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The Cherokee Indian Hospital Buprenorphine Program

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Nature of the Problem

Addiction is a disease; a chronic disease. You can put it in remission but it will always lurk within, looking for a way to express itself. It is thus a relapsing disease, and, with each relapse, it gets worse and harder to again control. Note that relapses often involve turning to a different 'drug of choice,' e.g., opiates instead of alcohol. Untreated addiction will, sooner or later, kill, i.e., it is a chronic, terminal illness.

It is partly genetic, although the genetics are so far poorly understood. It commonly emerges in adolescence when the genetic tendency is triggered into expression by an initial exposure. Many stories begin, "I took my first drink when I was 15, and never stopped." The disease clusters in families for reasons of genetic nature and nurture. "I'll never use drugs like my mother," also means, "I learned how to be an addict in childhood."

Remember that not all abuse is addiction. Drinking and driving is always abuse but not always addiction. Furthermore, physical dependence is not the same as addiction. Practically everyone will develop opioid dependence with sufficient exposure, but those who don't have the disease of addiction will wean off and stop when the drugs are no longer needed (or available; many Viet Nam veterans who used heroin regularly while in 'Nam did not go on to a life of addiction when they returned, although some did). Addiction involves loss of control and compulsive use, despite negative consequences.

While an addict is sick and needs to get well, not bad and needing to be good, he is also severely compromised. Maturation arrests when addiction becomes active, e.g., those who begin in adolescence remain locked in adolescence until they recover and can work on maturing, perhaps by working the 12 steps of Narcotics Anonymous (NA). Addiction limits one's education; you don't learn very much, even if you keep going to school. Obviously, employability and income suffer. Perhaps worst, addicts make lousy parents.

Making the diagnosis of addiction is usually not difficult. Many of our patients self-identify, presenting with a request for detoxification or 'detox.' Screening tools, e.g., the NIDA Quick Screen and AUDIT are often suggestive. Histories of deteriorating performance, isolation, drug- and alcohol-related legal trouble, loss of control of use, and tolerance all suggest the diagnosis. Laboratory studies may be helpful, especially urine drug screens, which should be used liberally.

Lest this is too discouraging, remember that the disease is treatable. Treatment requires patience, acceptance, flexibility, and creativity, but with help, people do recover. Besides, some of us enjoy treating addicts more than diabetics. Unlike diabetics, some really do get well, and they have much better stories.

In this Issue…

Substance Abuse Task Force

In 2007, we were experiencing nearly one death a month from drug overdoses, many in young people, usually involving opioids, on a reservation with approximately 13,400 enrolled members at that time. We were admitting an average of 168 patients a year to our 20-bed hospital for drug treatment services. In ten years we had identified 153 patients with hepatitis C from IV drug abuse. It was clear that these totals were incomplete but increasing.

In response to this epidemic, we formed a Substance Abuse Task Force to address our epidemic of alcoholism and prescription drug abuse, with representatives from the medical staff, nursing, our mental health program (Analenisgi), and administration. We recognized the need to change our approach to the disease of addiction in a number of ways. We needed to learn and believe that it is a disease deserving treatment, not punishment. We needed a responsive approach to unsafe abuse of alcohol and other drugs, for which we adopted the Brief Negotiated Intervention (also called the Alcohol Screening and Brief Intervention). We have begun to address overdose deaths with Overdose Prevention Kits from Project Lazarus (described below). We learned willingly to admit addicts and alcoholics in active addiction for 'detox,' rather than blaming them for their intoxication and waiting for them to sober up before we would treat them. We had to accept that relapse is part of the disease, and willingly readmit those who relapsed. All this has required real change in provider and staff attitudes and behavior. Gratefully, staff proved quite willing to make the change.

To do this we started by writing new policies. We then had a training session, open to practically everyone in the community, but designed primarily for medical, nursing, and mental health staff, which addressed the effort.

Brief Negotiated Intervention

The Brief Negotiated Intervention is a structured motivational interview with people using alcohol or drugs in hazardous or harmful ways. It is not for people in active addiction. It is best used in the ER or any other setting where someone is seen who has been harmed by his or her abuse, i.e., during a teachable moment. Patients in harm's way are given brief education about safe use and asked to choose to commit to what degree of change they feel they can accomplish. This is then written as a prescription or agreement for change for them to sign, and given to them. With some training, the intervention is done in ten minutes, e.g., while sewing a laceration, and has been shown to reduce risky behavior. For more information refer to: *http://www.ihs.gov/nc4/Documents/ASBI_Manual.pdf.*

Limiting the Availability of Narcotics

In Cherokee, opioids have been widely available. Many, particularly the favored 'roxy thirties' or oxycodone 30mg, are brought from outside the community by dealers. However, many are diverted and abused after being prescribed by our medical staff and area physicians.

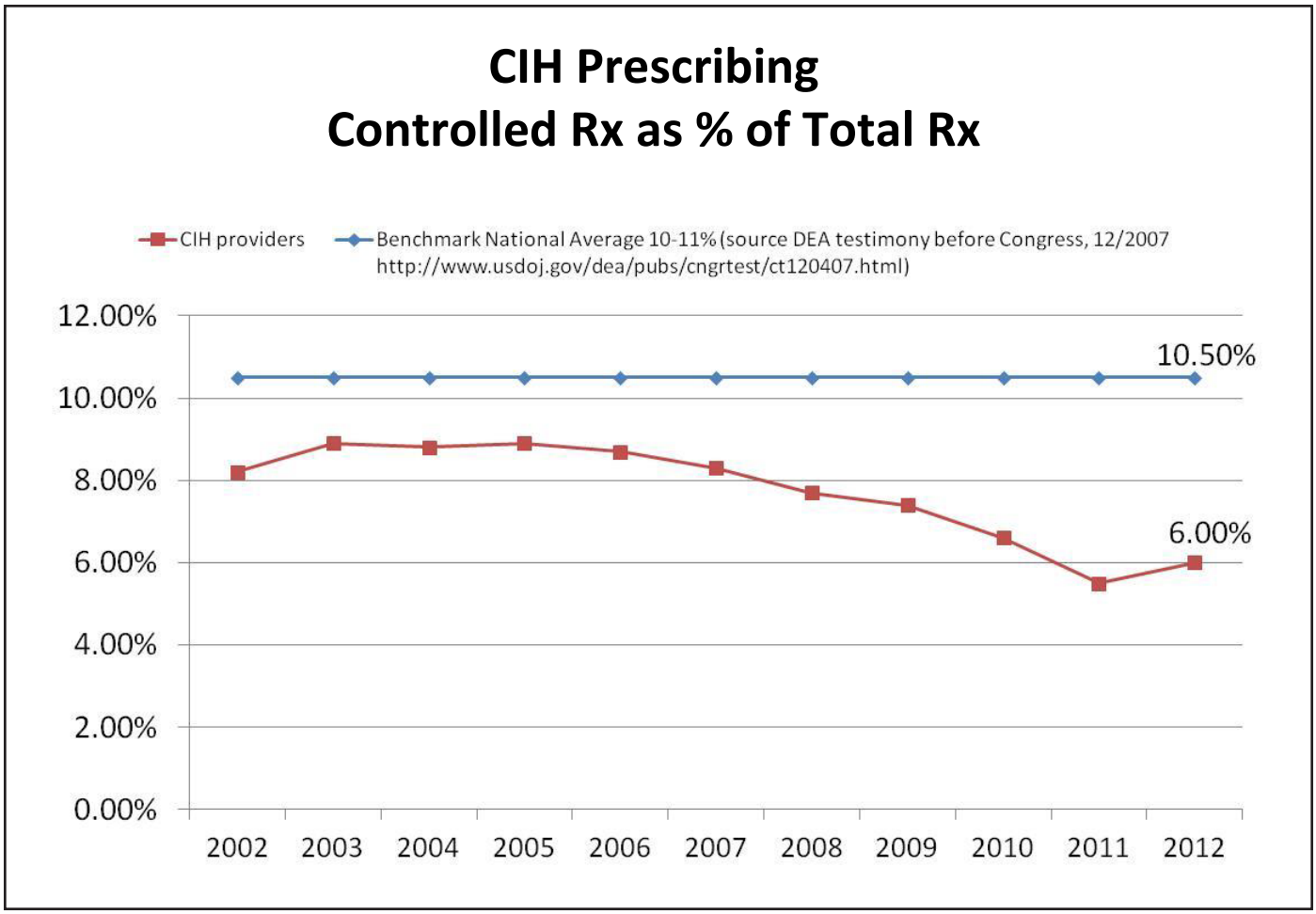
Measures taken in Cherokee to limit narcotics use and availability include:

1. Have all patients receiving chronic narcotics sign an agreement to obey rules for their use, and use urine drug screens and random pill counts regularly to enforce the rules,
2. Limit dispensing through the ER to serious injuries and only six tablets,
3. Educate providers on effective pain management, e.g., narcotics are not effective or indicated for neuropathic pain or fibromyalgia,
4. Identify and counsel individual providers who overprescribe,
5. Stop using the opiate addict's favorite, oxycodone, both short and long acting,
6. Monitor the state prescription drug monitoring program both locally and in surrounding states to identify patients obtaining medications from outside sources,
7. Enroll chronic pain patients in monthly Pain Support Groups, which serve to educate and support patients but also to supervise them,
8. Avoid long-term opiate use in patients with absolute or relative contraindications, such as addiction, histories of aberrant behavior, or significant psychiatric disorders, and
9. Make narcotic agreements, crisis notes, and orders not to give chronic controlled substances easily visible to all providers and staff (this is easy with alerts in EHR).

We have evidence of success. Nationally, 10.5% of prescriptions are written for narcotics. Cherokee's rate is down to 6 - 7%. Additionally, addicts report a steady increase in street prices.

Overdose Antidote Kits

Project Lazarus is a multifaceted project in Wilkes County, North Carolina, tackling their prescription drug abuse epidemic, the worst in North Carolina and one of the worst in the country. Information can be found at: *http://www.projectlazarus.org/*. They have developed a Naloxone Overdose Antidote kit that may be prescribed to anyone likely to need it, and which contains naloxone for intranasal administration, with instructions for use, after calling 911, in the event of an overdose. Patients' families who may need such a kit include all who receive chronic narcotics, whether with cancer, COPD, opioid dependence, or other chronic illness. These kits are now being prescribed at the Cherokee Indian Hospital.



Cherokee Indian Hospital Buprenorphine Clinic Program

With buprenorphine now available and three family physicians qualified to prescribe it, we developed a program of treatment for patients with opioid dependence. When patients present requesting detox, they are ordinarily admitted briefly to the hospital. This allows us to verify their dependence, stabilize them on a dose of buprenorphine, assess and address any additional diagnoses (many have other comorbid psychiatric diagnoses and hepatitis C), and arrange their outpatient treatment. Nurses are empowered to enforce our policies regarding telephone use, visitors, and behavior. Patients are asked to read and sign a set of documents outlining program rules and expectations, describing buprenorphine, asking them to describe themselves and their goals, and requiring confidentiality. It is all done using our electronic health record, which has qualified for meaningful use.

Once accepted into the Buprenorphine Clinic, patients are required to attend the Buprenorphine Clinic group and three additional meetings per week in order to see the doctor and remain on buprenorphine. The additional meetings may include any mixture of area NA/AA meetings, outside treatment program groups, and the Substance Abuse Treatment (SAT) Program provided by A Na Le Ni Sgi, our mental health program.

The Buprenorphine Clinic is divided into four therapist-facilitated groups. Group assignment is determined by clean time and gender: women new in the program (zero to four months), men new in the program, women with more then four months growth, and men with over four months growth. During the group meetings, one of our physicians, with a waiver to prescribe buprenorphine, meets with each patient individually to review progress and renew medication. Outpatient Based Opioid Treatment (OBOT) qualified physicians share this responsibility. It is doubtful the program could function with fewer than three. Our staff psychiatrists have OBOT waivers and assist with care of co-morbid psychiatric illness. Patients using benzodiazepines are required to receive them from a psychiatrist.

Patients must have a signature sheet signed at each meeting they attend and bring it when they meet with the physician as evidence of their participation. People who do not attend the group, or come late, will not have their

buprenorphine refilled. We generally do not replace lost or stolen medications (police reports are too easy to obtain). Our experience is that the more strictly we enforce these rules the better the patients do. Frequent and random urine drug screens and strip counts have been helpful in controlling diversion and identifying noncompliance. Patients are required to save all buprenorphine strip packets after using them to turn in the following week when picking up the next week's supply. This includes urine screens for buprenorphine as well as drugs of abuse. Carbohydrate-deficient transferrin (the Hgb A1C for alcoholism) helps monitor for alcohol abuse.

Addicts frequently slip, slide, and relapse; it's part of the disease. Knowing this, we use a "three strikes" rule, allowing patients two violations, such as a dirty urine or failure to attend meetings and bring a signature sheet, before they are dismissed after the third violation. This approach is hard to be consistent about and requires a lot of clinical judgment, but remember that we continue to treat diabetics no matter how badly they do. On the first strike a participant receives a 2 milligram dosage taper. On the second strike a participant receives another 2 milligram taper. Participants do not get a dose increase once a strike has been given. After the third strike a participant is given a rapid taper off buprenorphine. Patients are accountable for their choices and decisions; this is new to most of them. The Buprenorphine Clinic is designed to promote healthy, productive, responsible recovery, not just abstinence. When buprenorphine is ineffective or diverted, patients are referred to a higher level of care, i. e., residential treatment, and the medication is usually weaned and stopped as part of the transition.

We do not usually maintain people long term on buprenorphine. We expect them to acquire knowledge of the disease and recovery skills through the group treatment process and then try, after approximately three months, to wean them off the buprenorphine over several more months. Again, this is hard to be consistent about, and requires more clinical judgment. It is also our experience that some patients who are successful will relapse after being clean for prolonged periods, months to years, and need another round of treatment. Patients certainly do better if they continue, preferably forever, to participate in NA and/or AA after completing Substance Abuse Treatment and stopping buprenorphine.

We do have some patients, usually older and with long histories of severe addiction, who are maintained on buprenorphine. These patients are usually seen individually by one of the three physicians and expected to pay for their prescriptions rather than expect tribal coverage. Buprenorphine is covered by Medicaid and most private insurance plans, although it often requires prior authorization.

Most of the patients are young, 18 – 25, and have already been using for several years. They progress rapidly from taking pills, to insufflating (snorting), to injecting. This has produced a horrifying epidemic of hepatitis C, which portends huge costs in the next 10 – 30 years for treatment for those who become clean and survive. Most know they should not share needles but we have learned that they will gather at a table and draw liquid from a single common pool, thus spreading the disease without sharing the needle itself. Hopefully this will change as we educate the community.

Teenagers (age < 18) are a special concern. We have been reluctant to use buprenorphine with them, preferring to arrange residential treatment, if at all possible. The rare teenager we have treated is assigned to one of the physicians for careful supervision, and has done quite well.

The Tribe tribe does pay for residential treatment, although it is not located within the community. The availability of outpatient buprenorphine treatment has made people more reluctant to go away to treatment. It is hard to get people into treatment, even when they are willing, because treatment programs will not accept patients who are using buprenorphine, or are in active addiction in some cases. There are often long waits for a bed, and many patients relapse and disappear before they can go.

Pregnancy presents another challenge. Recent literature supports use of buprenorphine as an alternative to methadone, which has been the standard of care, because the infants of addicted mothers treated with buprenorphine are less likely to experience the neonatal abstinence syndrome, and otherwise do just as well as methadone treated dyads. There is argument whether it is preferable to use Subutex, which is easier to abuse and divert, or Suboxone, which, if injected, could precipitate withdrawal, preterm labor, and fetal distress. Conventional wisdom is that one does not wean addicts off narcotics during pregnancy for fear of precipitating premature labor (real evidence to support this 'wisdom' is hard to find). Weaning patients off buprenorphine also increases the risk of relapse, but a policy of not weaning or stopping the medication makes it hard when pregnant women violate the rules to do anything but complain to them. Such pregnancies are considered high risk and are delivered in our referral center. They have done well, without significant fetal loss or neonatal abstinence syndrome.

Acute pain and surgery are another problem. Guidelines for approaching these situations are available (see references). Much of the time pain can be treated with combinations of non-narcotic adjuncts, including acetaminophen, NSAIDs, muscle relaxers, medications for neuropathic pain, especially gabapentin, lidocaine, topical or viscous, and sometimes tramadol. When the daily dose of buprenorphine is too low to fully saturate receptors (usually less then 12mg per day), it can sometimes be transiently increased to good effect. When pain can be anticipated, e.g., elective surgery, buprenorphine can be held 2 – 3 days ahead of time and regular narcotics used, although one must remember that because of tolerance, patients may require unusually large doses.

Many fine resources are available. We have relied heavily on *The Red Road to Wellbriety in the Native American Way* from White Bison, and tools connected to it. The Substance

Abuse Treatment Program, our intensive outpatient treatment program, uses the *Counselor's Treatment Manual: Matrix Intensive Outpatient Treatment for People with Stimulant Use Disorders*, DHHS Publication No. (SMA) 07-4152. Other useful works include the Treatment Improvement Protocol (TIP) Series from DHHS.

Cost and Results

Initially we encountered some questions about the program's expense. It requires roughly a day of clinician time per week, about two days a week of nursing and therapist time, space for meetings, quantities of drug screens and related labs, and the cost of buprenorphine itself. Buprenorphine is available through a VA contract: Suboxone films, 8/2mg, $116.16/30 films, and Suboxone films, 2/0.5mg, $64.87/30 films. Epocrates lists Suboxone tablets 8/2mg, $238/30 tablets. Total cost in 2010 was $87,714 and in 2011 was $56,570, with much of the decrease in costs attributable to the advent of availability of the VA contract pricing during this time period. These costs are offset in an immeasurable degree by increased education, improved employability, and better parenting on the part of our patients.

Gratefully, as the program has grown and matured, and the extent of the need become obvious, we have not had to fight as much as one might expect for resources. It is probably good that we have not been grant supported. It is equally a huge credit to the tribe and our administration that they have been willing to take this on.

Since beginning the program in July, 2008, we have treated 352 different people. After four years, we continue to admit new patients to the program at a rate of 1 – 2 per week, and readmit another one who we have already met who has relapsed. There are currently 50 - 60 patients actively participating, and another 20 – 25 on long term maintenance. The local NA/AA meetings, which were few and small at the beginning, have grown in number and size and now provide a healthier support community. Some outcome data were collected in 2010. A program evaluation revealed that of 41 active and 121 former patients, 83% of active and 54% of former patients were clean in the previous month. Longer term outcomes have not been studied.

One can question the statistical significance, but when we began nearly five years ago we were experiencing one death a month from overdoses. We have had none in almost two years, although there have been several that are almost certainly addiction related, including a suicide, an MVA, and one with pending toxicology.

Addicts Can Be Fun

In conclusion, we believe this program is a unique integration of behavioral and primary care services, and one of only a few in Indian Country. There is a great deal of good humor in recovery: "I'm allergic to narcotics; every time I use, I break out in handcuffs." Professionals can enjoy caring for people with the disease of addiction, if they surrender to and accept the fact that it is a disease, and if they acquire working tools for treating it. Blaming and stigmatizing those with the disease is unprofessional and hurts those who do it, limiting their compassion and objectivity. Relapse, lying, and such must be recognized as symptoms of the disease. These are not bad people, failing to be good, but sick people trying to get well. Many do, gradually, over years get well, which is better than diabetics usually do. Besides, addicts have much better stories, if we open up to them and listen.

Additional Resources

Readers who wish more information or access to the author's document collection should direct inquiries to *lee.hyde@cherokeehospital.org*.

Acknowledgements

We wish to thank the members of the Substance Abuse Task Force who contributed so much to this effort: Tonya Crowe, Concheta Dehart, Mary Anne Farrell (Chairman), Patty Grant, Tom Hill, Lee Hyde, Jan Lambert, Keahana Lambert-Sluder, Wanda Lambert, Jeanie Postell, Robert Ross, Dominique Toedt, Michael Toedt, and Jennifer Ward.

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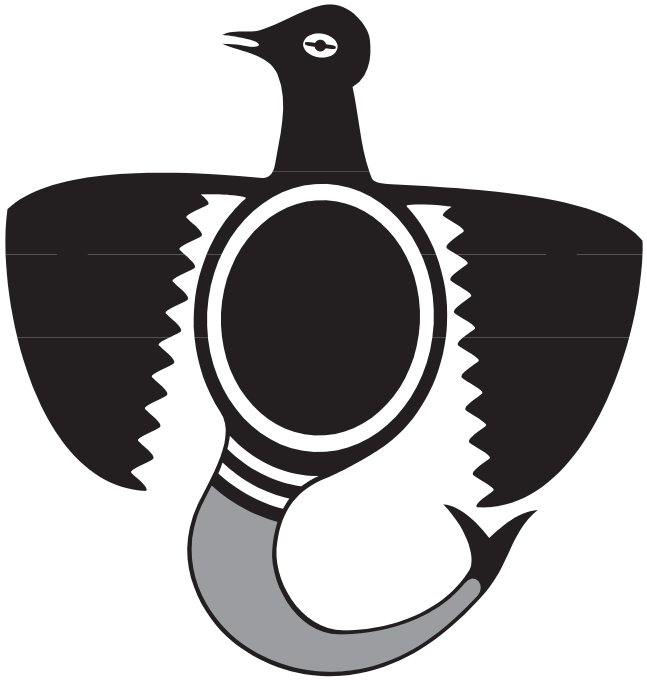


Our Apologies

We apologize for the delay in the production of this issue. Constraints on funding at the end of the fiscal year made it impossible to complete the preparation of the issue until now. We will catch up with our usual monthly publishing schedule as soon as possible. We are currently accepting submissions for the June issue.

The 18th Annual Elders Issue

The May 2013 issue of The IHS Provider, to be published on the occasion of National Older Americans Month, will be the eighteenth annual issue dedicated to our elders. Indian Health Service, tribal, and Urban Program professionals are encouraged to submit articles for this issue on elders and their health and health care. We are also interested in articles written by Indian elders themselves giving their perspective on health and health care issues. Inquiries or submissions can be addressed to the attention of the editor at the address on the back page of this issue.

Personal Observations about an Effective Preventive Intervention for Infant Obesity

Chul Hong Kim, MD, Staff Pediatrician, San Carlos Indian Hospital, San Carlos, Arizona

This manuscript is intended to encourage caregivers of young children to consider the long forgotten technique of bottle-feeding infants by training them to "eat slowly."

In December 2003, I retired from 26 years of solo, general pediatric and pediatric endocrinology practice in Aberdeen, Maryland. The next year in August 2004, I came to the San Carlos Apache Indian Reservation in Arizona to work in the Indian Health Service as the sole pediatrician at that hospital. I had prior knowledge that there was a higher prevalence of obesity, asthma, and other challenging health issues among American Indians and Alaska Natives. Two lingering questions for me have always been, with regard to the prevention of obesity: How early should prevention begin for a pediatrician? And then, How should a pediatrician intervene?

For the first year, from 2004 - 2005, I began paying close attention to growth curves and observing how caregivers fed infants and what they fed them (for more than 80% of infants, it was formula). I have reviewed growth charts for two periods: pre-2004 (patients 1, 2, 3) when the care was given prior to my arrival, and post-2005 (patients A - H) after being under my care.

Pre-2004 growth charts showed that excess weight gain started during the first few weeks of life, presumably due to overfeeding of formula. I determined that by intervening in the overfeeding of infants, abnormal excess weight gain (infant obesity/adiposity) could be prevented. Within those first few months, I began simple feeding counseling, written and oral, at each scheduled preventive health visits with the caregivers. Being the only pediatrician on the reservation, I was able to follow these babies at least up to 24 months of age. These efforts to use caregiver education to prevent excess weight gain during the first six months and to train infants to develop their self-regulation ability (hunger and satiety) even beyond 12 months of age have shown remarkable and sustainable results, I believe. My hope is that this feeding practice of training infants to eat slowly will reduce obesity, for infants, children, and adolescents, and ultimately decrease obesity-related diseases.

I would like to share my observations about how to prevent obesity in infancy and beyond. Obesity prevention needs to begin as early as the first well-baby visit, which is typically at two weeks of age or earlier. All formula-fed infants should and could be trained how to eat by counseling the caregivers about how to feed formula. Pediatricians could give instruction on this feeding method or style consistently for the first 12 months of life. This technique helps infants to learn to develop self-regulation of hunger (intake) and satiety (happiness) during their early infancy.

Intervention at 0 - 6 Months

Usually when a caregiver feeds an infant, she leaves the bottle nipple in the baby's mouth during the whole feeding. If the bottle nipple is allowed to stay in the baby's mouth, he or she may pause to breathe for only 2 - 3 seconds, then start sucking the bottle again. This causes the infant to drink and eat too fast. Instead, when an infant stops sucking the bottle to take a breath (usually 8 -12 sucks), the caregiver should take the bottle out of his mouth and burp him for the duration of 20 - 30 seconds. This means the caregiver burps the baby 4 - 6 times during and at the end of each feeding. This training enables infant to feel his stomach being filled up, which allows some time for satiety signals to be sent from the GI system to the brain (satiety center), which in turn makes the infant feel satisfied even if he takes in fewer calories of formula by eating slowly. This method helps an infant to develop early self-regulation just as a breast-fed infant does.

The post-2005 growth charts for patients A and B show that previously accelerated weight gain dropped down to the 75th - 90th percentiles.

Intervention at 6 - 12 Months

At these ages when baby foods are introduced, three specific principles are taught to the caregiver. First, as solid foods are begun, the amount of formula is decreased to 16 - 20 oz per day. Second, when the feeding time comes (if there are three meals a day), the baby should be fed solids first to fill the stomach, followed by offering 1 - 2 oz formula if the baby takes it. Third, the caregiver should prepare a 4-oz of bottle of water to take when going out. When the infant seems hungry before mealtime or is fussy before taking naps, 1- 2 oz of water can be given instead of formula or juice, both of which increase caloric intake. Post-2005 growth charts for patients C-E showed that weight stayed on the same percentile tracts.

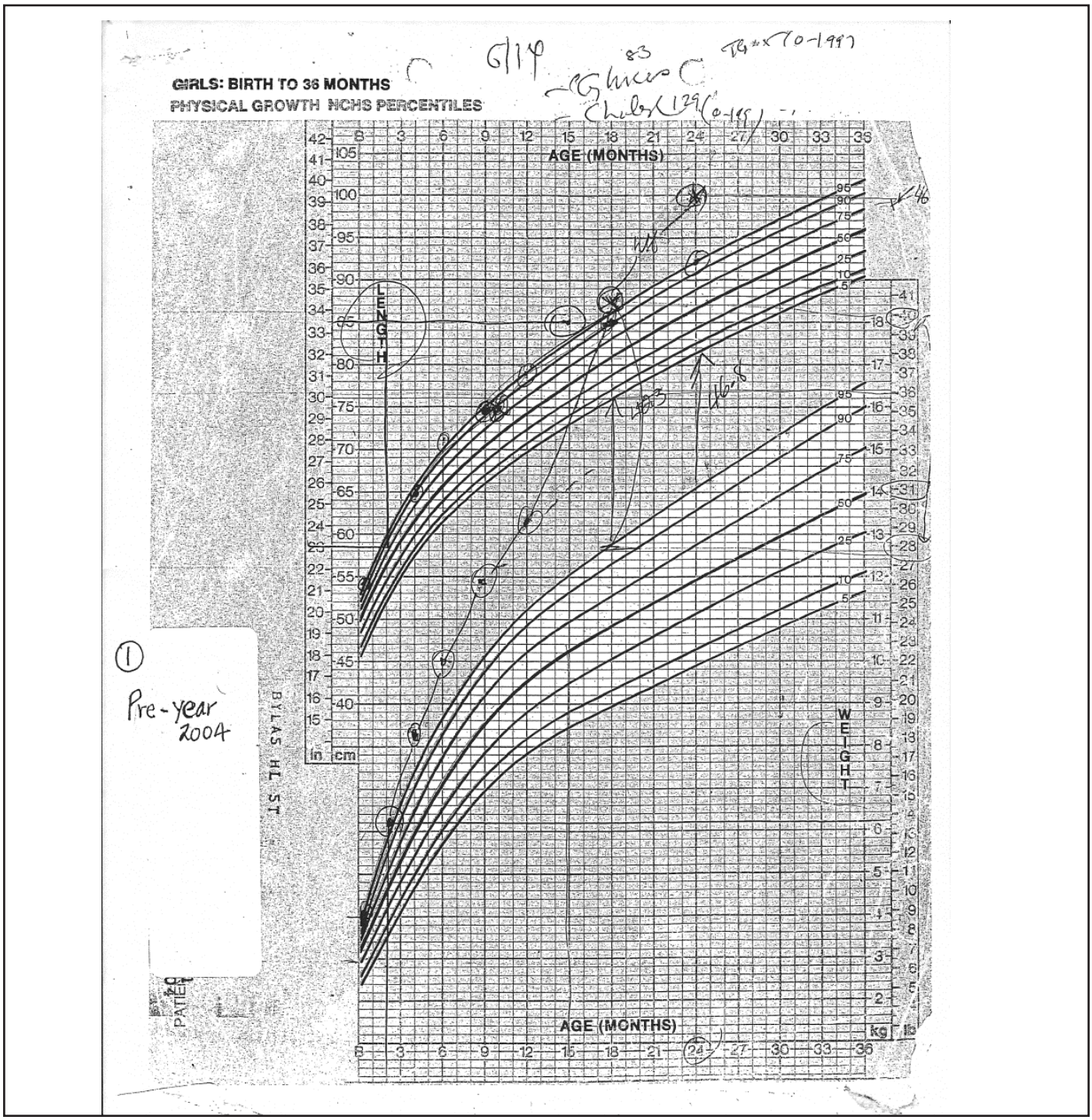
Intervention at 12 Months and Beyond

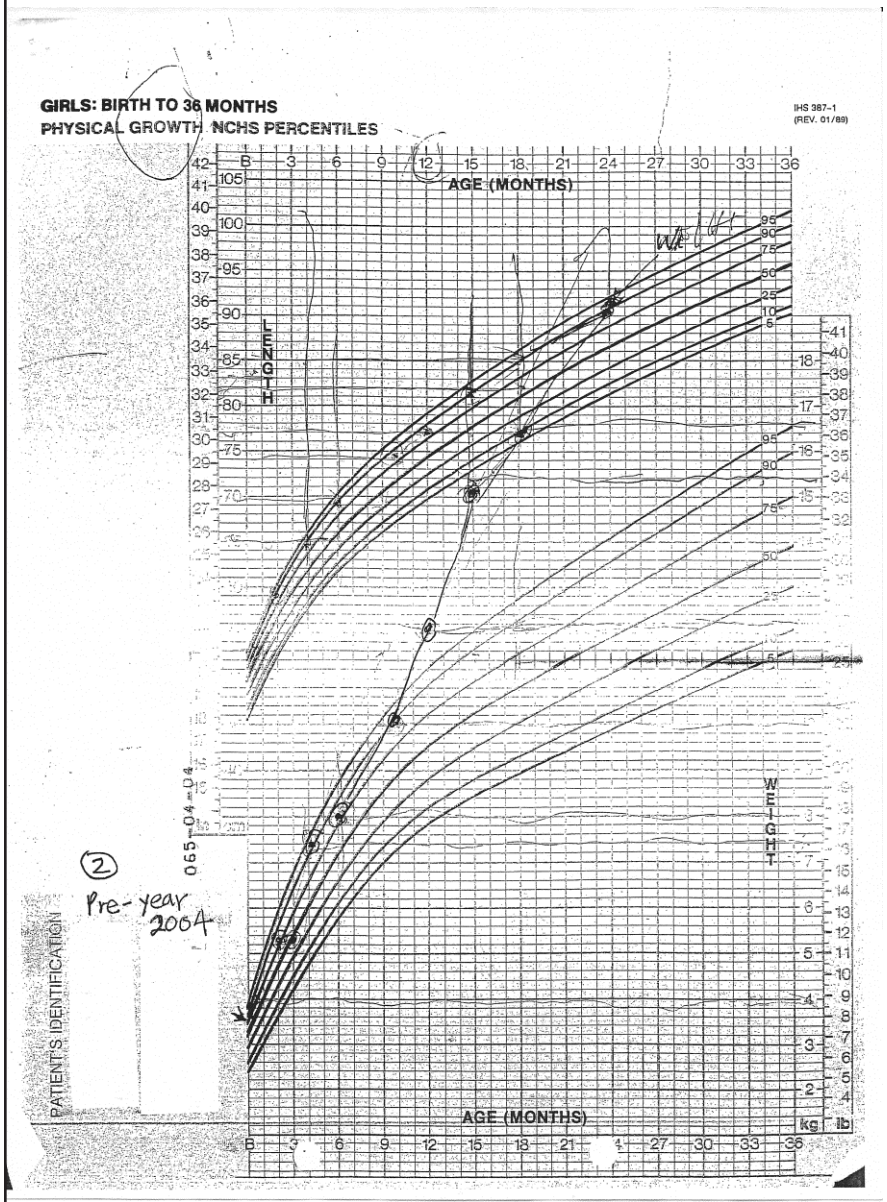
Caregivers should keep to conservative portion sizes of solids, milk (less than 8 oz/day), sweet beverages (less than 4 oz/day), screen (TV, computer, phone, e-tablet time; less than 1 hr/day), and they should increase body movements for the

child. All this educational counseling is given to the caregiver to encourage a change in eating and general lifestyle for the whole family so that they are models for the toddlers, who by this time have developed slow eating habits and enhanced self-regulation capability. In other words, they are chewing their food 10 -15 times and eating smaller amounts. (Patents F - H, post-2005 growth charts).

Appendix

Patient Growth Charts 2005 – 2006 (with identifying information blanked out)

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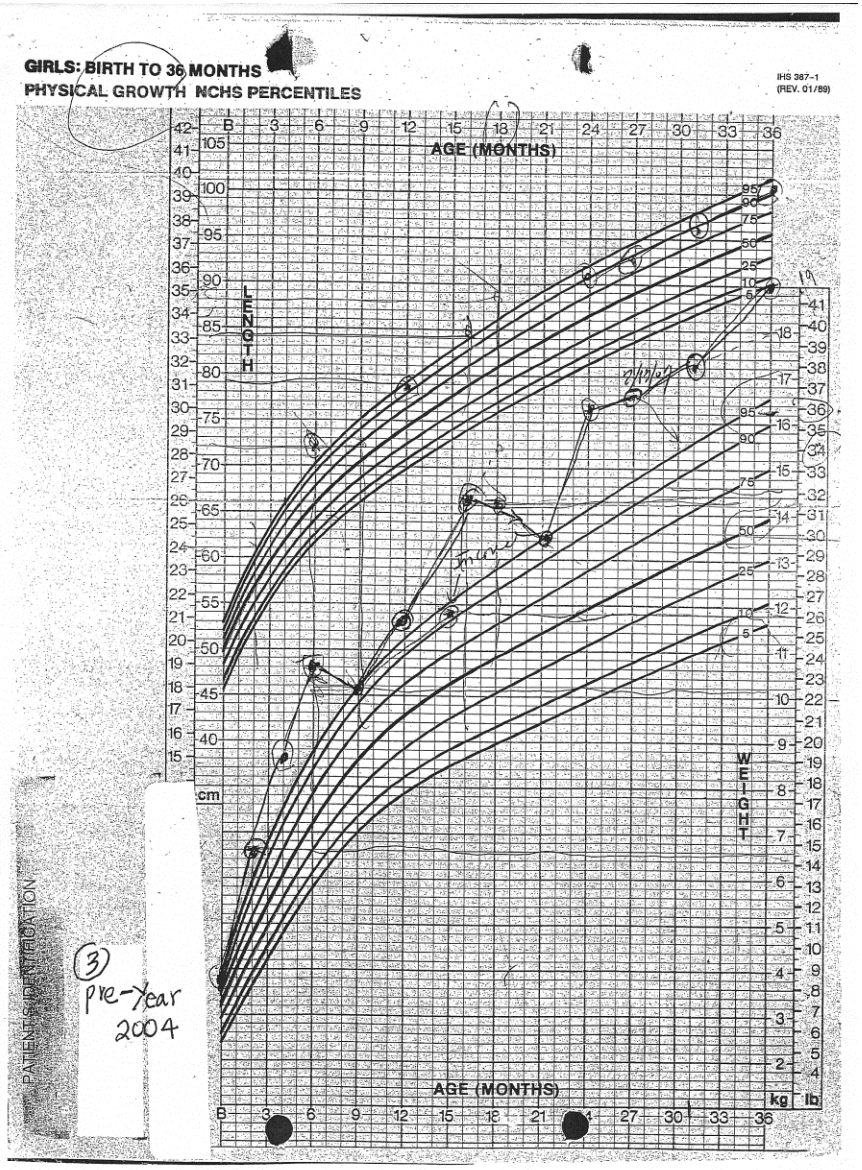
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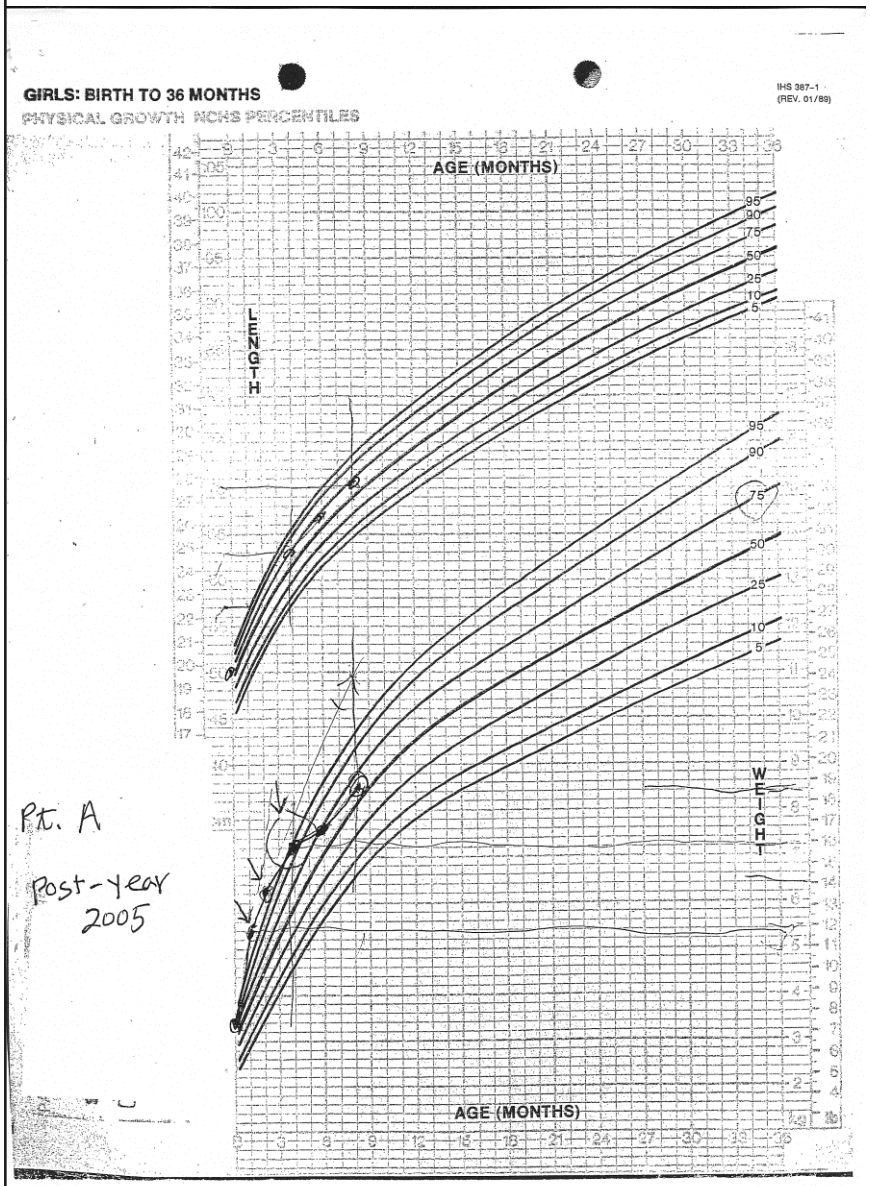
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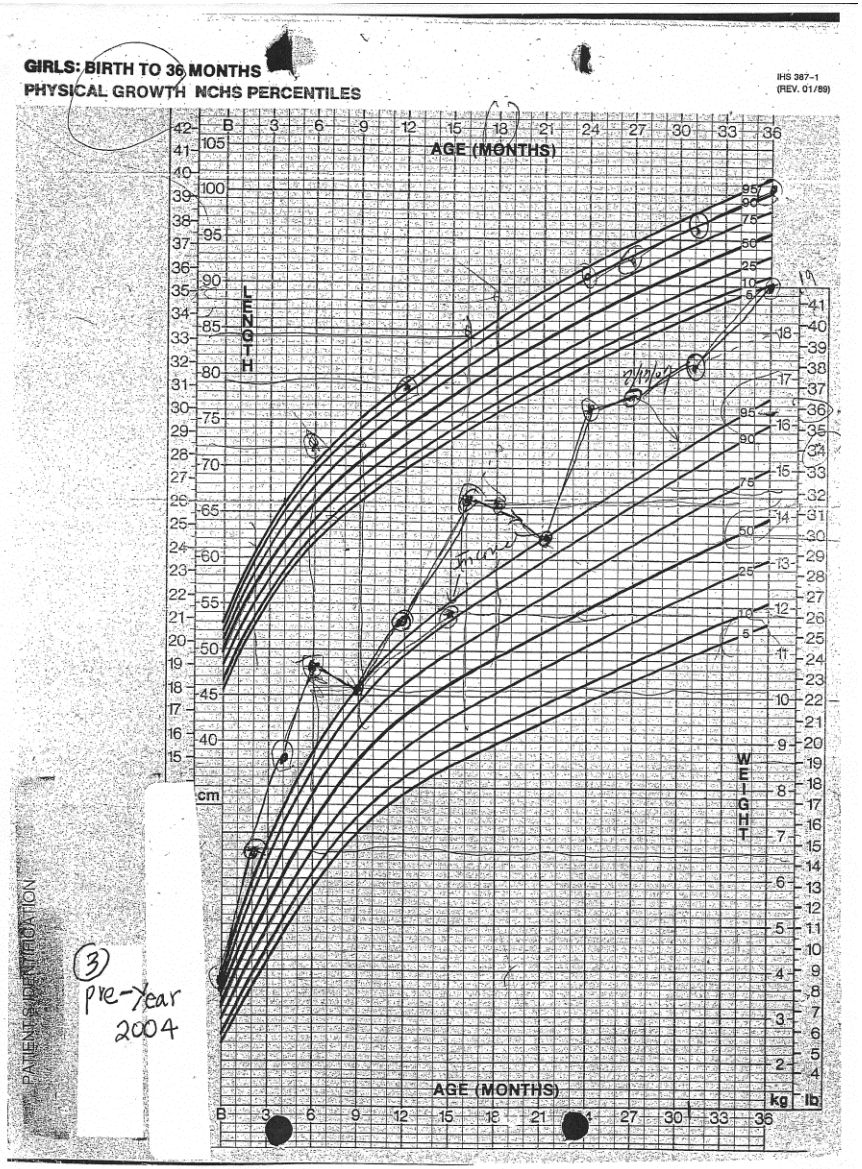
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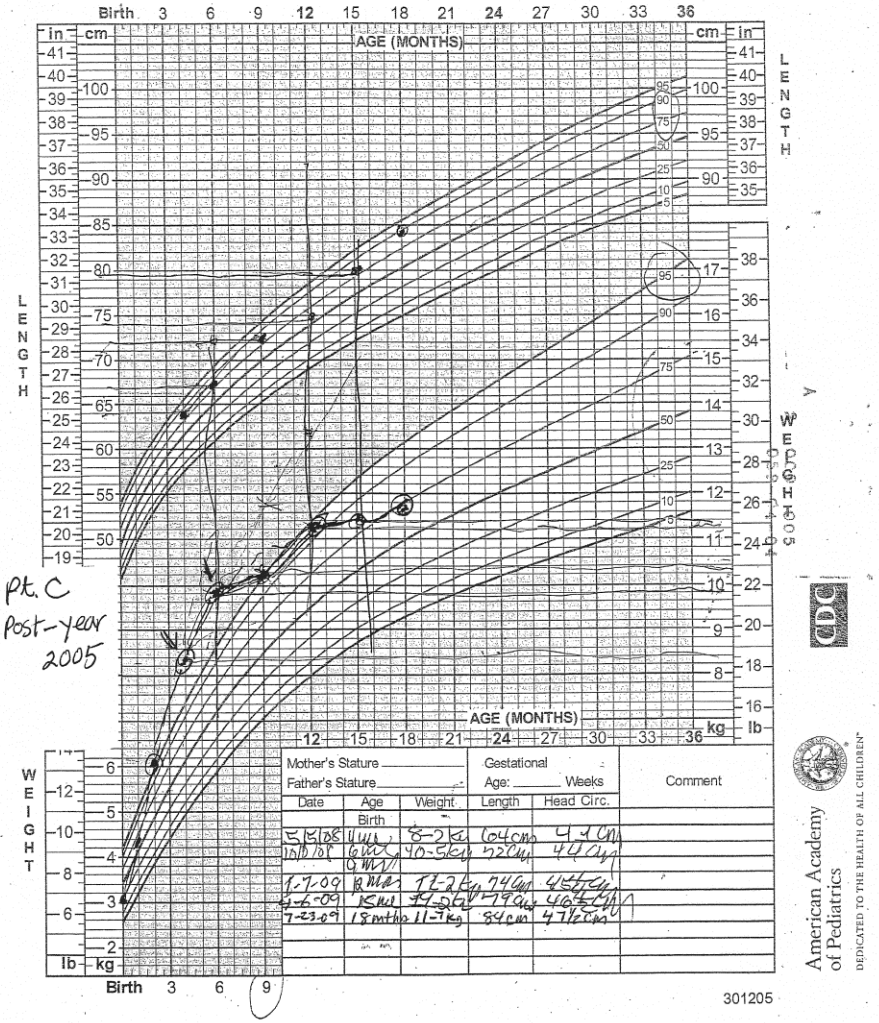
AGE (MONTHS)
LENGTH
WEIGHT
cm
kg
lb
PATIENT IDENTIFICATION
(3)
Pre-Year
2004
AGE (MONTHS)

Girls, birth to 36 months

Name _____

LENGTH FOR AGE AND WEIGHT FOR AGE PERCENTILES

Record # _____



Pt. C
Post-year
2005

Mother's Stature _____ Father's Stature _____			Gestational Age: _____ Weeks		Comment
Date	Age	Weight	Length	Head Circ.	
	Birth				
5/6/05	11 wks	8-2 kg	64 cms	4-7 cms	
10/10/05	6 mos 9 mos	10-5 kg	72 cms	44 cms	
1-7-09	18 mos	11-2 kg	74 cm	45-5 cm	
4-6-09	15 mos	11-2 kg	79 cm	46-5 cm	
7-23-09	18 months	11-7 kg	84 cm	47½ cm	

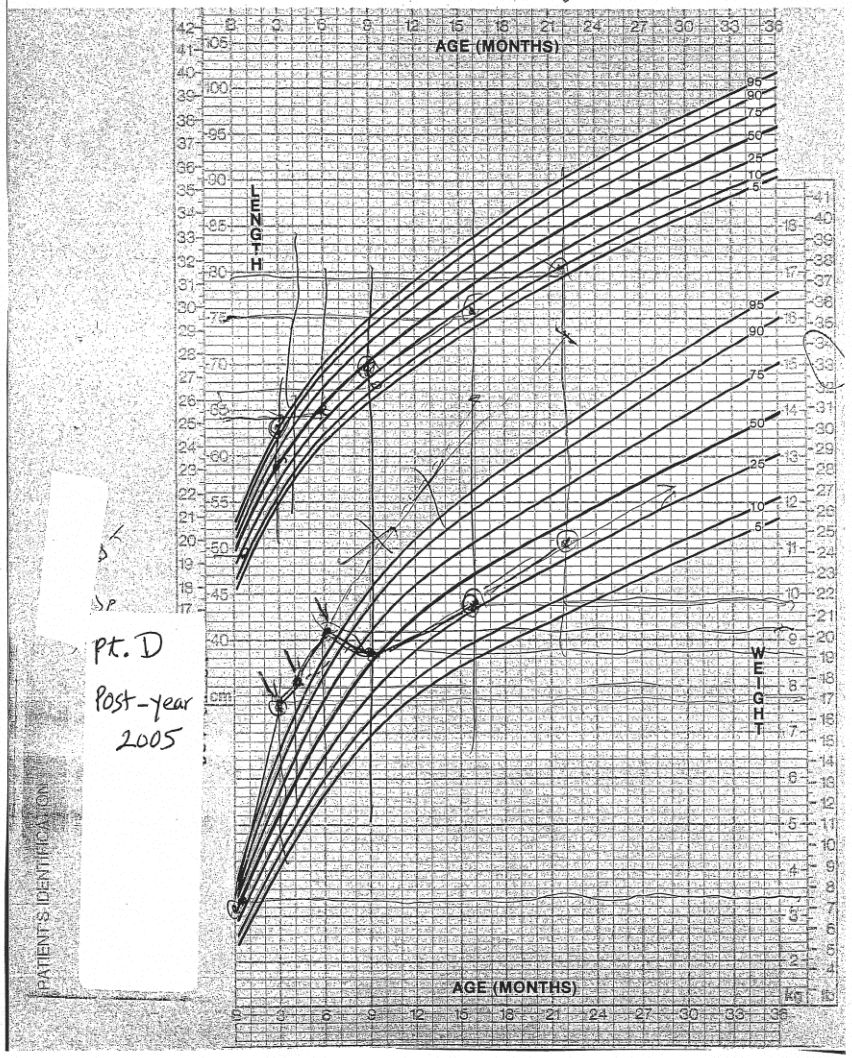
American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

CDC

301205

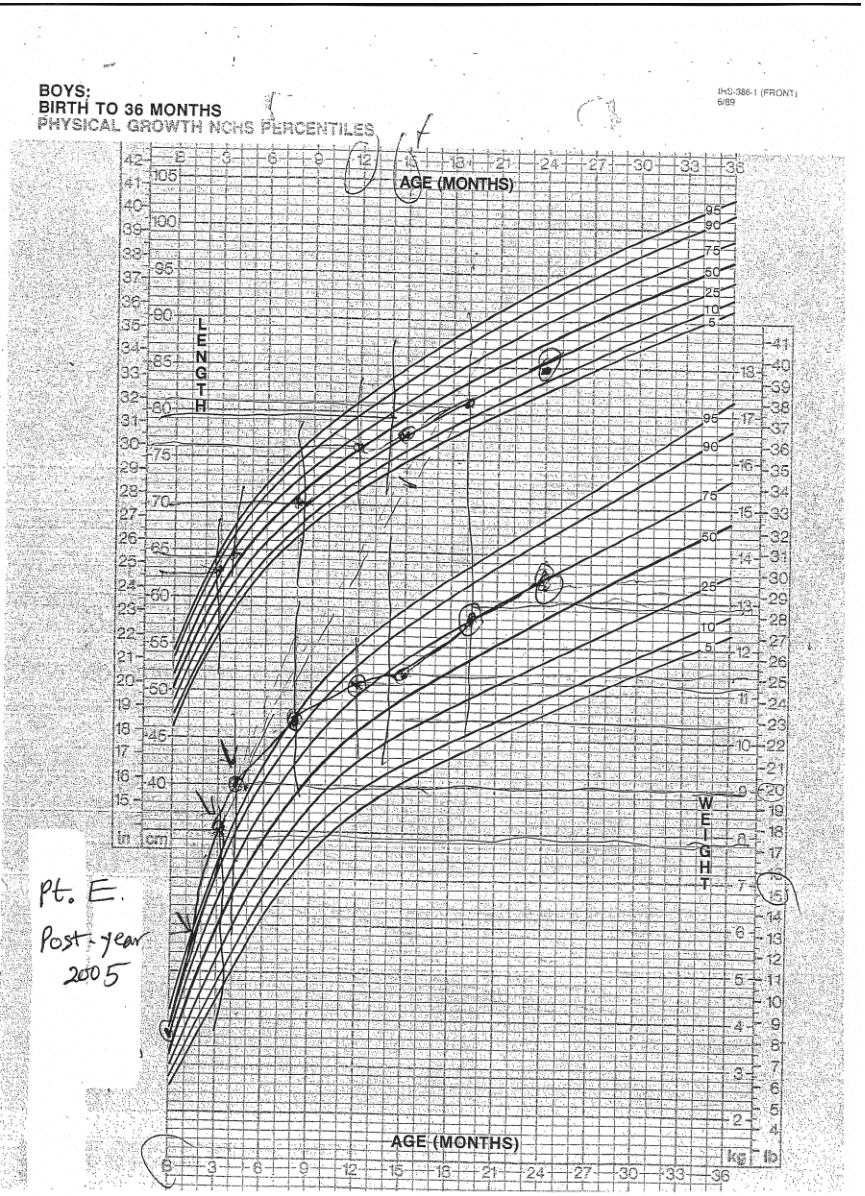
GIRLS: BIRTH TO 36 MONTHS
PHYSICAL GROWTH NCHS PERCENTILES

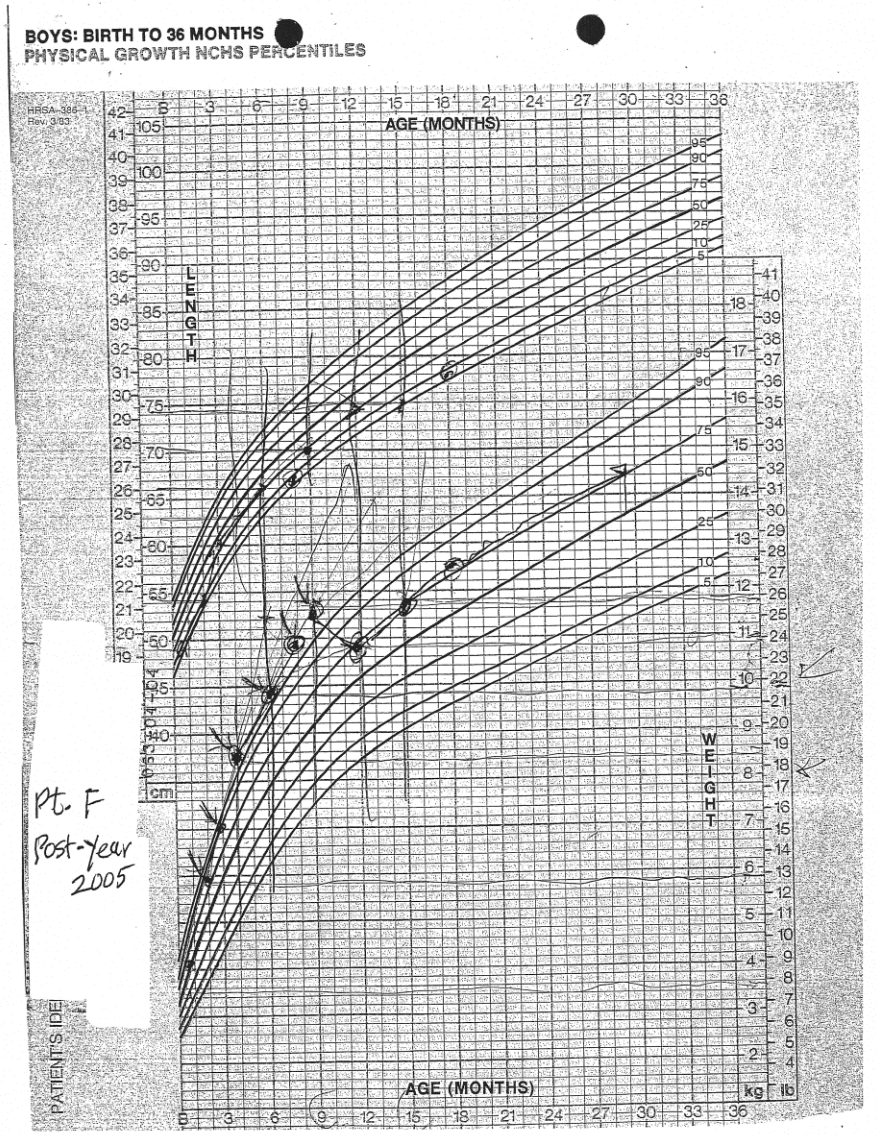
IHS 387-1
(REV. 01/89)

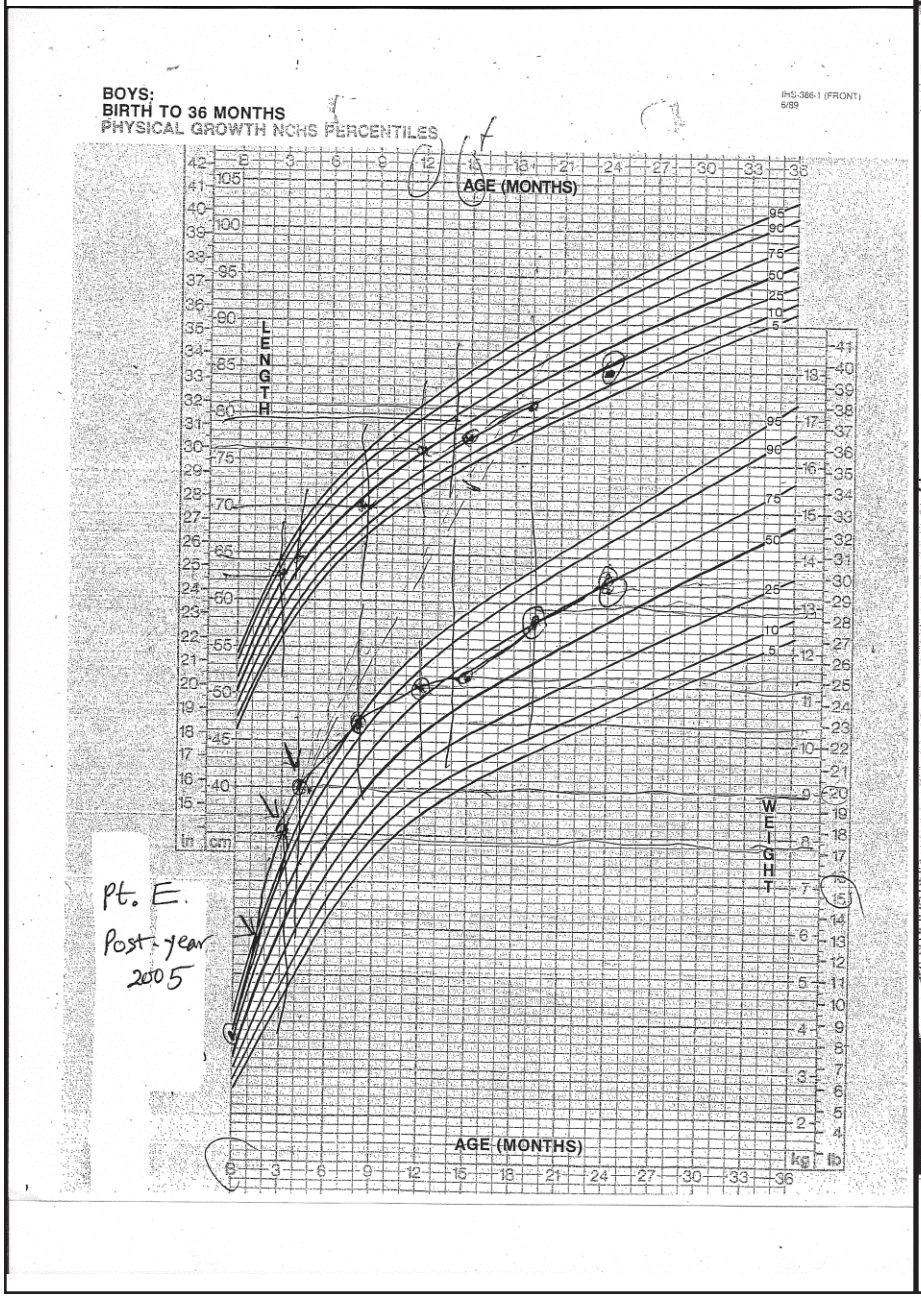


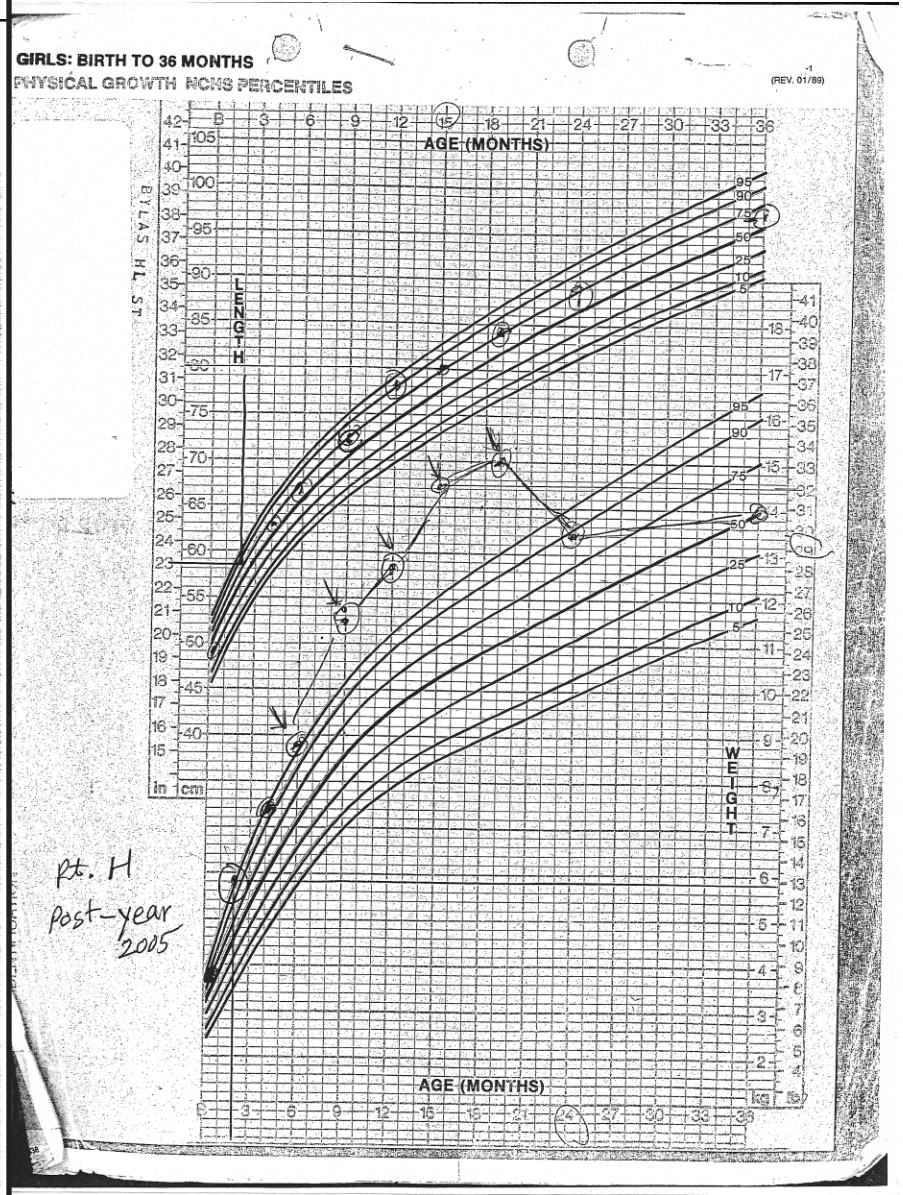
Pt. D
Post-year
2005

PATIENT'S IDENTIFICATION


BOYS:
BIRTH TO 36 MONTHS
PHYSICAL GROWTH NCHS PERCENTILES
IHS-386-1 (FRONT)
6/89
AGE (MONTHS)
LENGTH
WEIGHT
in
cm
kg
lb
Pt. E.
Post-year
2005


BOYS: BIRTH TO 36 MONTHS
PHYSICAL GROWTH NCHS PERCENTILES
HRSA-386-1
Rev. 3/83
AGE (MONTHS)
LENGTH
WEIGHT
cm
kg
lb
Pt. F
Post-year
2005
PATIENT'S IDE


BOYS:
BIRTH TO 36 MONTHS
PHYSICAL GROWTH NCHS PERCENTILES
IHS-386-1 (FRONT)
6/89
AGE (MONTHS)
LENGTH
WEIGHT
in
cm
kg
lb
Pt. E.
Post-year
2005


GIRLS: BIRTH TO 36 MONTHS
PHYSICAL GROWTH NCHS PERCENTILES
(REV. 01/89)
AGE (MONTHS)
LENGTH
WEIGHT
in
cm
kg
lb
Pt. H
Post-year
2005

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.*

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. (2/13)

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 47th 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 mid-level providers, dedicated nurse case managers, and ancillary staff to deliver the highest quality, team based health care to an active user population of 2800 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! (2/13)

Pediatrician
Blackfeet Community Hospital; Browning, Montana

This hospital-based government practice is seeking a BC/BE pediatrician to work with another pediatrician and a pediatric nurse practitioner. Practice true primary care pediatrics with inpatient, outpatient, and newborn hospital care. Attractive call and rounding schedule. Competitive salary with federal government benefits. The area provides a wide variety of outdoor recreational activities, being only 12 miles from Glacier National Park. For more information, please

contact Dr. Tom Herr at *thomas.herr@ihs.gov* or call (406) 338-6372. (1/13)

Director, Health and Human Services
Ysleta Del Sur Pueblo; El Paso, Texas

The Ysleta Del Sur Pueblo (YDSP) Health and Human Services Department is a team of health care professionals and staff fully committed to their patients' physical, emotional, and spiritual wellbeing, offering a comprehensive range of health and human services that ensure a safe environment, quality service, and accessible health care in an atmosphere of respect, dignity, professionalism, and cultural sensitivity.

YDSP's HHS department is seeking a Director. This person has responsibility and accountability for the development and implementation of a plan to bring HHS to an ongoing operating success. The Director will need the flexibility to make quick and efficient business decisions, while at the same time assuring that operations respect the broad guidelines and, more importantly, the service standards expected by tribal members and tribal leadership. To get more information or to apply, contact Jason S. Booth, CEO, Ishpi, Inc., telephone (651) 308-1023; or e-mail *jason@ishpi.biz*. (1/13)

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

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

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

We offer competitive salary, relocation/recruitment/retention allowance, federal employment benefits package, CME leave and allowance, and loan repayment. For more information, please contact Peter Ziegler, MD, SSU Clinical Director at (520) 295-2481 or by e-mail at *Peter.Ziegler@ihs.gov*. (12/12)

Family Physician with Obstetrics Skills
Pediatrician (or Internal Med-Peds) Physician
Ethel Lund Medical Center; Juneau, Alaska

The SEARHC Ethel Lund Medical Center in Juneau, Alaska is searching for a full-time family physician with obstetrics skills and a pediatrician (or internal medicine/pediatrics physician) to join a great medical staff of 14 providers (10 physicians, four midlevels) at a unique clinic and hospital setting. Have the best of both worlds by joining our practice where we share hospitalist duties one week every 6 - 8 weeks, 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 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 the Patient-Centered Medical Home, quality improvement with staff development from IHI, and adopting an EHR at the clinic and hospital in the near future. We have frequent CME and opportunities for growth, with teaching students and residents and faculty status at University of Washington available to qualified staff. This is a loan repayment site for the Indian Health Service and National Health Service Corps.

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; telephone (907) 364-4485, or e-mail *cbuley@searhc.org*. *Locum tenens* positions also available. (12/12)

Director
Center of American Indian and Minority Health
University of Minnesota Medical School;
Duluth, Minnesota

The University of Minnesota Medical School in Duluth, Minnesota, invites applications for a full-time Director for the Center of American Indian and Minority Health. The Center of American Indian and Minority Health (CAIMH) at the University of Minnesota Medical School strives to raise the health status of American Indian and Alaska Native people. This is achieved in part through programming and activities for

American Indian students grade K - 16 and medical school, and partnerships with American Indian communities and organizations. The CAIMH, housed on the Duluth Campus, educates American Indian and Alaska Native students in the field of health care, and more specifically, in American Indian and Alaska Native health, and collaborates on research focused on improving the health of American Indian and Alaska Native people.

For more information about the Center of American Indian and Minority Health, go to *http://www.caimh.umn.edu/*.

Required/Preferred Qualifications include an MD/DO degree; however, an alternative terminal degree may be considered in circumstances of exceptional fit. Previous employment experience in medical school. An academic background in a field relevant to medical education. All candidates must have evidence of essential verbal and written communication skills including clarity in the delivery of lectures and the writing of grants and other documents.

The Director position is a full-time time, 12-month appointment. Additional information is available online at *https://employment.umn.edu/* (Req. #182533). Review of applications will continue until the position is filled. The University of Minnesota is an Equal Opportunity Educator and Employer. Apply on-line at *https://employment.umn.edu/* Job Req # 182533. (12/12)

Clinical Director (Primary Care)
Family Medicine Physician
White Earth Health Center; Ogema, Minnesota

White Earth Health Center is located in northwestern central Minnesota on the White Earth Reservation, which is in the heart of lake country. The reservation is 36 by 36 square miles; its largest metropolitan location is approximately 75 miles from Fargo, North Dakota or 235 miles from the Twin Cities. We have a satellite clinic in Naytahwaush (approximately 30 minutes from the WE Service unit) operating on Monday, Tuesday, and Friday, and one in Pine Point (approximately 30 minutes from the WE service unit) that is open on Thursday. The satellite clinics have one full time family practice physician and one family practice nurse practitioner who staff them on a regular basis.

We are a Federal Indian Health Service outpatient/ ambulatory care facility that had 115,699 ambulatory visits for 19,494 registered patients this past year. We offer services Monday through Friday 8:00 am to 4:30 pm; on all federal holidays we are closed. Our services include a dental department with three full time dentists; a mental health department that consists of one psychologist, four counselors, one contract psychiatrist and one mental health nurse practitioner; and an optometry department comprised of the chief of optometry, one optometry technician/receptionist, and one contract optometrist.

Our medical staff consists of three full time family practice physicians, one contract family practice physician, one podiatrist, one internal medicine physician, one audiologist, a nutritionist, one pediatrician and three family nurse practitioners. We have pediatric and same day/urgent care clinics. The clinics are operating/implementing the IPC model.

We offer competitive salary, excellent benefits (health, life, retirement) and both sick and vacation leave. For further information, please contact Mr. Tony Buckanaga, Health Professions Recruiter at (218) 444-0486, or e-mail *tony.buckanaga@ihs.gov*. (11/12)

Registered Dietitian
Psychiatrist
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). (11/12)

WIC Coordinator
SEARHC; Sitka, Alaska

The WIC Coordinator/RD works as a member of the SEARHC health promotion team to assess for, plan, implement, administer, and evaluate nutrition and health education programming that responds to Goals 8 and 9 in SEARHC's Strategic Plan. The WIC Coordinator also works to ensure high quality WIC services are provided to eligible women, infants, and children throughout southeast Alaska. Additionally, the WIC Coordinator partners with organizations working with the WIC population to make appropriate referrals and to enhance the WIC program.

Baseline Qualification Requirements include a BS in community nutrition/dietetics or a nutrition-related field, and four years of clinical nutrition and/or community nutrition work experience with specific progressive experiences in maternal/child nutrition, outpatient medical nutrition therapy, and program planning and administration. Must be both a registered dietitian and licensed dietitian/licensed nutritionist in the State of Alaska. Must adhere to the American Dietetic Association code of ethics and complete 75 continuing education credits every five years as required by registration and licensure plus keep current on registration and licensing payments. Other/Preferred Qualifications include a valid Alaska driver's license, ability to travel, including to remote

southeast Alaska locations, supervision/mentoring training, public policy and advanced nutrition education strategy(ies) training, and MS/MPH in nutrition and/or dietetics or other health promotion related field

Contact Lisa Sadleir-Hart, MPH, RD, CHES, ACE, Community Nutrition Department Manager, SEARHC/Health Promotion, at telephone (907) 966-8735; facsimile (907) 966-8750; or e-mail *lisa.sadleir-hart@searhc.org*. (10/12)

Family Practice Physician
Jicarilla Service Unit; Dulce, New Mexico

The Jicarilla Service Unit (JSU) is a new, beautiful 65,000 square foot facility nestled in the mesas of northern New Mexico with views of the edge of the Colorado Rockies. We provide care to the Jicarilla ("Basket-maker") Apache community with a population of 4,400. Our clinic has an opening for a board certified/eligible family practice physician for purely outpatient care with a 40 hour work-week. Our site qualifies for IHS and state loan repayment programs. JSU has a fully functional electronic health record system. Our pharmacy has a robust formulary including TNF-alpha inhibitors and exenatide. The clinic also has an urgent care clinic for acute walk-in cases. Our staff currently consists of an internist, three family practice physicians, an optometrist, and three dentists. We also have a team of dedicated public health nurses who specialize in home visits for elders and prenatal follow-up. The Jicarilla Apache Nation is self-sufficient with revenues from oil and natural gas. Much has been invested in the infrastructure of the reservation, including a large fitness facility, a modern supermarket, a hotel and casino, and more. We are also located 45 minutes from the resort town of Pagosa Springs, which has year-round natural hot springs and winter skiing at renowned Wolf Creek Pass.

We welcome you to visit our facility in person. To take a video tour of the Nzh'o Na'ch'idle'ee Health Center online, go to *http://www.usphs.gov/Multimedia/VideoTours/Dulce/default.aspx*. Please call Dr. Cecilia Chao at (575) 759-3291 or (575) 759-7230; or e-mail *cecilia.chao@ihs.gov* if you have any questions. (10/12)

Clinical Nurse
Gallup Indian Medical Center; Gallup, New Mexico

Gallup Indian Medical Center (GIMC) is currently accepting applications from experienced nurses for positions within our hospital facility. We are particularly interested in nurses with experience in the Labor and Delivery, Emergency Room, and Ambulatory Care settings.

GIMC is a 78-bed hospital in Gallup, New Mexico, on the border of the Navajo Reservation. Our patient population includes Navajos, Zunis, and others. Gallup provides outdoor activities (biking, hiking, rock climbing, and running, to name a few). As a Navajo Area Indian Health Service Hospital, we provide clinical specialties that include Internal Medicine, Cardiology, Anesthesia, Psychiatry, Emergency Medicine, OB/GYN, General Surgery, Orthopedics, Ophthalmology, ENT, Radiology, Pathology, and Pediatrics.

Nurse employment benefits include competitive salary, comprehensive health insurance, double time pay for holidays worked, night and Sunday pay differential, no census days, and continuing education. Government housing is not available, as we are not located on the Navajo Reservation. Opportunities are available for growth and advancement depending on your personal nursing career goals. We welcome your questions, curiosity, and application submission.

For more information on how and where to apply, contact Myra Cousens, RN, BSN, Nurse Recruiter at (505) 726-8549, or e-mail *myra.cousens@ihs.gov*. (10/12)

Family Practice Physician/OB
Sonoma County Indian Health Project (SCIHP);
Santa Rosa, California

Live, work and play in the wine country. Sonoma County Indian Health Project (SCIHP) Santa Rosa, CA California, is seeking a full-time –Temporary Ffamily Practice practice Physician physician to join our team. SCIHP is a comprehensive community care clinic serving the Native American community of Sonoma County. Medical phone call 1/6 nights required, OB hospital call participation preferred but not required. Three to six month position—With the possibility of permanent hire. Obstetrics and inpatient care at the hospital required. SCIHP is a comprehensive community care clinic. Candidates must currently hold a California Physician/Surgeon (MD) or Osteopathic Physician/Surgeon (DO) license and be BE/BC in a primary care discipline. For the right candidate we offer competitive compensation. For more information, please contact Human Resources by fax (707) 526-1016; or by e-mail: *welovedoctors.hr@gmail.com*. (10/12)

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. (7/12)

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)

Print Version of *The Provider* Has Ceased Publication

The federal government is always exploring ways to reduce costs. One recent initiative is an effort to reduce printing expenses. For this reason, we have stopped publishing and distributing the print edition of *The Provider*.

We will continue to publish the monthly electronic 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.

We encourage all our readers to subscribe to the listserv (go to *http://www.ihs.gov/provider/index.cfm?module =listserv)* so that you will receive monthly reminders about when the latest issue is posted to the website. This will also give us an improved count of the number of readers.

Electronic Subscription Available

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

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).*

Circulation: The PROVIDER (ISSN 1063-4398) is distributed on the CSC website to health care providers working for the IHS and tribal health programs, to medical schools throughout the country, and to health professionals working with or interested in American Indian and Alaska Native health care. If you would like to subscribe, go to *http://www.ihs.gov/Provider*.

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

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