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What's in a Name? From the Administration on Aging to the Administration for Community Living

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You may have heard that the Administration on Aging (AoA) is now part of a larger organization in the Department of Health and Human Services called the Administration for Community Living. Like many, you may wonder what this means. There are several important implications of this move. First, all AoA programs will continue to be provided under the AoA structure as defined by the Older American's Act, including nutrition programs, programs for American Indian/Alaskan Natives and Native Hawaiians, transportation

services, elder rights and ombudsman services, as well as many other supportive services. Second, AoA is joined by the HHS Office on Disability and the Administration for Intellectual and

Annual Elders Issue

This May 2013 issue of *The IHS Provider*, published on the occasion of National Older Americans Month, is the eighteenth 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 2014 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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Developmental Disabilities. While it may not be immediately clear why disabilities and aging programs would want to join together in this way, both groups are at significant risk for institutionalization, and there is significant overlap in the policies as well as services and supports that help people from both groups live in the community. Hence the new name, Administration for Community Living.

The remainder of this article goes into greater detail on the workings of ACL, and the specific roles of each of its components.

The Administration for Community Living (ACL), was formed by Secretary Sebelius in April 2012 as a single agency charged to work with states, localities, tribal organizations, nonprofit organizations, businesses, and families to help more seniors and people with disabilities have the option to live in their homes and fully participate in their communities.

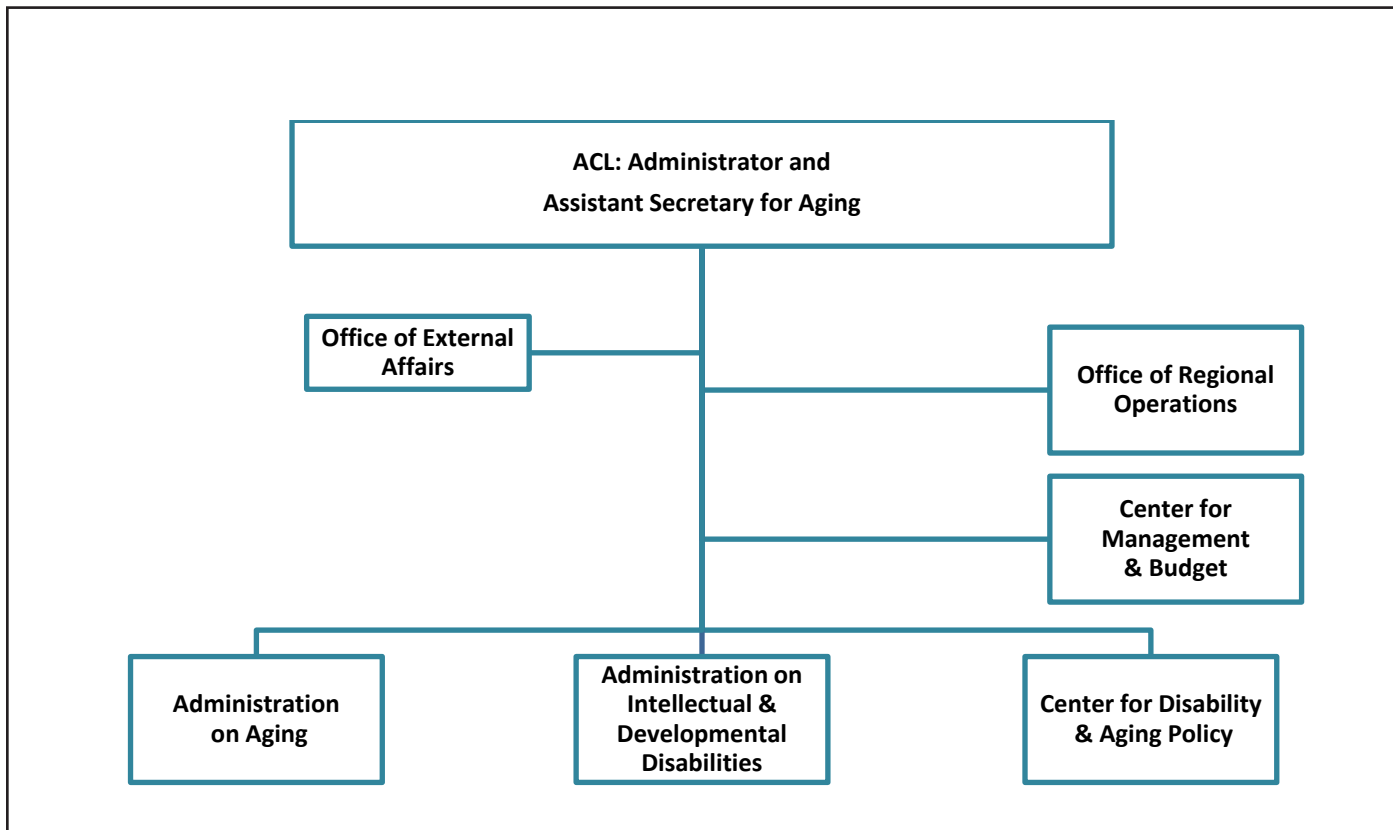
ACL brings together the efforts and achievements of the Administration on Aging, the Administration on Intellectual and Developmental Disabilities, and the HHS Office on Disability to serve as the Federal agency responsible for increasing access to community supports, while focusing attention and resources on the unique needs of older Americans and people with disabilities across the lifespan. See the organizational chart below.

ACL's mission is to maximize the independence, well-being, and health of older adults, people with disabilities, and

their families and caregivers.

Those with disabilities or functional limitations of any type, regardless of age, have a common interest. For these populations, access to home and community-based supports and services can make the difference in ensuring that people can fully participate in all aspects of society, including having the option to live at home instead of having little choice but to move into some form of institutional care. ACL works to improve this access through two distinct program lines that address the unique needs of each community: programs serving seniors and caregivers under ACL's Administration on Aging (AoA) and programs for people with intellectual and developmental disabilities and their families under ACL's Administration on Intellectual and Developmental Disabilities (AIDD).

AoA advances the concerns and interests of older people, and works with and through the national aging services network to promote the development of comprehensive and coordinated systems of home and community-based care that are responsive to the needs and preferences of older people and their caregivers. The network is comprised of 56 State and Territorial Units on Aging (SUA), 629 Area Agencies on Aging (AAA), 256 American Indian, Alaskan Native, and Native Hawaiian organizations, nearly 20,000 direct service providers, and hundreds of thousands of volunteers. AoA's core programs, authorized under the Older Americans Act (OAA),



help seniors remain at home for as long as possible. These services complement existing medical and health care systems, help prevent hospital readmissions, and support some of life's most basic functions, such as bathing or preparing food.

AIDD advances the concerns and interests of people with developmental disabilities and their families, working through a network that includes, in each state and territory, State Councils on Developmental Disabilities, State Protection and Advocacy systems, and University Centers for Excellence in Developmental Disabilities (UCEDDs). AIDD programs fund capacity-building and systems change efforts to ensure that people with developmental disabilities and their families participate in the design of, and have access to needed community services, individualized supports, and other forms of assistance that promote self-determination, independence, productivity, and integration and inclusion in all facets of community life.

AoA's Services for Native Americans programs were first established in 1978 with the provision of nutrition and supportive services, and in 2000 expanded with the addition of caregiver support services. They provide grants to eligible tribal organizations to promote the delivery of home and community-based supportive services, including nutrition services and support for family and informal caregivers, to Native American, Alaskan Native, and Native Hawaiian elders. These programs, which help to reduce the need for costly institutional care and medical interventions, are responsive to the cultural diversity of Native American communities and represent an important part of the communities' comprehensive services.

ACL is currently devising strategies to support access for tribal members to the full range of programs serving people with disabilities and seniors. For instance, ACL supports the

development of a no-wrong door model to facilitate access to programs, services, and supports for seniors and people with disabilities through the Aging and Disability Resource Center (ADRC) grant program. The full implementation of the ADRC program would include integration with tribal services and supports in a culturally competent manner.

Additional efforts are being made at ACL to support the development of relationships between tribes and state agencies responsible for serving seniors and people with disabilities. These include ensuring that various grant program announcements encourage potential grantees to include tribes and tribal needs in their proposals. For instance, very little is known about people with intellectual and developmental disabilities (IDD) in Indian Country. The designation of disability is fraught with cultural, social, and economic variation that needs to be addressed in culturally informed ways. Similar thinking needs to be considered in terms of the various roles that seniors play across the landscape of Indian and non-Indian cultures.

To enhance and strengthen these distinct program lines going forward, ACL will promote consistency and coordination in community living policy and seek to better align the medical, clinical, and community-based supports that are critical to all constituencies. ACL's Center for Aging and Disability Policy will provide a focal point for these efforts to develop new policies and initiatives that support both older Americans and persons with disabilities in accessing services and supports and fully participating in their communities. While this work is just beginning at ACL, there is much promise for a future where programs work together to support people based on level of need and where individual preferences are honored and cultural traditions are respected.



Addressing Alzheimer's Disease and Related Dementias in the Indian Health System

Bruce Finke, MD, Nashville Area Indian Health Service, Northampton, Massachusetts; and Blythe Winchester, MD, MPH, Staff Physician, Cherokee Indian Hospital, Cherokee, North Carolina

“Now, at times, she thinks that Dad is out fishing and will be home soon. In some ways, this is good, because she does not always have to know that he is gone, and continuously have to suffer the pain that loss can bring after a lifetime like theirs together. But there are many times that she is totally lucid and knows that he is not with her, but is waiting for her to be with him when her times comes too. We have as a family kept Nana in her home, in the surroundings most familiar to her. There, every day she is close to all of her family who love her and accept her, wherever she may be mentally. She knows that she is home, and that she is safe and loved, despite her confusion.”

Marquart K. Nana. *The IHS Primary Care Provider*. Vol 29 No. 5. May 2004.

Kathleen Marquart wrote those words in *The IHS Primary Care Provider* nearly a decade ago, reflecting the experience of so many families living with a person affected by Alzheimer's disease and related dementias.

A widely cited study of the national prevalence of dementia in the United States estimated that 13.9% of individuals older than 70 had dementia, representing 3.4 million people. Some 9.7% (about 2.4 million people) older than 70 have Alzheimer's disease (AD), making it by far the most common cause of dementia.¹ Other causes of dementia usually included with AD when referring to Alzheimer's disease and related dementias (ADRD) include vascular dementia, Lewy Body Disease, Frontotemporal Dementia (FTD), and mixed dementias.

We don't have accurate prevalence rates for Alzheimer's disease and related dementias among American Indians and Alaska Native (AI/AN) people, but there is no reason to believe that the age-adjusted prevalence rate is lower than in the general population. Both diabetes and cardiovascular disease have been associated with increased risk of dementia, raising concern that dementia rates among AI/AN people may be higher than in the US as a whole.^{2,3}

The financial burden for the health care system (and by extrapolation to the Indian health system) is high. A recent study suggests that the total monetary cost of dementia (including the value of care provided by families) in 2010 was between \$157 and \$215 billion dollars.⁴ The cost of care

purchased (excluding care provided by families) was \$109 billion dollars, similar to estimates for the direct health expenses associated with heart disease and higher than those associated with cancer.⁵

The National Plan to Address Alzheimer's Disease, developed as a result of the National Alzheimer's Project Act (NAPA) signed into law in 2011, addresses research toward treatment and prevention of Alzheimer's, as well as efforts to improve care, services, and support to people with Alzheimer's, and their families and caregivers.⁶ The IHS participation in the development of this plan has highlighted the question, What can IHS, tribal, and urban Indian health programs do to provide the best possible care for persons with dementia and their families?

While there are some specialized geriatric assessment and management programs in IHS, tribal, and urban Indian health programs, most medical care for persons with dementia is provided through population-based primary care. For this reason, efforts to improve the care and services for persons with dementia and their caregivers must be rooted in primary care.

The team-based, patient-centered platform of care that many IHS, tribal, and urban sites are developing through participation in the IHS Improving Patient Care (IPC) program provides a better, more capable organization of primary care for persons with dementia. The need remains to identify and develop the specific elements of that care: to furnish the “medical home.”

An approach to improving care for persons with dementia and their families should take into consideration the following areas of work:

1. - Recognition of dementia, both in clinical and community-based settings.
2. - Accurate and efficient diagnosis of dementia (including the treatment or exclusion of potentially reversible causes of cognitive impairment) and a standardized assessment that includes determination of the stage of disease, level of function, immediate safety risks, and patient and family needs.
3. - Medical and behavioral treatment appropriate to stage and symptoms, and provision of necessary social support for persons with dementia and their families, informed by the values and preferences of the person with dementia.
4. - Caregiver training and support.
5. - Integration of clinical care with dementia-capable long term services and support.

Recognition of Dementia

Dementia is frequently not recognized in routine care in the primary care setting, and the high incidence of delirium accompanying acute illness can make the accurate diagnosis of dementia difficult in the ill individual in the emergency department or during hospitalization. While there is a broad consensus that recognition of dementia facilitates the provision of services to support the individual with dementia and their families, the United States Preventive Services Task Force (USPSTF) has concluded that the evidence is insufficient (“I” recommendation) to support routine screening for dementia in older adults.⁷

The Veterans Health Administration (VHA) has piloted a strategy to encourage detection that is based on improving recognition of the warning signs of dementia among both VA staff and family members of persons with dementia. While this strategy is still being formally evaluated, it shows initial promise. This approach would be feasible in both IHS, tribal, and urban Indian health programs and in the Tribal Senior Centers and Elder’s programs funded by the Administration on Aging (AoA) American Indian, Alaska Native, and Native Hawaiian program under Title VI of the Older Americans Act.

The Medicare Annual Wellness Visit or similar periodic exam focused on comprehensive elder assessment and preventive services offers an opportunity to assess cognitive function in the clinical setting.

A campaign focusing on the warning signs of dementia, targeting clinical staff, families, and tribal elders programs, will raise awareness of dementia and can bring individuals and families in for diagnosis, assessment, and support.

Diagnosis and Assessment

An individual suspected of having cognitive impairment requires a more complete evaluation focusing on diagnosis and excluding potentially treatable causes of cognitive impairment. While there is no single, consensus approach to the diagnostic evaluation, there are pathways that are well supported by research and expert judgment.⁸ A careful medication review is an important component of the evaluation. This is a primary care competency, and the work-up of possible dementia should take place in the primary care setting. Geriatrics or neurology referral or psychometric testing should be reserved for situations when there is diagnostic difficulty or uncertainty. A standardized approach to the diagnostic work-up of dementia will improve reliability and can be supported by a template in the electronic medical record.

But the evaluation should not stop with the diagnosis. The person with newly diagnosed dementia deserves a complete assessment of stage of illness, function, and the impact of the condition on their lives. This assessment will give the patient and family essential information about what to expect, guide treatment options, provide a baseline for evaluating response to treatment, and understand need and eligibility for services. The assessment should include function (basic and advanced activities of daily living), cognition, and difficult or disturbing behaviors, including behaviors that might pose a risk to safety.

The assessment should also address the support system available to the person with dementia from family and their social network. Who will be picking up the functions that are let go as they move together through the stages of dementia? How much capacity and reserve do the caregivers have, and what are their vulnerabilities?

There is a growing body of assessment tools and instruments that can help us to do a reliable assessment of the person with dementia and their support system. None of these instruments have been formally evaluated in Indian Country, and only a minority have been tested in cross-cultural settings. When these assessments are collected as structured data and entered in specified fields in the electronic medical record, the data can be retrieved and used to help manage care using the registry functionality of the electronic medical record, either in the IHS EHR or commercial products. At the very least, a complete assessment that can be readily found in the record and regularly updated will provide a huge benefit for the person with dementia and their caregivers.

A complete and well-documented assessment of the person with dementia and their family and social support system provides a place to start with planning and a baseline for treatment decisions.

Medical and Behavioral Treatment Appropriate to Stage and Symptoms, Informed by the Values and Preferences of the Person With Dementia

The assessment serves as the basis for a plan of care, developed with the person with dementia and their family. Although the person with dementia may be limited in their ability to think through complex options or even to communicate about their preferences, the plan of care should capture and respond as much as possible to their values and preferences. This includes any preferences they may have regarding care at end of life.

Treatment should include pharmacologic and non-

pharmacologic strategies to improve function, treat symptoms, and address troubling or unsafe behaviors. Given the challenges of dementia management and the inconsistent response to both medications and behavioral therapies, it is essential that the assessment provide a clear baseline prior to treatment and that we monitor response to the treatment.^{9,10} An instrument that provides a multi-domain assessment of cognition, function, and behavior can be used to objectively assess response to medication therapy.¹¹ Medications that are not showing clear positive impact on function, behavior, or symptoms after an appropriate trial should be discontinued.

Oral health is frequently ignored in persons with dementia and is an essential component of care.

Individuals with a diagnosis of dementia should be followed regularly and reassessed periodically, with the plan of care updated to reflect changes. Periodic medication review is an important element of this reassessment.

The care of a person with dementia should be guided by a plan that reflects their values and preferences for care, and therapeutic approaches should be revised based on regular reassessment of cognition, function, and symptoms.

Caregiver Training and Support

Providers of care for persons with dementia operating through a nursing facility, a home care or home health agency, or an elder day program are subject to a variety of regulations that dictate minimum standards for training and skills. This is not the case with family caregivers of persons with dementia. Family and friends provide most of the care for persons with dementia, very often with little support or guidance. Family caregivers should be offered a standardized, basic training in caring for persons with dementia and a way to get additional help and guidance for specific problems that may arise. The REACH-VA is an example of such an approach that has demonstrated significant impact on the care of persons with dementia and the well-being of their caregivers.¹²

Assessment of caregivers' well-being and needs for training and guidance should be a routine part of the care of persons with dementia.

Care for the person with dementia requires care for the caregivers. Training and support for caregivers should be a standard element of the care for the person with dementia.

Integration With Dementia-Capable Long Term Services and Supports

The clinical services for the person with dementia should be coordinated with those long term services and supports that are available. There should be some ability to provide home visits for individuals with late-stage dementia.

While tribes are actively engaged in developing long term services and supports, for many in Indian Country, these services are available only through providers outside of the tribe or community, if at all. These services might include:

- Home visits
- Elder day care services
- Personal care services
- Chores/finances/shopping/transportation
- Respite
- Environmental home modifications
- Palliative and end-of-life care
- Facility-based care options

Knowing what services are available and coordinating with those services is a core competency of primary care for persons with dementia.

A strong system of care for persons with dementia should include coordination with all long term services and supports available to those with dementia and the capability to provide home visits to persons with late stage dementia.

What is Required to Make this Happen?

The care outlined here is not intended to represent an idealized model of care. It is proposed as the basic care every person with dementia and their family deserves. To provide this care will require:

1. - A campaign to increase recognition of dementia in clinical and community settings through training, community outreach, and implementation of a yearly elder wellness visit such as the Medicare Annual Wellness visit.
2. - A standardized and structured process for diagnosis and assessment supported by the electronic medical record and applications such as iCare.
3. - Use of a plan of care with periodic review, documented in the electronic medical record.
4. - Reliable processes for periodic medication review and for guiding the use of medications in the management of dementia.
5. - Staff competency in behavioral (non-pharmacologic) interventions.

6. - Dental staff competency in care for persons with dementia.
7. - Adoption or adaptation of a structured program of caregiver training and support and the staff training required to support it.
8. - Ongoing coordination with tribal programs and non-tribal services to maximize availability and appropriate use of long term services and supports and to integrate clinical care with these services.
9. - Home visit capacity.

Most IHS, tribal, and urban programs do not currently have this capacity and, as recognized by the National Plan to Address Alzheimer's Disease, this situation is not unique to Indian health. The burden of dementia will increase in Indian Country as our population ages. The Indian health experience with diabetes care should instruct us: we need to understand what good care looks like and then systematically build the capacity to provide that care.

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Additional Resources

- A publicly available Clinician Fact Sheet on Detection of Dementia can be found on the VHA Health Promotion and Disease Prevention website at http://www.prevention.va.gov/Resources_for_Clinicians.asp
- For more information on the Medicare Annual Wellness Visit see *The IHS Primary Care Provider*, May 2011 issue at http://www.ihs.gov/provider/index.cfm?module=archived_2010_2019 and an excellent resource with links from the ACP Center for Practice Improvement at http://www.acponline.org/running_practice/payment_coding/medicare/annual_wellness_visit.htm
- The American Geriatrics Society Guide to Dementia Diagnosis and Treatment can be found at <http://dementia.americangeriatrics.org/>
- Persons with Alzheimer's disease and their families can find valuable information at Alzheimers.gov at www.alzheimers.gov
- The Alzheimer's Disease Education and Referral Center of the National Institute on Aging has many resources for persons with Alzheimer's disease, family caregivers, and professionals at <http://www.nia.nih.gov/alzheimers>

Long Term Care Ombudsman Program for Tribal Residents

Tiffany Yazzie, Independent Living Support Program Specialist, designated as the Regional Ombudsman Coordinator, Area Agency on Aging, Region 8, Inter-Tribal Council on Arizona, Inc., Phoenix, Arizona

Need for Long Term Care Advocacy

In 1992, amendments to the Older Americans Act created the Vulnerable Elder Rights Title, Title VII, and provided funding that Arizona tribes could access from their designated Area Agencies on Aging. Today, three tribes work with the Inter Tribal Council of Arizona, Inc., and have at least one state certified ombudsman making facility visits to ensure tribal members are not subject to abuse, neglect, and substandard care. These trained and certified tribal employees are further known as tribal ombudsmen, who share the same tribal background as the residents they visit in off-reservation facilities. Over the years, this method has been shown to provide tribal residents a service that is culturally sensitive and specific to their own tribal heritage.

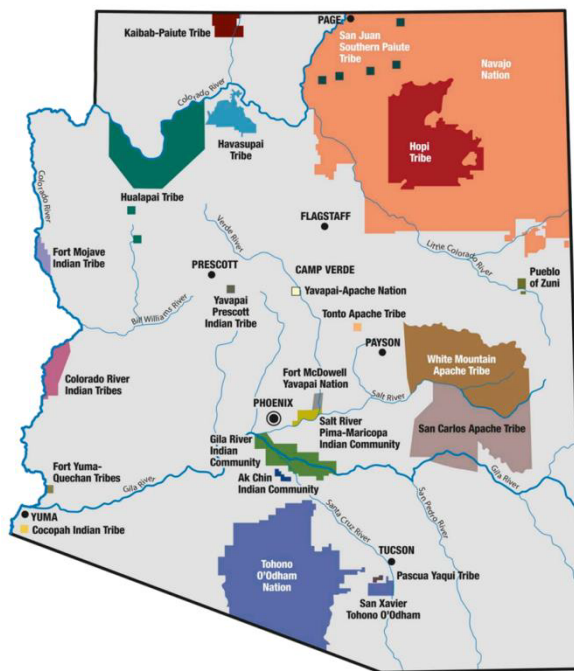
Tribal traditions in Arizona encompass a wide range of linguistic, subsistence, social, and cultural diversity. American Indian tribes in Arizona have maintained their identities and, to varying degrees, their cultural traditions and languages.

The Inter Tribal Council of Arizona, Inc.

The Inter-Tribal Council of Arizona was established in 1952 to provide a united voice for tribal governments located in the State of Arizona to address common issues of concern. On July 9, 1975, the council established a private, non-profit corporation, Inter Tribal Council of Arizona, Inc. (ITCA),

under the laws of the State of Arizona to promote Indian self-reliance through public policy development. In 1979, ITCA was designated as an Area Agency on Aging by the state to receive Older Americans Act funds. Today, ITCA subcontracts with 17 tribes to provide nutrition and/or non-medical home and community based services to approximately 10,000 elders. The service area encompasses a diversity of tribal reservations spanning from the bottom of the Grand Canyon to the metropolitan city limits, rural deserts, and high mountainous regions of Arizona. The 17 tribes include:

- Ak-Chin Indian Community
- Havasupai Tribe
- San Carlos Apache Tribe
- Cocopah Tribe
- Hopi Tribe
- Tohono O'odham Nation
- Colorado River Indian Tribes
- Hualapai Tribe
- Tonto Apache Tribe
- Fort McDowell Yavapai Nation
- Kaibab-Paiute Tribe
- White Mountain Apache Tribe
- Fort Mojave Indian Tribe
- Pascua Yaqui Tribe
- Yavapai Apache Nation
- Gila River Indian Community
- Salt River Pima Maricopa Indian Community



Long Term Care Ombudsman Program for Arizona Tribes

The Long Term Care Ombudsman Program is a coordinated effort between ITCA and member tribes who subcontract for the service. With Title III-B, Title VII and state funds, tribes support their elders and disabled individuals who are placed into off-reservation skilled nursing or assisted living facilities licensed by the state. The supporting roles tribes take on include visiting residents regularly, educating facility staff or community members, referring case complaints to appropriate agencies, and advocating and mediating situations on behalf of the resident. Most often tribal ombudsmen are the only visitors tribal residents see on a consistent basis.

There are only three ITCA member tribes who provide the ombudsman service: Hopi, White Mountain Apache, and Pascua Yaqui. Each tribe has at least one certified, paid staff to provide this service. There are currently no certified volunteers. ITCA works with the tribes to recruit, screen, select, and train tribal workers or volunteers from the community and works with the state long term care ombudsman coordinator to obtain state ombudsman certification for trained recruits. The volunteer recruitment is pursued at the discretion of each tribe because ITCA encourages tribes to take an active role in program development. The task of recruiting volunteers in tribal communities is difficult because part of the job is to travel off the reservation to make facility visits. If any volunteers are eligible, most do not have the funds or transportation to travel on their own. Therefore, all program activities are conducted by paid tribal staff from the elder services programs.

All current tribal ombudsmen are members of their respective tribal communities and speak their native languages. By having a background similar to their clients, these tribal representatives are better able to meet the culturally sensitive needs of their residents. Their ability to relate with residents helps tribal ombudsmen identify and resolve commonly overlooked concerns of residents through education, mediation, and interpretation.

The Long Term Care Setting in Arizona

The Arizona Department of Health Services Office of Licensing reported that 147 skilled nursing facilities and 1,963 assisted living facilities were licensed in Arizona in 2013. Of these, only two ITCA member tribes have established a skilled nursing facility, an assisted living facility, and/or adult day care program to support tribal elders and disabled adults to remain on the reservation: Gila River Indian Community and Tohono O'odham Nation. As for other tribes, this means the only access to long term care would be in facilities off and even far from reservation lands. The state has specially trained and certified advocates who work to improve the quality of life and the quality of care of residents living in long term care facilities. However, most ombudsmen are non-tribal personnel or volunteers unfamiliar of the culture and language spoken by most tribal elders. This setting also describes the situation most tribal members face when interacting with facilities and staff unaware of the various tribal cultures in Arizona.

Common Concerns of Tribal Residents

According to an extract from 2006 ITCA grant proposal for the Indian Health Service Elder Care Initiative Project, "Testimony by tribal ombudsman indicates that elders placed in nursing home facilities off the reservation suffer from isolation, loneliness and depression. These feelings of loneliness and depression often result from the elders being displaced from their traditional homeland and family environment. The facilities may provide appropriate care to the

tribal elders but the experience of feeling disconnected from the familiar – food, language, spiritual ceremonies, and community – may lead to loneliness and depression."

The familiarities of home are still common concerns seen by tribal ombudsmen today. Most often these concerns can be overlooked or misinterpreted as behavioral problems by facility staff, and cause further discomfort for residents. Sharing examples of frequently seen concerns is one step to educating the public about the cultural needs of tribal residents. Here are a few examples relating to language, culture, community, food, and drinks.

Language

Residents, especially tribal elders, seen in facilities still speak their language, and often, cannot speak or understand English. Residents consider language as not only a familiar connection to home and family, but a strong connection to their mental and physical well-being. This ability to communicate needs clearly with facility staff is one key factor to developing a care plan suitable to residents' needs and to improving their quality of care. Tribal ombudsman see residents are more receptive to speaking with another community member rather than facility staff. The access to effective and on-going communication, in a language a resident understands, is a resident right and a common concern for tribal residents.

Culture

Residents have specific customs and practices that facilities are unaware of or know little about. There is a cultural diversity amongst Arizona tribes reflected especially in the customs tribal members carry into their daily activities. One example is the daily practice of praying with cultural items. Tribal residents have concerns when housekeepers remove sacred prayer offerings placed by the resident on the window sill or bedside. Most often housekeepers do not know what a pile of ash, a beaded necklace, a feather, a stone, or a pile of rock salt represent to a resident. Thus, the cultural item may be displaced or discarded during cleaning. Tribal ombudsmen often mediate the situation with facility staff and explain why residents find this act offensive and disrespectful, because these offerings are considered sacred tributes to the spirits, or symbols of protection. Tribal residents are certainly justified to be concerned and are entitled to be treated with respect and with due consideration for their cultural practices.

Culture also plays a part in how residents are cared for. Tribal ombudsmen have resolved concerns of female residents involving the touching of shoulders by facility caregivers. For some tribal cultures, women were taught their shoulders were part of their breast. Concerns arise when caregivers are unaware and touch the resident's shoulders to alert them of their presence or to assist in dressing the resident. The resident's discomfort is amplified when the caregiver is male.

Tribal ombudsmen have also mediated concerns of male residents involving the touching of thighs by facility

caregivers. For some tribal cultures, men were taught their thighs are part of their private areas. Concerns arise when female caregivers are unaware and touch the resident's thigh to assist them out of bed or to use as an exit cue. Unaware, the female caregiver is seen by the male resident to be "interested" in intimate contact because they constantly touched their private parts. Misunderstood, a male resident is seen by the female caregiver to be flirty and forward. Overall, sexual tensions arise when personnel are unaware of what body parts a resident might feel are private or intimate.

Community

Residents commonly ask tribal ombudsmen about what events are happening back home. Both elders and disabled adults enjoy reading their tribal and local newspapers or hearing about the current events such as ceremonies, tribal fairs, and social dances. Residents consider these activities as shared experiences that other tribal members can recognize and relate to. Residents can participate in these activities, as it is their right to participate in social and community activities of their choice. Tribal ombudsmen resolve concerns with supplemental information when such materials are not accessible to residents because facilities most often do not know where to look for such information.

Food and Drinks

Residents want traditional meals or traditional foods incorporated into their diet. Tribal ombudsmen have heard residents reminisce about farmed foods such as corn, beans, squash, and melons that can be used in several customary dishes such as corn-squash stew, corn to make tamales with a side of beans, corn bread to eat with hominy stews, and melon desserts. Or residents may have a longing to taste foraged foods from the mountain forests such as acorns used in acorn stew. Tribal ombudsmen often hear concerns about traditional foods when residents are displaced in off-reservation facilities and want the familiar tastes of home.

Residents want hot coffee, if not for taste, but for a reminder of home. Tribal residents consider coffee as a social drink; whereas some other, non-tribal cultures may prefer tea, coffee is a much desired drink for tribal residents. The aroma of hot coffee exudes a welcoming reminder of home and of

pleasant times visiting with relatives and friends. This example of getting a hot cup of coffee is a service and a resident's right to "receive services with reasonable accommodations of their individual needs and preferences" because "the facility and staff must allow each resident to direct the patterns of his or her daily life (Arizona Long Term Care Ombudsman Manual, 2011)." Concerns about coffee do arise when a resident is served a cold cup of coffee or none at all.

Conclusion

The method of delivering ombudsman services on off-reservation lands took root in Arizona before the first long term care facilities were established on reservations. Today, few tribes have access to long term care on reservation lands and rely on off-reservation facilities to meet their needs. Since the Older Americans Act Title VII funds were made available in 1993, a few tribes have begun to implement the Long Term Care Ombudsman Program to provide a much needed service for tribal members residing in off-reservation facilities. Training and certifying tribal community members to become ombudsmen was a successful approach to meeting tribal residents' culturally specific and sensitive concerns that facilities or non-tribal staff may overlook or misinterpret. In collaboration with ITCA, the experiences of tribal ombudsmen have identified common concerns of tribal residents that highlight the need to educate about, mediate, and interpret tribal customs, beliefs, and practices. This method still continues at ITCA because, ultimately, these tribal ombudsmen are often the only visitors tribal residents see on a consistent basis, and they provide relief from isolation for tribal residents who long for a connection to home.

For More Information

To learn more about the Long Term Care Ombudsman Program in Arizona, ITCA suggests the following sources:

- Arizona State Long Term Care Ombudsman Program webpage: <https://www.azdes.gov/daas/litcol>
- Inter-Tribal Council on Aging, Inc., Area Agency on Aging, Region 8 webpage: <http://www.itcaonline.com>
- Contact ITCA Area Agency -on Aging, Region 8 by telephone at (602) 258-4822



Long-Term Care Ombudsman Program: Opportunities for Services for American Indians

Becky A. Kurtz, JD, Director, Office of Long-Term Care Ombudsman Programs, Administration for Community Living, US Department of Health and Human Services, Washington, DC

Introduction

Across the United States, Long-Term Care Ombudsman Programs seek resolution of problems and advocate for the rights of residents of long-term care facilities. The Administration for Community Living encourages Long-Term Care Ombudsman Programs, tribes and tribal organizations to collaborate in order to support American Indians living in long-term care facilities, both on and off of tribal lands.

Do you know a tribal elder living in a long-term care facility off of tribal lands? Do you have a long-term care facility on your tribal lands? If so, the elders living in these settings may have access to the services of a Long-Term Care Ombudsman. This article will describe this service and ways it can support tribal elders.

About the Long-Term Care Ombudsman Program

Created by Congress in the 1970s, Long-Term Care Ombudsman Programs serve residents living in long-term care facilities (in other words, nursing homes, board and care, assisted living, and similar settings). The programs work to resolve resident problems, including problems related to poor care, violation of rights, and quality of life. Ombudsmen also advocate at the local, state, and national levels to promote policies and consumer protections to improve residents' care and quality of life.

Each state has an Office of the State Long-Term Care Ombudsman, headed by a full-time State Long-Term Care Ombudsman who directs the program statewide. Across the nation, thousands of local ombudsman staff and volunteers, designated by the State Ombudsman as representatives, assist residents and their families by resolving complaints and providing information related to long-term care. The Long-Term Care Ombudsman is the local problem-solver for individuals living in long-term care facilities and an invaluable resource to residents, their families, and facility staff.

Section 712 of the Older Americans Act requires State Long Term Care Ombudsmen to:

- Identify, investigate, and resolve complaints made by or on behalf of residents;
- Provide information to residents about long-term care

services;

- Ensure that residents have regular and timely access to ombudsman services;
- Represent the interests of residents before governmental agencies and seek administrative, legal, and other remedies to protect residents; and
- Analyze, comment on, and recommend changes in laws and regulations pertaining to the health, safety, welfare, and rights of residents.

There are 53 state ombudsmen (50 states, plus the District of Columbia, Puerto Rico, and Guam). In most states, the Office of the State Long-Term Care Ombudsman is housed within the state unit on aging or another state agency. In others, the Office is housed in a private non-profit agency. Most states have contracts with or through Area Agencies on Aging to provide direct ombudsman services to residents locally. There are 576 designated local entities across the nation.

While there are wide variations in funding sources among the states, the federal government is the primary entity funding the Ombudsman Program nationwide, providing 58 percent of total funds expended in federal fiscal year 2011. These federal funds were primarily Older Americans Act funds (Titles III-B and VII) administered by the Administration for Community Living (ACL). States provided 36 percent of funds, and other non-federal sources funded the remaining six percent.

ACL understands that many older adults prefer receiving long-term services and supports in their homes. While the Older Americans Act does not authorize ombudsman services for people living in their own homes, some states have expanded Long-Term Care Ombudsman Program authority and, with other funding, serve these individuals.

Creating or Expanding Tribal Ombudsman Services

A few Long-Term Care Ombudsman Programs have tribal members who serve as staff or volunteer ombudsmen, providing culturally competent services to residents who are tribal members. For example, in Arizona, the Inter Tribal Council of Arizona (a designated Area Agency on Aging) has trained ombudsmen from three tribes: Hopi, White Mountain Apache, and Pascua Yaqui. The ombudsmen are designated as representatives of the State Long-Term Care Ombudsman to perform this function (as required by the Older Americans Act).

ACL strongly supports the development of tribal members

to serve as long-term care ombudsmen. Where culturally competent tribal ombudsmen exist, they provide a valuable service to tribal residents of long-term care facilities. For example, a tribal ombudsman successfully supported a tribal elder in obtaining her goal to move back to tribal lands for the last days of her life, even though she could not access the same services that she had in a non-tribal nursing facility. Tribal ombudsmen help residents living off tribal lands to stay connected to their tribes through language and customs. They support the staff and family caregivers of these residents. They also assist other ombudsmen to provide more culturally sensitive services to tribal members.

Serving Residents of Facilities on Tribal Lands

Increasing numbers of tribes have nursing facilities, assisted living, or board and care homes on tribal lands. When a nursing facility is certified to receive Medicaid and/or Medicare funding, it is required by federal law to provide residents with access to a long-term care ombudsman. At least one tribal facility has been cited by the federal government for failure to provide residents with access to a long-term care ombudsman. ACL is committed to working with tribes to assure that residents living in facilities on tribal lands have access to culturally competent ombudsman services.

Availability of Funds to Support an Ombudsman Program

Federal funding sources for Long-Term Care Ombudsman Programs are primarily Title III-B and Title VII of the Older Americans Act. States also provide funding to provide these

services. Whether these funds or services are available to tribes to carry out a tribal ombudsman service will depend on the tribe's relationship and agreement with the state. In addition, tribes may use Title VI funds to provide ombudsman services. It is important to note that the services must be "substantially in compliance" with provisions of the Older Americans Act Title III (see Section 614(a)(9) of OAA). ACL is available to assist tribes in understanding how to comply with these requirements.

For more information

To locate the Long-Term Care Ombudsman program serving your area, you may get contact information from the National Ombudsman Resource Center at www.ltombudsman.org; or telephone (202) 332-2275.

To learn more about Long-Term Care Ombudsman Programs, ACL suggests the following resources:

ACL web page on the Long-Term Care Ombudsman Program: http://aoa.gov/AoARoot/AoA_Programs/Elder_Rights/Ombudsman/index.aspx

National Ombudsman Resource Center: www.ltombudsman.org; or telephone (202) 332-2275.

"State Long-Term Care Ombudsman Program: A Primer for State Aging Directors and Executive Staff," available at: http://www.nasuad.org/documentation/nasuad_materials/NASUAD%20Ombudsman%20Report%20final.pdf; or copies can be requested from the National Association of States United for Aging and Disabilities (NASUAD) at (202) 898-2578 or info@nasuad.org.

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 August issue.

Palliative Care in Alaska

Christine DeCourtney, MPA, Manager, Cancer Program Planning and Development, Alaska Native Tribal Health Consortium, Anchorage, Alaska

Developing and implementing health care services in Alaska's 500,000+ primarily roadless square miles requires creativity, determination, and adaptability. Sixty years ago, most of the birth to death cycle of life was managed by family and friends in home communities. With the advent of modern medicine, more communities said goodbye to elders as they were "medevaced" to hospitals and nursing homes hundreds of miles away. The elders died in unfamiliar surroundings without family and friends. The cycle is changing once again. There are programs developing that help those nearing the end of life remain in their home communities and/or connect with their faraway families through technology when they can't go home.

The first formal palliative care program for Alaska Native people was developed in the Bristol Bay area of Alaska with a grant from the Robert Wood Johnson Excellence in End of Life Care Program. The results showed that elders and others could remain at home with support. However, other findings indicated that the high turnover in staff in remote locations could limit the availability of people trained in palliative care, especially when the program included only one nurse. When the nurse left, often the program did not continue. It was also clear that although training was provided at the onset of the program, most community health care providers and community members did not want to participate in palliative care training until someone in their village needed that care. This means that when the situation arises there must be training readily available to help the community members and health care providers feel comfortable caring for someone at the end of life. Through an NCI grant, palliative care training was developed to increase the number of people trained at the Alaska Native Tribal Health Consortium (ANTHC), the statewide support organization, to provide palliative care and create a more stable work force that could work with remote providers to improve their knowledge of palliative care as needed.

At ANTHC and the Alaska Native Medical Center (ANMC) work has continued to allow people who want to return to their village to do so. The key to success is ensuring that there is a primary caregiver in place and that the home environment is safe. Still, there is no one program that works for everyone in Alaska. Cultural, geographic, familial, and resource differences contribute to difficulties in establishing a statewide system of palliative care for Alaska Native people. However, palliative care concepts can be integrated into all

programs. These include the following: palliative care begins at diagnosis; everyone is part of the palliative care team; everyone has a culture and community and these should be identified and honored; there are resources — start with what you have, not what you don't have; and palliative care is about living, not dying.

ANTHC's internationally recognized telehealth system is an important component of how palliative care is evolving in Alaska. For example, a young mother with advanced breast cancer who had to stay in Anchorage for treatment desperately missed her three young children. A Video TeleConference (VTC) between Anchorage and her home community allowed her to visit with her children who were in their grandmother's care. Happy chatter and laughter could be heard down the hall while mother and children caught up and reassured each other. For another patient, a man at the end of life, a portable VTC unit was wheeled to his bedside while family and village members crowded into the village clinic to say goodbye to this respected elder who was too weak to go home.

Care decisions that for cultural reasons need participation from extended family can happen more easily through VTC. In another example, a nineteen year old suffering recurrence of an aggressive cancer was able to join her parents and younger brother at ANMC and connect with her home village and her father's parents in another village before surgery. They spoke their comforting Native language and sang a hymn. The grandparents sat right in front of the camera while new babies, aunts and uncles, nieces and nephews, and friends gathered to share news and well wishes. At the end of the call, the grandfather gave a blessing.

Dr. Matthew Olnes, Oncology/Hematology Medical Director at ANMC, started a program so that patients who can no longer benefit from active treatment can make a choice, either fly to Anchorage once a month for follow-up visits or have a "doctor visit" by going to the village clinic and joining the doctor and staff by VTC. This is successful from many standpoints. While the doctor cannot do a hands-on exam, he can observe the patient and ask questions. In addition, as the Community Health Aides/Practitioners (CHA/P) are included on the call, they remain an active part of monitoring disease progression and are not just called in for an emergency situation. The greatest benefit is that the patient is home in familiar surroundings with family and friends, and needed resources identified through the VTC can be provided sooner.

During his first VTC doctor's visit, John (the patient), his caregiver, and the CHAs gathered in the

village clinic. Dr. Olnes and staff in the ANMC Oncology clinic were on the line. “Are you eating okay?” asked Dr. Olnes. John said, “Yes.” His wife Paula said, “I make him different Native foods every day!”

Dr. Olnes proceeded with questions, asking about pain medicine and if he needed more. Olnes sends notes about the call to the primary care provider at the regional hospital and makes sure she or he is aware of additional needed medications so they can be flown to the village in time. During the call, the CHA noted that John has difficulty hearing. Billie Kelley, the Oncology social worker, let the family know that she would try to locate a hearing aid for him.

To allow the patient to make a statement as to the benefit of the call instead of coming in for an appointment, Olnes asked if this was an “okay way to meet” instead of flying to Anchorage. The patient and family said, “It’s okay.” Then John’s wife said, “But we miss the nurses.” John nodded. Each call now includes clinic staff who worked with patients during chemotherapy to engage John and Paula in “small talk” as they did during a visit to oncology. This combination of technology and the “personal touch” make for the best palliative care visit.

As technology expands across the state, tablet devices with cameras can be taken into the patient’s home when they can no longer travel to the clinic, and the patient can still meet with their health care team. Current technology also allows a primary care provider to join the VTC for a three way call. For example, a primary care provider from the regional hospital joins the patient and oncologist, or the patient and CHA. Telehealth is allowing these connections to occur in real time without the expense and discomfort of traveling. The option to travel is always offered to the patient, but most decline to make the arduous journey to Anchorage, which can include up to four airplane connections.

In other parts of Alaska, two doctors and a nurse at the Yukon Kuskokwim Health Corporation (YKHC) volunteer time to help residents with hospice care in their home

communities. With the exception of ANMC, where a palliative care doctor, nurse, and social worker are being recruited, most of the palliative care initiatives come from “champions” — those individuals who strongly believe in the importance of palliative care and are willing to demonstrate their commitment by volunteering, integrating it into existing programs and expanding their knowledge with educational opportunities.

Palliative care training for patients, families, and community health providers can also be provided in this manner at the time when it is needed and specific to the patient’s needs. Oncology clinical staff can talk with CHA/Ps about specific support through telephone calls or VTC. In addition, clinic staff can talk with a small group of family caregivers through VTC to discuss how each of them can help the person who is nearing the end of life. ANTHC has also offered several international telehealth palliative care symposiums. The sessions were recorded and are available for viewing at <http://www.paliativeak.org>. Those interested in accessing the symposium presentations will need to create a new account and register online. Topics include pain management, nutrition, and holding family meetings.

ANTHC is developing a palliative care comfort bag to send to end-of-life patients. Small communities do not have ready access to items taken for granted in big cities like adult diapers, bed pads, urinals, and mouth-cleaning supplies. Disposable, biodegradable supplies that use practical designs are particularly important in small communities with minimal sanitation services. The needs of each patient and available resources are identified, and a care package is assembled with supplies as well as palliative education materials for caregivers and families.

In Alaska, you can wait until all of the resources are available, or work with the resources you have. Ingenuity, adaptability, compassion, and commitment are the most important resources. The Alaska Native people have used these skills and resources to survive for thousands of years. They are just as important when implementing palliative care across the state of Alaska. Technology and personal connections go hand-in-hand to provide opportunities for elders and others to remain home in familiar surroundings as the circle of life closes.

Palliative Care Brochure Available

A brochure for patients entitled *Palliative Care: Easing the Journey with Care, Comfort and Choices* is described as “an introduction to palliative care for patients, families, communities, caregivers and health care teams. Readers may view this by going to <http://www.anthc.org/chs/crs/upload/PallCareBkltMar10.pdf>. Individual copies are available at no cost, while larger quantities may be purchased for \$4.95 plus shipping. For more information, contact Christine Decourtney at cdecourtney@anthc.org.

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 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. (4/13)

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.aimh.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)

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

Sonoma County Indian Health Project (SCIHP) Santa Rosa, CA California, is seeking a full-time family practice 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

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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.

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