; Phoenix, Arizona

The Departments of Family and Internal Medicine at the Phoenix Indian Medical Center have openings for board certified/eligible outpatient family and internal medicine physicians. Our adult primary care services are provided by eleven family physicians, six internists, and two midlevel providers. Our physicians work in multidisciplinary health care teams with the active participation of nurse care coordinators, nutritionists, pharmacists, nurses, clerks, and other staff, all of whom work together to provide a medical home for patients with chronic illnesses. We have an advanced access appointment system and have been using the Electronic Health Record for over six years. Full time 8 and 10 hour per day schedule options are available. Competitive federal salaries and benefits are available, and Commissioned Officer applicants are also welcome. Job applications should be made online at *USAJOBS.gov*. For more information, please contact Dr. Eric Ossowski, Family Medicine, or Dr. Dorothy Sanderson, Internal Medicine at *dorothy.sanderson@ihs.gov*; telephone (602) 263-1537. (10/13)

Hospitalist (Family Practice or Internal Medicine) Physicians
Phoenix Indian Medical Center; Phoenix, Arizona

The Phoenix Indian Medical Center (PIMC) is actively

seeking board certified/eligible family medicine or internal medicine physicians to staff its inpatient unit. PIMC is an inpatient and outpatient facility located in downtown Phoenix that provides medical care to patients from over 40 tribes. Hospitalists typically round/admit/consult on 8 to 12 patients per shift. Typical admitting diagnoses include diabetic ketoacidosis, hepatic encephalopathy, pneumonia, asthma, pyelonephritis, and cellulitis. Specialty services available to provide consultation on the inpatient service include surgery/wound care, ENT, obstetrics and gynecology, rheumatology, infectious diseases, nephrology, orthopaedics, podiatry, and dermatology. Competitive federal salary and benefits are available, and Commissioned Officers are also welcome to apply. Interested physicians should contact Dr. Dorothy Sanderson at *dorothy.sanderson@ihs.gov*, or telephone (602) 263-1537, ext. 1155. (10/13)

Family Physician with Obstetrical Skills
Ethel Lund Medical Center; Juneau, Alaska

The SEARHC Ethel Lund Medical Center, Juneau, Alaska is searching for a full-time family physician with OB to join a great medical staff of 14 providers at a unique clinic and hospital setting. Have the best of both worlds by joining our practice where we share hospitalist duties and spend our remaining time in an outpatient clinic with great staff and excellent quality of life. We have the opportunity to practice full spectrum family medicine with easy access to consultants when we need them. Maintain all your skills learned in residency and expand them further with support from our tertiary care center, Alaska Native Medical Center.

Clinic is focused on Patient Centered Medical Homes, quality improvement with staff development from IHI, and using the Indian Health Service HER. Frequent CME and opportunities for growth: teaching students & residents and faculty status at University of Washington available to qualified staff. Loan repayment site for Indian Health Service and National Health Service Corps and State of Alaska SHARP program.

Work in Southeast Alaska with access to amazing winter and summer recreational activities. Live in the state capital with access to theater, concerts, annual musical festivals and quick travel to other communities by ferry or plane. Consider joining a well rounded medical staff of 14 providers at a beautiful clinic with excellent benefits. For more information contact, Dr. Cate Buley, Assistant Medical Director, Ethel Lund Medical Center, Juneau, Alaska 1-907-364-4485; email *cbuley@searhc.org*. Position open March 2014. Look us up online at *www.searhc.org* job vacancies. (8/13)

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

The Sells Service Unit (SSU) in southern Arizona is recruiting for board certified/board eligible emergency room physician, family/internal medicine physician, and physician assistants 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) 295-2481 or by e-mail at *peter.ziegler@ihs.gov*. (8/13)

Mid-Level Practitioner
Health Director
Quileute Tribe; La Push, Washington

The Quileute Tribe has a job opening for a full-time mid-level practitioner. Must be a certified physician assistant, licensed in the state of Washington, and must have a valid Washington driver's license. Submit your application, professional license, cover letter, resume and three references by August 16, 2013, although the position will be open until filled.

We are also looking for a health director, who will provide administrative direction, negotiate and administer IHS contracts, develop and administer budgets, write reports, insure HIPPA compliance, comply with ACA, manage EHR, evaluate staff, and insure third party reimbursements are done. Must have a bachelor's degree related to health administration, and two years of management experience. This position is open until filled.

Telephone (360) 374-4366 or visit our website at *www.quileutenation.org* for a job application and job description. Alternatively, you may contact Roseann Fonzi, Personnel Director, PO Box 279, 71 Main Street, La Push, Washington 98350; telephone (360) 374-4367; fax (360) 374-4368; or e-mail *roseann.fonzi@quileutenation.org*. (8/13)

Pediatrician
Gallup Indian Medical Center; Gallup, New Mexico

The Gallup Indian Medical Center is in northwest New Mexico, on the edge of the Navajo Reservation, about 140 miles west of Albuquerque. The Department of Pediatrics has immediate openings for board-certified/eligible pediatricians. Our current seven (7) pediatricians divide their time between outpatient and inpatient, offering comprehensive medical care to children, birth through age 18 years. We provide well-child and preventive care for children with chronic diseases (including asthma and obesity), provide some walk-in care for acute conditions, admit patients to our Pediatric Inpatient Unit, attend high-risk deliveries, and occasionally stabilize certain ill newborns and children for transfer to higher level of care in cooperation with our Women's Health Unit and Emergency Department. We enjoy the services of a dedicated pediatric nurse case manager to assist in referrals. Children in need of pediatric subspecialty care are referred to centers in Albuquerque or Phoenix. Other services represented include Emergency Medicine, Internal and Family Medicine, OB-GYN (with midwifery), General Surgery, Orthopedics, Podiatry, Diabetes Specialist, Optometry and Ophthalmology, Dental, Physical Therapy, Occupational Therapy, and Speech & Language Therapy, as well as comprehensive laboratory and radiology services on-site. Job applications should be made on-line at USA Jobs. For more information, please contact Dr. John Ratmeyer by e-mail at *john.ratmeyer@ihs.gov* or by telephone at 505-722-1000 (page). (4/13)

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 and low risk obstetrics, and ER care. We currently staff for 12 full time physicians, and 5 full time FNP/PA positions. Our facility is located in northern Arizona, 90 miles NE of Flagstaff and 70 miles N 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 and within a 90 mile radius to 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 Jon Stucki, MD at (928) 737-6147 or *jon.stucki@ihs.gov*. Additionally, you may contact Darren Vicenti, MD, Clinical Director at (928)737-6141 or *Darren.Vicenti@ihs.gov*. CVs can be faxed to (928)737-6001. (4/13)

THE IHS PRIMARY CARE PROVIDER

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

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

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

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