THE IHS PRIMARY CARE PROVIDER

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

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Annual Elders Issue -

This May 2012 issue of *The IHS Provider*, published on the occasion of National Older Americans Month, is the seventeenth 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 2013 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.

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Partnership for Life: The Cherokee Project. - A Collaboration Between the - Charles George VA Medical Center - and Cherokee Indian Hospital Authority -

Penny James, MSW, LCSW, LCAS, Franklin/Cherokee HBPC Program Coordinator, Franklin, North Carolina

The Charles George Veterans Administration Medical Center (CGVAMC) is located in western North Carolina and has community-based outpatient clinics (CBOCs) in Franklin and Rutherfordton. The CGVAMC serves mostly rural veterans within a 20 county catchment area, which includes Cherokee, North Carolina, home of the Eastern Band of Cherokee Indians. The Charles George VA Medical Center is named in honor of Medal of Honor recipient and member of the Eastern Band of Cherokee, Charles George, a Korean War Veteran who sacrificed his life to save his fellow soldiers.

In 2004, CGVAMC and Cherokee Indian Hospital Authority (CIHA) formalized a partnership and sharing agreement to improve access to health care and services for the Eastern Band of Cherokee (EBCI) Indian veterans, which included a memorandum of understanding. As a result of this partnership, a Native American VA care coordinator position was created that was jointly funded by VAMC and CIHA. This agreement provides the framework for our continued collaboration between the CGVAMC, CIHA and the EBCI.

The Native American VA care coordinator position was established at the Cherokee Indian Hospital in 2005. Mr. William "Skip" Myers, RN, was selected for this position because he had experience as an employee of both health care systems. He began his efforts by developing a list of Cherokee veterans who are eligible for services at CIHA and VA. In this role, Skip is able to enroll veterans into the VA and coordinate VA specialty visits. Further, Skip was instrumental in designing the case management program for Cherokee Indian Hospital and now actively participates on their Managed Care Committee.

Home-based primary care (HBPC) is a program offered by the CGVAMC to veterans; it serves as the primary care provider for veterans with complex chronic diseases for whom traditional clinic based care is not possible. The HBPC program provides comprehensive, longitudinal care often until the end of life through the use of home visits. Services include ongoing monitoring of medical needs and changes in functioning, routine comprehensive assessments, coordination of care, and the prevention or early detection of worsening conditions.

HBPC works with the veteran, their family, their caregiver, and the community to ensure quality care. The program uses an interdisciplinary team of health care professionals who work together to create a plan of care specific to each veteran. Services are delivered by an interdisciplinary team that includes a nurse practitioner, registered nurse, rehabilitation therapist, social worker, dietitian, psychologist, and pharmacist, and is under the direction of a physician.

The HBPC program is designed for veterans to improve quality of life and restore health so the veteran can function at the highest level. HBPC works to reduce emergency department visits, hospital admissions, and the length of acute bed days of care. Another goal is to support caregivers in their desire to keep a loved one at home. One example includes Mr. R., a 38-year-old married Cherokee male who worked in tribal government until he was diagnosed with a progressive neurological degenerative disease. Since admission to HBPC more than two years ago, Mr. R. has become bedbound, lost his ability to speak, and has become totally dependent on his wife, who provides most of his daily care. Through HBPC and the larger VAMC, Mr. R. received a grant for home modifications to include a handicapped accessible bathroom. In addition to the traditional HBPC services of nursing, social work, and nutritional support, the HBPC OT worked with the veteran to obtain some of the latest, most innovative computer assistive technology devices available. The VAMC also provides in-home aid assistance, which helps with bathing and other personal care. All of these supports have allowed this veteran to remain at home with his family, which has been his greatest wish.

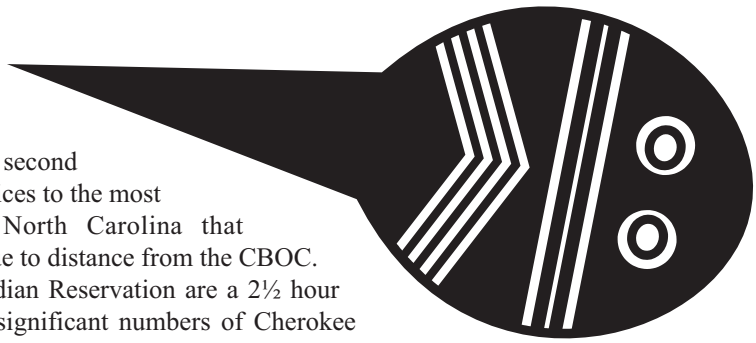
In spring 2009, the CGVAMC received funding through the Office of Rural Health to develop a satellite HBPC program at the CBOC located in Franklin. The intent was to serve 45 veterans in the HBPC program, with a special emphasis on

Cherokee veterans. Although the HBPC program grew quickly and was successful in meeting the targeted capacity, we were not able to fully serve all veterans in the six-county area of rural western North Carolina, including Cherokee veterans living on or near the Qualla Boundary. To meet the needs of Cherokee and non-Cherokee veterans in western North Carolina, the satellite HBPC program needed to expand, and a proposal for a new Cherokee HBPC team was submitted to the Office of Rural Health in summer 2010.

The intent of the Cherokee HBPC program is to develop an innovative and proactive partnership between the VA health system and the EBCI in western North Carolina — both the Cherokee Tribe and Cherokee Indian Hospital Authority. The proposal represents the best aspects of a partnership: implementing a well-designed and successful model of health care with interested and progressive stakeholders. This expansion has three goals. The first goal is to develop a model that enables Cherokee veterans to receive services through both the VA and the CIHA systems without having to "choose" between them. A second goal is to expand HBPC services to the most remote parts of western North Carolina that currently cannot be served due to distance from the CBOC. Sections of the Cherokee Indian Reservation are a 2½ hour drive from the CBOC, and significant numbers of Cherokee Indians live in clustered communities without easy access to health care. The third goal is to develop a model that serves Cherokee non-veterans as well; this model could then be replicated throughout the reservation, staffed by CIHA employees, such that frail and medically compromised Cherokee could receive the specialized services available through the HBPC-type program. Ultimately, of course, the goal is to help CIHA develop an HBPC model, staffed by CIHA employees, who can provide care to non-Cherokee who would benefit from primary care in the home setting. HBPC would continue to provide technical support and services to Cherokee veterans.

The Cherokee HBPC program received funding from the Office of Rural Health (ORH) in March 2011. Ultimately, this funding will enable 120 - 135 patients living near the Cherokee Indian Reservation to receive HBPC services. Although this expansion and partnership is still in its infancy, great strides have already been made. VA HBPC staff have been hired, oriented, and trained, and CIHA leadership has provided office space within the hospital for HBPC. Additionally, HBPC staff have participated in cultural competency training provided by CIHA.

At present, physicians employed by CIHA have been privileged through the CGVAMC and will provide medical oversight and supervision for patients they already serve who are then referred to HBPC. These physicians work closely with the HBPC Physician, who is privileged through the CIHA system and able to fully access both electronic health records systems for patients. Because of this arrangement, Cherokee Veterans do not need to discontinue their relationship with Cherokee providers in order to enable HBPC to serve as the primary care provider. CIHA will also offer support staff from social work and food and nutrition; these staff members will be available for consultation and collaboration for Cherokee patients, especially for issues that require a more in-depth knowledge and understanding of cultural norms and practices.



Cherokee veterans enrolled in both CIHA and HBPC continue to receive medication through CIHA, which has no copayment requirements. They receive specialty care through whichever system can best meet their needs. Care is coordinated by the HBPC mid-level provider, who can access both systems and reduce duplication and conflict. Cherokee veterans enrolled in HBPC receive increased benefits of care, coordination, resources, and entitlements.

The CGVAMC and CIHA continue to partner in other areas, including pharmacy. Because of the existing sharing agreement that allows access to the electronic medical record, the CGVAMC is now providing pharmacy coverage for CIHA after working hours and on weekends and holidays. Additionally, the geriatrics and extended care team has collaborated with CIHA staff to provide palliative care and hospice training, with plans for sharing additional training resources in the near future. Staff at both facilities are committed to this partnership and share a common goal, that is, to continue to provide excellent medical services for all veterans.

For additional information, please contact Penny James, MSW, LCSW, LCAS, Franklin/Cherokee HBPC Program Coordinator, 647 Wayah Street, Franklin, NC 28734; telephone (828) 231-8679.

Transitions in Care Settings: A Time of Risk -

Bruce Finke, MD, Nashville Area Indian Health Service, Northampton, Massachusetts

The transition in care that occurs when an individual is discharged from the hospital to either their home or a nursing facility is a very high-risk time for elders and their families. About one Medicare patient in five is readmitted within 30 days of discharge; one in three are readmitted within 90 days. It has been estimated that a large portion of readmissions are potentially preventable. A look at the causes of potentially avoidable readmissions to the hospital suggests that there are frequent failures in the processes of care transition. Only half of patients readmitted within 30 days had a physician visit before readmission.[1] Some 19% of Medicare discharges are followed by an adverse event within 30 days; two-thirds of these are adverse drug events.[2]

There is a large national effort underway to improve care across transitions. The Partnership for Patients initiative of the US Department of Health and Human Services (DHHS) aims to reduce readmissions by 20% compared to 2010 rates by the end of 2013. The Administration on Aging is undertaking a large national initiative to engage the Aging Network, including Tribal Senior Centers, in creating safer care transitions.

The people we care for in the Indian Health system frequently move back and forth across settings and systems of care. Much of their care takes place in hospitals outside of our system. These transitions are further complicated by geographic and cultural distance. And when potentially preventable hospitalizations occur, the costs often fall to Contract Health Services.

In the accompanying article, Kay Branch tells a very personal story that takes place outside of the Indian health system but that brings home the challenges and opportunities for better care across transitions. It is a story that is sadly familiar to all of us working in Indian health and to the elders and families we care for.

We have valuable assets in the Indian health system to address and improve transitions in care. The development of team-based primary care and integrated care management in our health centers and hospital-based clinics supported by the Improving Patient Care program offers new capabilities to manage care across transitions. Public health/community health nursing, community health representatives, and senior centers are valuable and highly capable resources for assisting elders and their families through transitions in care. Finally, the growing tribal capacity to provide long term services and supports, including home health nursing, palliative care, hospice, and personal care services means that the culturally appropriate community-based services required for safe transition are increasingly available in the communities we serve.

We can do this right in Indian Country if we understand that transitions in care represent a period of high risk for our elders and if we commit to bringing the resources we have available to us to bring patients through this transition safely.

For more information about improving care across transitions, look to the following resources:

1. Care Transitions Quality Improvement Organization Support Center *www.cfmc.org/caretransitions/*
2. The Aging Network and Care Transitions: Preparing Your Organization Toolkit *www.aoa.gov/AoARoot/AoA_Programs/HCLTC/ADRC_CareTransitions/Toolkit/index.aspx*
3. Healthcare.gov *www.healthcare.gov/center/programs/partnership/safer/transitions_html*
4. CMMI Community-Based Care Transitions Programs *http://innovations.cms.gov/initiatives/Partnership-for-Patients/CCTP/partners.html*

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2. Forster AJ, Murff HJ, Peterson JF, Gandhi TK, Bates DW. The incidence and severity of adverse events affecting patients after discharge from the hospital. *Ann Intern Med*. 2003;138:161-167.

Personal Observations about Care Transitions -

Kay Branch, Elder Care Program Coordinator, Alaska Native Tribal Health Consortium, Anchorage Alaska

On Thanksgiving Day, 2011, there began a series of events that emphasized to me the importance of good care transitions. I've worked in elder care for nearly 20 years, and thought I understood how to help someone get their needs met. I had been reading about the new care transition projects under the Centers for Medicare and Medicaid Services, and I knew about the Indian Health Service Improving Patient Care program. My mom's situation proved a difficult learning experience for me, about paying attention and acting as a patient advocate, and illustrated the need for increased communication between hospitals, nursing homes, physicians, and family members during this trying time.

My mom passed away on February 15, 2012. She was at home. I was with her. So was the rest of my family. She was 83 years old. She had a long, slow journey with Alzheimer's disease, with more and more frequent bouts of extreme pain from advanced osteoporosis. She was first hospitalized on Christmas 2010 for pain and osteoporosis. We couldn't leave her alone at the hospital because of her dementia. We took turns and slept there. Over the next year I visited as often as I could. My father became a wonderful caregiver for her, and my sister moved back into their house. We were lucky; we spent a lot of joyful time with her over the next year, watching the birds, feeling the breeze, and watching her favorite movies over and over. My father wrote down the story of their early years together.

Thanksgiving Day, Mom wasn't feeling well; she was in a lot of pain. The family decided to take her to the hospital. She was there for about a week, and then transferred to a nursing home for rehabilitation. Although her pain was under control at the hospital, the physician at the nursing home (who was also her primary care doctor) changed her medication. It wasn't working. My family was there 24 hours a day because we knew that if she woke up and didn't see anyone she knew she would be afraid, try to get up, and probably fall. We were there in shifts; mine was midnight to 6 am. The nursing staff was efficient and caring; they got to know us well. The physical and occupational therapists were exceptional, very kind and patient as they tried to get Mom to participate in the therapy she needed so she would get better. But she was in such pain. We kept asking about her pain medication. We talked to the physician when he came in, to see if she could have something stronger. I was afraid that if she couldn't participate in therapy, Medicare would no longer pay for her stay. Finally, after a week of the pain increasing to an intolerable level, her medications were changed. The difference was staggering. Mom started to smile, participate in therapy, and complain about the meals. After a month, she was ready to go home.

On the day of her discharge the physician was out of town, and so was his nurse practitioner. There was no prescription for pain medication; the nursing home could not send anything home with her. Finally, right before discharge they were able to obtain a prescription from another physician, but it was not the same as what she was receiving in the nursing home.

Mom went home on January 3, 2012. Once again her pain began to worsen. On January 11, the family took her to the emergency room; her pain was unbearable. She saw a neurologist who had examined her five years before. He gave her different, stronger pain medications. She went home.

On January 12, 2012, because of her dementia she couldn't remember to call someone to help her get up. She stood, fell, and cut her head. She went back to the emergency room. She was admitted. Her pain regimen was still inadequate. She was also constipated from all the medication. The palliative care team was brought in. They talked to us, wanted to know what pain medications had worked. They called the nursing home and put mom back on the same pain regimen she had there. Mom started feeling better. We got a referral to hospice. Finally, we took her home and had the support she needed to be free of pain, and we had what we needed to be with her and help her in her last days.

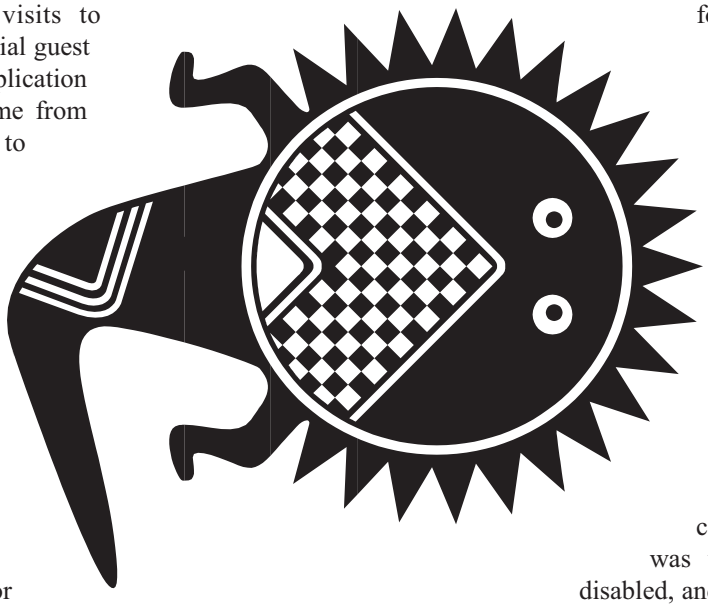
My family isn't American Indian or Alaska Native. This happened in Florida in the private health care realm. I have had the wonderful experience of working with Alaska Native elders and their families over the past 17 years, and don't want people to have to suffer like my mom. I know we can do better than this in the IHS and tribal health system. We must, for the sake of our elders and their families.

The Caring House Adult Day Health Program -

Elizabeth Antone, RN, BSN, MBHCM, The Caring House, Gila River Indian Community, Sacaton, Arizona

In 2006 the Gila River Indian Community (GRIC), in Sacaton, Arizona, appointed an "Owner's Team" to create the design of the Adult Day Health Program that would be part of the new skilled nursing facility, The Caring House. With the building completed and plans for the operation of adult day health services well underway, GRIC received the needed start-up funds from an Indian Health Service Elder Care Initiative grant in August 2010.

GRIC began a marketing campaign to recruit program participants or "guests." The marketing phase included holding meetings in each of the seven GRIC districts to introduce the program, and additional recruitment through the local elderly program and the State of Arizona Long Term Care Program administered by the tribe. GRIC staff also conducted home visits to provide assistance to the potential guest in completing the formal application process. Self-referrals also came from family members responding to flyers placed throughout the community. Guests and their families were able to tour the new facility.



The day health program opened on June 1, 2011, and has been a tremendous success. The goal of the day health program is to extend the time elders remain in their home or that of their relatives. Families needed a resource for day care for their elder parents or relatives while they work or have medical appointments themselves. The center is open from 8 am until 5 pm daily. Transportation is provided. Once at the center, guests are provided with an array of services to assist them in performing their activities of daily living. Medication administration, and glucose and blood pressure monitoring are some of the services provided. Guests receive snacks and a nutritious meal appropriate to their specific diet. The staff is composed of a registered nurse, licensed practical nurse, certified nursing assistant, and an activity aide. Activities are designed and coordinated by the accredited activities director for the Caring House Skilled Nursing Facility and include current events, reminiscing, chair exercises, making crafts for cultural events and holidays, gardening, trips to museums or the zoo, or a meal at a nice restaurant. Educational sessions are provided on diabetes care, nutrition, and other health topics. Traditional music is played throughout the day and one can always catch guests toe tapping to a good song while they are making their crafts. Those who can still stand and dance will do so and have been heard to say "I still got it!" One of the favorites on the list of activities is "words of inspiration," where any of the guests can share with the group their spiritual support. Crafts are for sale as part of the fundraising to travel to local zoos, museums, and holidays events in the community.

Current guests who were initially reluctant to attend were asked what they like about the program, and some of the replies were, "I didn't feel like getting out of bed before, now I like to dress up and get ready for the day to come here, and I can hear about what's going on in the community and the world." "I was very depressed being elderly, disabled, and stuck at home; I didn't realize how much until I came and I am a different person now. I have received physical therapy here and am stronger now." "The best thing about this program is the food, but then I like to dance too." Transportation is provided if needed by the long term care program. Marketing and recruitment are ongoing and potential new guests stop by to visit the program. Brochures are available.

Clinical Tools and Training from - the Division of Diabetes -

Chronic Kidney Disease Training - 3 sessions

One hour CME/CE web based trainings are available 24/7 at no cost.

- Screening and Monitoring Chronic Kidney Disease, by Ann Bullock, MD
- Chronic Kidney Disease Management, by Andy Narva, MD
- Chronic Kidney Disease Nutrition by Theresa Kuracina, MS, RD, CDE

These and other Web-Based Diabetes Trainings are available on the Division of Diabetes web site.

NOTE: There are a total of **9 hours** of free CME approved online courses, available at the link below: *http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=trainingWebBased*

Diabetes Treatment Algorithms

The Diabetes Treatment Algorithms (including CKD Algorithm) provide clinicians with a quick reference to treatment algorithms based on national guidelines and the Standards of Care and Clinical Practice Recommendations: Type 2 Diabetes. These algorithms:

- Are tools to provide information for clinicians needed at the POC.
- Are step-by-step management guides for the associated condition.
- Have information on dosing, common adverse reactions and contraindications for medications on the IHS National Core Formulary.
- Provide treatment targets and goals.
- Give recommended monitoring parameters.

The algorithm cards are downloadable and are available at: *http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=toolsDTTreatmentAlgorithm*

ALGORITHM CARDS:

- Type 2 Diabetes and Chronic Kidney Disease
- Urine Albumin Screening and Monitoring in Type 2 Diabetes
- Type 2 Diabetes and Glucose Control
- Type 2 Diabetes and Insulin
- Type 2 Diabetes – Lipid and Aspirin Therapy
- Type 2 Diabetes and Hypertension
- Type 2 Diabetes and Neuropathy
- Foot Care and Type 2 Diabetes

Advancements in Diabetes Seminars

Join us monthly for a series of one-hour live WebEx seminars for health care professionals who work with patients who have diabetes or are at-risk for diabetes. Provide up to 12 CME/CE hours per year.

- Seminars are generally held at 1:00 pm Mountain Time.
- Presented by experts in the field who discuss what's new, update your knowledge and skills, and describe practical tools you can use to improve care for people with diabetes.
- One hour of no cost CME/CE credit. **Accredited Sponsors**: IHS Clinical Support Center, the IHS Nutrition and Dietetics Training Program and the IHS Division of Oral Health.
- Registration for each of the seminars starts approximately two weeks prior to the seminar and continues until the start of the seminar. Registration and seminar information, including handouts, is available via the following link: *http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=trainingSeminars*
- Upcoming seminars include:
  - May 23, 2012 @ 1:00 pm MDT: Individualizing Diabetes Targets: One Size Does Not Fit All, by Ann Bullock, MD
  - June 28, 2012 @ 1:00 pm MD: Group Medical Visits and Diabetes, by Jean-Paul Dedam, MD
  - July 18, 2012 @1:00 pm: Care Coordination: Transitioning to Dialysis, by Stephanie Mahooty, NP

For information contact the Division of Diabetes at diabetesprogram@ihs.gov.

Finding the Path to - Culturally Appropriate End-of-Life Care -

Dorothy Low, RN, Program Manager, Desert Pathways Program, Tohono O'odham Nursing Care Authority, Sells, Arizona

Provision of medical care always needs to include an assessment of the cultural factors that impact how the patient will receive and utilize the information and medications they are given. In no area is this more important than when addressing end-of-life issues that impact the patient as well as the family unit. In 2006 the Tohono O'odham Nursing Care Authority board (TONCA) identified the need for culturally sensitive end-of-life care as a component of developing a continuum of care for elders on the Tohono O'odham reservation.

The decision was made to pursue opening a Medicare certified hospice program, which was accomplished in 2008. The hospice program development included tribal members who were primarily aware of hospice from being involved with the outside hospice that had provided care to appropriate residents at Archie Hendricks Senior SNF. As the community was educated about the availability of this option, frequent comments were heard about family members who had received end-of-life care at facilities 60 - 100 miles from home because there was no hospice care available on the reservation.

As the program was launched, the expectation was for a slow but steady growth as people became aware of the service. However, growth eventually stagnated and we began to hear of situations where people were refusing hospice care and passing away without support. One of the primary reasons for this seemed to be that people thought of hospice as a place you go to die within a few days rather than a way of caring for someone for several months. In addition, we became aware that there were people in the community who were struggling with symptom management of a serious illness or who needed education and support to understand what the providers were telling them and what the path of their illness likely was going to be.

In an effort to address these identified issues, we developed the Desert Pathways Program based on an O'odham phrase about the "uncertain roads of serious illness." The program goal is to provide an umbrella of services including education, symptom management, support for care choices made by the patient and family unit, spiritual/emotional support, and hospice care when appropriate. When staff have been involved with a family providing for their needs, hospice can be introduced as a way to better meet the needs of their loved ones; this is much less threatening than when hospice is introduced as a stand-alone topic.

The development of this new program, which included extensive community education, was boosted by a Robert Wood Johnson Foundation grant in recognition of Frances Stout, RN, BA (IHS, retired) as a Community Health Leader. This allowed the program to hire a full time community educator to begin the process of making people aware of this new service, and making connections with families that need such services. Currently the TONCA board is continuing the salary of the community educator to provide ongoing connections between community members and the program.

In addition to the financial support from the RWJ grant, the program also benefited from an objective and experienced consultant arranged for by the foundation. Wenonah Stabler, who had been a prior honoree as a Community Health Leader, made an on-site visit and shared her perspective on palliative and hospice care derived from her own experiences in introducing these programs into another tribal area. Her suggestions and insights were very beneficial.

An early component of the program was to develop quality measures for the services provided. This included categorizing types of visits made on behalf of Desert Pathways, which have been predominately helping with education and symptom management. Staff making these visits work closely with the patient's primary care provider at IHS. We also have measured the impact on our hospice length of stay. In 2009, without Desert Pathways, hospice average length of stay was 43 days. In 2011 that number rose to 73 days. This speaks to the benefits of having a relationship with the patient and family that looks at hospice as one piece of a comprehensive palliative care program instead of a "stand alone" function.

TONCA is committed to sharing "lessons learned" with other tribes or communities that would like to develop further end-of-life services. If we can be of assistance, please contact us at (520) 383-1893.

Cherokee Elder Care explores Quality of Life - for PACE Participants -

Shirley Inglis, RN, MS, Quality Assessment Performance Improvement (QAPI) Coordinator, Cherokee Elder Care, Tahlequah, Oklahoma; and Daniel R. Stout, BS Health Care Administration student, Northeastern State University, Tahlequah

Cherokee Elder Care in Tahlequah, Oklahoma, is the only PACE program in Oklahoma and, as of this writing, the only PACE program anywhere sponsored by a tribal government. Growing from a beginning of two participants in August 2008, we approach the 100th current participant milestone as we continue to grow slowly but steadily.

As an IDT (Interdisciplinary Team) driven model with active participant and caregiver participation in care decisions, PACE (Programs for All-Inclusive Care of the Elderly) provides comprehensive health care to individuals 55 years and older who are diagnosed with multiple complex medical issues and who meet skilled nursing facility LOC (Level of Care) as defined in their own states.

PACE programs are structured with three way collaborative agreements between CMS (Centers for Medicare and Medicaid Services), state Department of Health Services (Oklahoma Health Care Authority in Oklahoma), and a sponsoring organization; in Oklahoma, Cherokee Nation Comprehensive Care Agency, dba Cherokee Elder Care is the sponsor. Governed by both federal and state regulations, and with oversite from the governing board, all PACE programs report a set of quality indicators such as immunization rates, emergency room and hospital visits, as well as readmissions rates, grievances, and appeals, etc. As with many health care programs, Cherokee Elder Care regularly assesses participant satisfaction in addition to the defined quality indicators mentioned above which are gathered across all PACE programs.

During year three of Cherokee Elder Care's operation, participant satisfaction surveys indicated satisfaction with medical care through PACE "always" or "usually" 97% of the time. One-hundred percent of participant "felt respected by staff." Participants are satisfied with transportation services "always" or "usually" 100% of the time. Cherokee Elder Care's Quality Assessment Performance Improvement program is, by regulation, driven by data gathered from both quantitative and qualitative means. While still very positive percentages from participants, a few "seldom" responses in the areas of food, on-call, and activity programming were noted for administration and staff. Using these data, plans of action have been implemented to address those areas.

However, a question we had not answered was, "Has being a PACE participant made a difference in your life?" With the support of the Board of Directors, and assistance from the Kathryn M. Buder Center for American Indian Studies at Washington University in St. Louis, Missouri, through a student internship, we designed and adapted an initial quality of life questionnaire addressing the following domains: body, mind, context, spirit, and general questions. Cherokee Nation Human Services leaders also reviewed the questionnaire and the process. From the Board of Directors' came the recommendation that an individual outside of, but still familiar with, the PACE program at Cherokee Elder Care administer the survey. A student in health care administration at Northeastern State University located in Tahlequah administered the survey to all participants who had been in the PACE program longer than six months. An encouraging participant participation rate of 74% was achieved.

Goal of Quality of Life survey: Introduction. We are asking for your help with questions to better understand how being a part of Cherokee Elder Care may have changed your life. Your answers to the questions will help the Cherokee Elder Care staff know if they need to make changes in the program or help you in different ways. I will ask you questions that will let us know if being at Cherokee Elder Care, or using the services that come into your home, has made your life better, has not changed it, or you feel life is not as good as before.

Results: Body. Some 65% of participants reported that their physical strength to do what they want to do became better with 23% reporting that physical strength stayed the same. Anecdotally, one participant stated that she likes working with PT/OT; people's positive attitude helps me out a lot. Another participant likes riding the exercise bike and walking inside. Another appreciated the rehab help after knee surgery.

About 42% of participants reported more energy since coming to PACE, while 42% reported that energy stayed the same. Being more motivated was reported by one participant while another reported doing her own exercises at home.

Results: Mind. Seventy-seven percent of participants reported that the feeling of being involved in life has become better, while 19% report it has stayed the same since coming to

PACE. Participants reported more opportunities to learn new things at a rate of 56% while 38% report that item has stayed the same. Being around other people, opportunity to meet new people, likes coming here to socialize and share experience, being around people helps were encouraging comments to read. One participant mentioned liking the field trips and people (volunteers) who come in and do new things.

Results: Context. Participants reported, at a rate of 63%, that the way you get along with people you are closest to has become better. Being here has relieved family members from taking care of (me) her. One notation thanked the licensed certified professional counselor on staff for help in this area and another participant states that she can now talk to family about life experiences. About 31% of participants report feeling safer in their home and 61% continue to feel the same degree of safety as before PACE. One writes they feel safer thanks to the alert system

Results: Spirit. The feeling of having a purpose in life has become better for 60% of participants. Some 65% report hope for the future has become better, with 31% reporting hope has remained the same; one participant states he has good and bad days. One participant feels healthier and has more drive. There's encouragement here says a regular participant who reports he has more hope.

Results: General. Since starting Cherokee Elder Care, 79% of participants report that their overall health or satisfaction with life is better. It's the best thing that has happened to me; I love being around people.

Cherokee Elder Care was encouraged to gather both measurements and words to describe the participants feelings about how life had changed or not as a result of enrolling in the PACE program. The PACE participants provided their personal viewpoints on how they felt both physically and emotionally, as well as how those feelings or sense of well being improved life's purpose. The resulting material was more than encouraging to the staff, particularly in that almost eight out of ten participants report that satisfaction with life is better since enrolling in PACE. As a direct result of this survey, Cherokee Elder Care will continue focusing on improving cultural, spiritual, and physical activities in order to foster hope for the future for all participants and their families.

Through the PACE model of care, Cherokee Elder Care will continue to explore ways to serve the frail, over 55, elderly population of eastern Oklahoma with comprehensive, compassionate, individualized, quality care.

For more information on PACE visit the NPA (National Pace Association) web site at www.npaonline.org.

Update on Faye

The story of Cherokee Elder Care's number one PACE participant, Faye Richardson, was published in an article titled "Faye's Story: Life's Circle" that ran in *The IHS Primary Care Provider* in May 2010. Faye was the first of two individuals to start at Cherokee Elder Care on August 1, 2008. Faye continues to live a life of quality. Over the past four years she has seen a lot of changes and helped CEC grow. Last year she made the decision to live independently. She moved from her home where she was living with her daughter, into her own apartment. Faye said she enjoys her independence. "You have to keep going forward instead of backwards in life. I try to do what the medical staff asks me to do, and they have done a great job with me; my care goes on. They treat me well and I am well satisfied with my medical care." Faye recently had eye surgery, now she feels she is able to see all her family and friends better. She continues to attend the ADHC two days a week and has a personal care aid that comes to her home three days a week. Family and members of her church visit her regularly, in the evenings and on weekends. "Faye's Story" continues in her "Life's Circle."

Wisdom Warriors: Living Long, Living Strong -

Shelly Zylstra, Planning Director, Northwest Regional Council, Bellingham, Washington

A commonly heard buzzword today is "evidence-based." In short, this means that a system or program has been proven effective through studies published in professional journals. Several evidence-based models have been found to be effective in keeping older adults healthy, but the Stanford University Chronic Disease Self-Management Program (CDSMP) is likely the most widely used. Using CDSMP as a starting point, some tribes in the Pacific Northwest have begun a health promotion program for their elders called Wisdom Warriors, which has the potential to benefit elders who participate.

CDSMP was developed by the Stanford University Department of Family and Community Medicine. Researchers conducted a series of focus groups with people with chronic conditions to determine which areas of their lives were most important to them in managing their illness. With these priorities in mind, and building upon the understanding that self-efficacy can enhance and improve health, researchers developed a series of workshops during which participants can learn skills and establish competency through practice.

CDSMP was developed and extensively reviewed to assure that it was effective in both the short- and long-term. Since its development in 1996, the program has been used in a variety of countries, languages, and cultural groups, and with chronic illnesses of all types. People who took the workshops, when compared to those who did not, demonstrated significant improvement in exercise tolerance, cognitive symptom management, communication with physicians, self-reported general health, health distress, fatigue, disability, and social/role activities limitations. They also spent fewer days in the hospital, and there was also a trend toward fewer outpatient visits and hospitalizations. These data yielded a cost to savings ratio of approximately 1:4. Many of these results persisted for as long as three years.

The program consists of a series of six workshops, each 2 1/2 hours long, which contain multiple activities. Integral to the program is acknowledgement that most chronic illnesses share common symptoms: pain, fatigue, tense muscles, shortness of breath, stress, anxiety, depression, and the disease itself. Although referred to as the "symptom cycle," there is no predictable or usual way that people with chronic illness experience them. Acknowledging that these symptoms are common to virtually all chronic conditions to some extent establishes common ground within the group, regardless of their type of illness.

In order to manage these symptoms, class participants work with a "self management tool box" of strategies that are taught and practiced during the class and during the week between classes. Techniques in the toolbox include physical activity, managing medications, managing fatigue, planning, better breathing, working with health professionals, problem-solving, managing pain, using your mind, communication, healthy eating, and understanding emotions. Participants learn that each symptom has a tool that works well to manage it, and, little by little, progress is made and confidence is built.

Another hallmark of the program is the "action plan" where leaders model and participants establish a goal for the coming week. Action plans are specific (What?, When?, How often?, How much?) and must be action-oriented and demonstrably achievable. In addition, a participant must have a confidence level of 7 (on a scale of 1 - 10) that it can be accomplished! For example, a goal for health might be weight loss; however, in order to accomplish that, an action plan would be to walk, in the morning, two days per week, for 20 minutes with a confidence level of eight. Each participant establishes his or her own action plan each week and reports on their progress the following week. Participants can ask the group for suggestions to improve their progress, which in turns teaches problem solving and enhances communication.

In the Pacific Northwest, tribes, in conjunction with the Northwest Regional Council, an Area Agency on Aging, are taking CDSMP one step further through a program called Wisdom Warriors. Elders and others who complete the course receive a fringed deerskin bag at a graduation celebration. They then meet monthly to revisit the techniques they learned in the workshops and apply them to health promotion areas: good nutrition, exercise, cultural/spiritual activities, intergenerational experiences, health management activities, and screening and prevention. Tribal and community experts provide discussion groups about the monthly topic and elders make "action plans" for the month in the monthly focus area. For example, if screening and prevention is the topic, a clinic nurse could conduct a class about the importance of having a colonoscopy. Elders could establish an action plan to get an appointment to schedule the procedure and/or do a fecal occult blood test some time during the coming month. The clinic nurse can assist with scheduling or provide the tests for participants to take home. Elders who complete their plan earn

a bead to put on the fringe of their bag and, at the end of the year, a charm to hold the beads on the fringe.

The Wisdom Warriors program is in its infancy, but CDSMP classes have been held, and tribal elders are making huge strides in managing chronic illnesses. Weight loss, better diet, increased exercise, and an enhanced belief in their ability to manage are just a few of the positive outcomes from the class. Maintaining the core values established in the class and emphasizing the importance of the lessons learned has proven to be a powerful way to extend the reach of the Program.

If you would like to talk about the Wisdom Warriors program or establishing a Chronic Disease Self Management Program in your community, Shelly Zylstra (*zylstra@dshs.wa.gov* or (360) 676-6749) would be happy to share what she has learned. Elders are a precious commodity. Anything we can do to enhance the quality of their lives and keep them contributing to the community is worth considering.

Help us Save Money -

The federal government is always exploring ways to reduce costs. One recent initiative is an effort to reduce printing expenses. As our readers know, last year we made a transition from an every month print version of *The Provider* to a quarterly print version, thus saving both printing and mailing costs. About 5000 readers still have paper subscriptions.

Although we made this change in the printing schedule, we continued to post the monthly edition of our journal to the CSC website. Currently, about 900 individuals are subscribers to the listserv that notifies them when each monthly issue is posted, and lists the contents of that issue. It is unknown how many readers simply access the website on a periodic basis without relying on the listserv for reminders that the monthly issue is available. It is also unknown how many individuals subscribe to both the print version and the listserv.

As one contribution to the effort to minimize costs, we would suggest to our readers the following: 1) if you have a paper subscription and are no longer using it, or if you know of someone who has left your facility but is still receiving the paper edition, please contact *Cheryl.Begay@ihs.gov* in our office to let her know that these subscriptions can be stopped; 2) if you have both a paper subscription and access to the on-line version, and it makes little difference to you which version you use, you may want to consider stopping the paper version and use the one on-line; and 3) if you are using the on-line version and are not on the listserv, you may want to join (go to *http://www.ihs.gov/provider/index.cfm?module=listserv*), as this provides us with more accurate data about readership.

It is likely that at some point in the not-too-distant future, there will be a mandate to discontinue paper distribution entirely in favor of website publishing. Now might be a good time for our readers to begin this transition.

Please let us know if you have any questions or suggestions.

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

IHS Child Health Notes -

Quote of the month

"The great tragedy of science is the slaying of a beautiful hypothesis by an ugly fact."

Thomas Huxley

Articles of Interest

Effectiveness of adenoidectomy in children with recurrent upper respiratory tract infections. *BMJ*. 2011; 343 doi: 10.1136/bmj.d5154. *http://www.bmj.com/content/343/bmj.d5154*

Acute upper respiratory tract infection is a common diagnosis in children in primary care. Upper respiratory tract infections (URIs) not only affect children's health but also account for a large proportion of annual health care expenditure and high indirect costs for the family and society. An estimated 20% of children experience recurrent upper respiratory tract infections, and some of these children are referred to the ear, nose, and throat surgeon for procedures. The goal of this study was to assess the effectiveness of adenoidectomy in children with recurrent upper respiratory tract infections.

Children were randomized to either immediate adenoidectomy or watchful waiting. The primary outcome measure was the number of URIs per person year calculated from data obtained during the follow-up period.

During the median follow-up of 24 months, there were 7.91 episodes of URIs per person year in the adenoidectomy group and 7.84 in the watchful waiting group (difference in incidence rate 0.07, 95% confidence interval −0.70 to 0.85). No relevant differences were found for days of upper respiratory tract infections and middle ear complaints with fever in episodes and days, nor for health-related quality of life. The prevalence of URIs decreased over time in both groups.

Editorial Comment

Recurrent URIs occur in one of five children, and this predisposes to complications such as otitis media and sinusitis. A frequent number of children are referred to ENT surgeons for upper airway surgery, although there is no evidence that such interventions are beneficial. Interestingly, the adenoidectomy rate is more than three times higher in the Netherlands, where this study was done, than in the US. This study confirms that surgical intervention offers no benefit over watchful waiting. It also confirms what most of us already suspected: URIs are mostly self-limited and decrease in frequency with increasing age. Sometimes the best thing to do is to do nothing.

Infectious Disease Updates

Rosalyn Singelton, MD, MPH

Hospitalizations for Lower Respiratory Infections in American Indian and Alaska Native Children: Improving But Still a Disparity

In 1999 - 2001 the lower respiratory tract infection (LRTI) hospitalization rate in American Indian/Alaska Native (AI/AN) children < 5 years was 1.4-fold higher than same aged children in the general US population. Nearly a decade later, in 2006 - 2008, LRTI rates have decreased 32% in both the AI/AN and general US child populations; however, the rate difference remains about the same. LRTIs comprise nearly half of all hospitalizations for AI/AN children compared with one-fourth of hospitalizations for the general US child population. Highest rates of LRTIs were seen in the Alaska and southwestern AI/AN regions, especially in children. The LRTI rate in Alaska and southwestern AI/AN infants was three times the US rate. The disparity was most pronounced for pneumonia in infants – especially in Alaska.

Why are LRTIs a big deal? In many IHS/tribal facilities, LRTIs (mainly pneumonia and bronchiolitis) are the leading causes of pediatric hospitalization. In addition to significant acute illness, LRTIs result in significant long-term morbidity in the form of chronic recurrent wheezing in infancy. Pneumonias can lead to chronic suppurative lung disease (including bronchiectasis) in older children. While rarely seen in healthy US children, bronchiectasis is common among western Alaska Native children (10 - 20/1000 births) who also experience the highest AI/AN pneumonia rates (nearly 10-fold higher than the US child population).

Reasons for inequities in LRTI hospitalization rates include household crowding, lack of running water, indoor air pollutants such as wood smoke, inadequate ventilation, and low parental educational level. There are several exciting projects and studies addressing these issues in Indian Country, including a woodstove change out study among Nez Pierce, indoor air quality studies among Alaska Native and Canadian Inuit children, Cold Climate housing research, bronchiectasis research with Australia and New Zealand, and evaluations of

villages receiving piped running water.

Do you have a great project or personal experience to share? We'd like to hear from you.

Singleton RJ, Holman RC, Folkema AM, et al. Trends in lower respiratory tract infection hospitalizations among American Indian/Alaska Native children and the general US child population. *J Pediatr*. 2012; epub before print

Recent literature on American Indian/Alaska Native Health

Jeff Powell, MD, MPH

Disparities in Infant Mortality and Effective, Equitable Care: Are Infants Suffering from Benign Neglect? *Annual Review of Public Health*. 2012. 33:75-87

For this months' CHN literature review, another article focusing on infant mortality caught my attention. This article, available to federal and tribal staff via the NIH library, provides a broad perspective on disparities in infant mortality. While the March review provided concrete data on the static disparity in Alaska Native infant mortality, this review highlights infant mortality trends among all US populations. By way of jumping to the conclusion, the article raises important questions about what is being done to impact infant mortality disparities among Native Americans and other US populations.

As the title implies, these authors are challenging health care systems and those of us working within them, to seriously address whether we are providing effective, equitable care. The article offers several examples of how clinical care, and the research that drives it, is progressing unjustly in this country.

First, the overview: infant mortality data (including neonatal and postneonatal infants) show broad disparities. American Indian and Alaska Native (AI/AN) infants have the second highest rate of death. The disparities reveal highly variable rates between ethnicities. Infants born to Asian/Pacific Islander mothers have one of the lowest infant mortality rates known. Immigrant Mexican women have infants at very low risk of dying, while Puerto Rican infants have a high mortality rate (similar to Non-Hispanic black Infants). Table 1 and Figure 1 in the article review cause-specific and overall infant mortality.

The authors' detailed consideration of cause-specific mortality provides an opportunity to reflect on health care delivery equity. For example, in 2005, Non-Hispanic black infants had an astonishingly high rate (305 per 100,000 babies) of death related to low birth weight (the rate for Non-Hispanic white babies was 76/100,000). Further, despite major medical advances, the trends over time do not reflect improvement in this gap. The question becomes, are the medical advances (and the research that drives them) the wrong interventions to address disparities? Or, do the advances simply magnify inequities in access to quality health care? For example, progesterone therapies during pregnancy have helped prevention of later-term premature deliveries for white women, but have had much less positive impact for black women. Non-Hispanic black women have much higher rates of inadequate early prenatal care, and have much higher rates of very preterm deliveries (factors that make progesterone therapy less effective). So in the context of inequitable health care access and higher risk of Non-Hispanic black very preterm infants, the infant mortality gap widens.

Turning to consider AI/AN infants, the top causes of death are congenital malformations and sudden infant death syndrome (SIDS). Congenital malformations are a troubling disparity, reflected by the relatively small evidence base for prevention discussed in this article. Folate consumption has been shown to have improved significantly in the past 20 years, yet disparities persist. I personally do not know whether AI/AN women's folate consumption has been fully evaluated.

SIDS disparities raise further questions about the effective, equitable care needed to close the gaps. The authors here demonstrate twenty-year mortality trends (Figure 3, 1989 to 2009). While the SIDS prevention "Back to Sleep" campaign is broadly credited with distinct and rapid reductions in SIDS deaths, mortality disparities persist. Our March review showed that Alaska Natives did not benefit broadly from this campaign. So the question becomes, Why has the SIDS campaign not provided more in terms of infant death prevention? For perspective, Table 1 shows that AI/AN SIDS rates are the highest among any group (112 per 100,000 infants, which is twice the rate of all races combined, more than four times the rate of Asian/Pacific Islander infants). The major intervention for SIDS has been a culturally neutral (if not culturally uninformed) approach with the back-to-sleep campaign. I have wondered for many years, if Navajo newborns and infants traditionally use cradleboards and, in my experience, rarely if ever are placed on the stomach, why should the standard "back to sleep " campaign be effective for our community here in Shiprock, New Mexico? Is it likely (and I think the persistent SIDS disparities point to this), that we are missing potentially effective interventions?

If we expect these disparities to go away, we need some additional approaches. This article pushes us to consider key questions. Are we guilty of benign neglect? Have we accepted the current state of health care delivery as sufficient? Have we accepted the status quo of inaction in the face of this disparity? The authors conclude that infant mortality disparities will not improve until society commits to finding interventions that support women, infants, and their families in health care and community settings. This broad support demands significant progress in research (e.g., community based, culturally relevant, participatory) and intervention strategies (e.g., preconception and interconception care reflecting the socio-ecological determinants of health) targeting AI/AN infant mortality. Benign neglect of preventable infant mortality is not an acceptable option.

Growing the System of Long Term - Services and Supports in Indian Country -

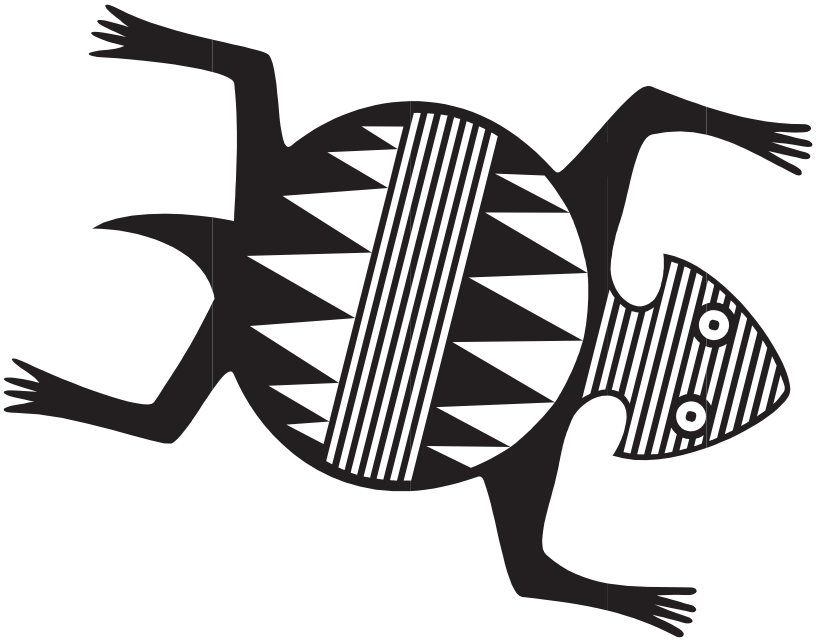
Bruce Finke, MD, Nashville Area Indian Health Service, Northampton, Massachusetts

On March 21 - 23 over 150 participants from tribal programs, Indian Health Service (IHS) facilities, and Urban Indian Health programs gathered in Denver to learn about the development and operation of facility-based care, home- and community-based care, hospice and palliative care, and care transitions. They shared their expertise and experience and learned from each other what works. They took home ideas, tools, and contacts.

On the fourth Wednesday of every month, from 2 - 3 pm ET, folks from across Indian Country participate in webinars focusing on the development of long-term services and supports (LTSS; long-term care). These webinars began in January with an introduction to the basics of long term services and supports and have addressed home and community-based services, care transitions, and patient-centered nursing facilities. The expert faculty for these webinars comes from both inside and outside of Indian Country.

In fall 2011, the IHS, Centers for Medicare and Medicaid Services (CMS), and the Administration on Aging (AoA) signed a memorandum of understanding (MOU) to coordinate technical assistance activities to support the development of long term services and supports in Indian Country. The monthly webinars and annual conference are activities under the MOU. A resource-rich website is in development. It is certainly the goal for the activities under the MOU to provide knowledge and information; an equally important goal is to create a community in Indian Country of those working to develop and provide these services and supports.

For recordings of existing webinars and materials from the 2012 LTSS Conference, visit our temporary website at *www.kauffmaninc.com/ltss*. To join the listserv and learn about future webinars, e-mail *LTSSInfo@kauffmaninc.com*. Plan to join us next spring for the 2013 AI/AN Long Term Services and Supports Conference. Join this growing community, working to develop and provide these services and supports that allow elders and younger people with disabilities to live full, engaged lives in their tribes and communities.



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*

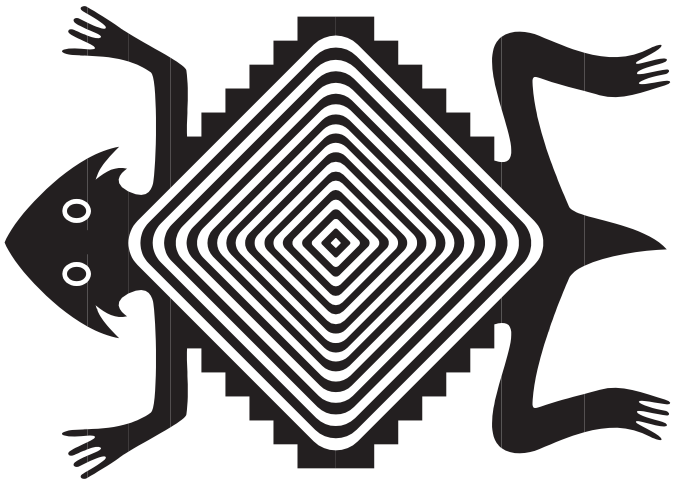
Available EHR Courses

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*.

15th International Congress on Circumpolar Health
August 5 – 10; Fairbanks, Alaska

The International Congress on Circumpolar Health (ICCH) is a primary source of information exchange and scholarly communication relating to circumpolar health. Through the ICCH, the International Union for Circumpolar Health (IUCH) creates a forum for circumpolar health professionals (medical scientists, policy and decision makers, Native peoples, and community leaders) to share the research findings and program successes that are unique to northern regions.

From August 5 - 10, 2012, the IUCH will reassemble for the 15th time in Fairbanks, Alaska, United States. Registration is now open for the Congress; you need not be an IUCH member to attend. To register and learn more about the Congress and IUCH, please visit *http://icch15.com/*.



POSITION VACANCIES

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

Family Practice Physician (1) -
Physician Assistant or Family Nurse Practitioner (2) -
United Indian Health Services, Inc. (UIHS), -
Howonquet Clinic; Smith River, California -
and -
Family Practice Physician (1) -
UIHS, Potawot Health Village; Arcata, California -

UIHS is a premier health care organization located in beautiful northern California along the Pacific coast near the majestic redwoods. The organization is a unique nonprofit made up of a consortium of nine tribes, with a mission "To work together with our clients and community to achieve wellness through health services that reflect the traditional values of our American Indian Community." UIHS provides wraparound services that include medical, dental, behavioral health, and community services. Our focus is to empower our clients to become active participants in their care. If you value outdoor adventures such as backpacking, kayaking, biking, fishing, and surfing, and you envision yourself providing services to an underserved but deserving community in a caring and holistic manner, come join our team. Please visit our website at *www.uihs.org* or contact Trudy Adams for more information at (707) 825-4036 or email *trudy.adams@crihb.net*. (5/12)

Central Scheduler
Medical Clinic Manager
Human Resources Director
Psychiatrist
Physician (Internal Medicine or Family Practice)
Consolidated Tribal Health Project, Inc.;
Calpella, California

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

CTHP has a Title V Compact, which gives the clinic self governance over our Indian Health Service funding allocation. An application for any of these positions is located at *www.cthp.org*. Send resume and application to Karla Tuttle, HR Generalist, PO Box 387, Calpella, California 95418; fax (707) 485-7837; telephone (707) 485-5115 (ext. 5613). (5/12)

Hospitalist
Gallup Indian Medical Center; Gallup, New Mexico

Gallup Indian Medical Center (GIMC) is currently seeking energetic and collegial internists for our new hospitalist program. The hospitalists care for all adult inpatients previously taken care of by family medicine and internal medicine physicians, and provide consultation services. We have seven FTEs for hospitalists, and while we are still growing, we enjoy further inpatient staffing support from internal medicine and family medicine.

GIMC is a 99-bed hospital in Gallup, New Mexico, on the border of the Navajo Reservation. Clinical specialties at GIMC include internal medicine, family medicine, critical care, cardiology, neurology, orthopedics, ENT, radiology, OB/GYN, general surgery, ophthalmology, pathology, pediatrics, emergency medicine, and anesthesiology. The hospitalists' daily census is approximately 25 - 30. There is a six bed ICU. Our patient population includes Navajos, Zunis, and others living nearby, as well referrals from smaller clinics and hospitals.

Gallup has a diverse community and is very livable, offering a thriving art scene, excellent outdoor activities (biking, hiking, rock climbing, cross-country skiing), safe neighborhoods, diverse restaurants, national chains and local shops, and multiple public and parochial school options. The medical community is highly collegial, is committed to continuing education, has an on-going collaboration with Brigham and Women's Hospital, and has a high retention rate.

For more information, contact Eileen Barrett, MD, at (505) 722-1577 or e-mail *eileen.barrett@ihs.gov*. Or please consider faxing your CV to (505) 726-8557. (4/12)

Wellness Center Director
Nurse Practitioner
Chehalis Tribal Wellness Center; Oakville, Washington

The Chehalis Tribal Wellness Center provides health

services to tribal and community members living on or near the reservation. The Chehalis Tribal Wellness Center is located on the 4,849 acre Chehalis Reservation in southwest Washington State. The Chehalis Reservation is situated approximately 26 miles southwest of Olympia and six miles northwest of Centralia. Services include ambulatory medical services, dental services, women's health, diabetes prevention and treatment, and contract health services. The facility has 12 exam rooms, a triage and trauma area, digital radiology, laboratory services, and a large dental clinic. The Chehalis Tribal Wellness Center is a full-service family practice clinic that has been serving Chehalis tribal members since 1979. If you would like further information about current clinical job opportunities with us, please contact Sylvia Cayenne at (360) 273-5911 or visit our website at *chehalistribe.org*. (2/12)

Physician
Nimkee Memorial Clinic; Mount Pleasant, Michigan

The Saginaw Chippewa Indian Tribe is seeking a full time physician. The Saginaw Chippewa Indian Tribe (SCIT) is a band of Chippewa Indians located in central Michigan. The tribal government offices are located on the Isabella Indian Reservation, near the city of Mount Pleasant. The tribe owns and operates Soaring Eagle Casino in Mount Pleasant. SCIT also holds land on the Saganing reservation near Standish, with a community center in addition to the recently completed Eagle's Landing Casino on the Saganing reservation.

Besides its gaming enterprises, the tribe owns other businesses and community operations, including the Sagamok Shell Station, the Ziibiwing Cultural Society (a tribal museum), a substance abuse facility, a community clinic, and health facilities. Educational programs include the Saginaw Chippewa Academy (an elementary school), as well as a presence in the local public schools through Native American advocates and tutors. Saginaw Chippewa Tribal College is an accredited two-year college that operates with funding from the tribe.

Nimkee Memorial Clinic is open Monday through Friday from 8 am to 5 pm and is located on the Isabella Reservation. Local hospital services are provided through McLaren Central Hospital. The Nimkee Medical Clinic employs five providers, including two family practice physicians, one internist, a family nurse practitioner and a physician assistant. Nimkee Clinic also includes an on-site pharmacy.

The clients served are members and direct descendants of the SCIT and members of other US federally recognized Indian tribes residing in a five county service area including Isabella, Clare, Midland, Missaukee and Arenac counties. The tribal physician plays an essential part in the comprehensive, quality health care delivered in a holistic approach, to prevent disease and to promote wellness in the Native American community served. Ambulatory care services are provided to people of all ages and include general clinic visits of various levels of care, health promotion and disease prevention, immunization clinics, men's health clinics, women's health clinics, diabetes management, and pharmacy.

Interested applicants may apply for the position and upload a resume and credentials using the website at *www.sagchip.org*. The full job description will be available to view on the website as well. Any questions in regards to this position, please contact Kassy Heard at (989) 775-5605 or *kheard@sagchip.org*. (2/12)

Urgent Care Family Medicine Physician
Northern Navajo Medical Center;
Shiprock, New Mexico

The Urgent Care Clinic at Northern Navajo Medical Center in Shiprock, New Mexico has an opening for a BE/BC family medicine physician. Shiprock is located just south of Colorado with close proximity to the Four Corners area and the Rocky Mountains. This is a fast-paced urgent care clinic with over 35,000 patient visits per year. Work with a team of six physicians and nine physicians assistants caring for the Navajo people. The schedule is flexible, there is no call, and the salary is competitive with the addition of IHS Physician Market Pay. Loan repayment is available through IHS and NHSC. If you are interested in learning more about this excellent opportunity please e-mail *nancy.kitson@ihs.gov* and attach your CV. (2/12)

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

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

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

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

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

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

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

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

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

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

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

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