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Improving Severe Injury Surveillance in the Phoenix Area Using Arizona Hospitalization and Mortality Data

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Introduction

Injuries are the leading cause of death for American Indians and Alaska Natives (AI/AN) ages 1 to 44 years.¹ The annual lifetime cost of injuries involving AI/AN people is over two billion dollars.² Accurate and comprehensive data are needed to identify injury prevention priorities, obtain resources, and evaluate the effectiveness of interventions.³⁻⁸

Many Indian Health Service (IHS) Areas have conducted standardized, recurrent injury data collection activities entitled Severe Injury Surveillance Systems (SISS). The SISS relies on emergency room (ER) logs at local IHS hospitals in each service unit to identify potential injury cases in a number of Arizona service units in the Phoenix Area. The local hospital's medical records are then reviewed

to confirm an injury diagnosis and to obtain additional data, such as demographic information and circumstances of injury.

A recently-published study of motor vehicle crash injuries at one Phoenix Area reservation prompted us to reexamine our approach to severe injury surveillance.⁶ The study indicated that local ER-based surveillance could underreport injury cases because trauma cases often bypassed treatment at the local hospital. We therefore sought to expand our ability to identify injury cases using data from the state of Arizona; specifically, the state's Hospital Discharge Data system, and mortality data from the Health Status and Vital Statistics Section.

We sought answers to two basic questions: Would the statewide databases include many more cases, or simply duplicate cases identified by the existing IHS SISS? Could we rely exclusively on the state's data, thereby avoiding the considerable time, effort, and costs involved in local data collection?

Methods

A severe injury was defined as an injury that 1) resulted in one or more days of hospitalization or a fatality; and 2) was classifiable within the external cause (E-code) range

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E800-E999.9 in the International Classification of Diseases, Version 9, Clinical Modification (ICD-9-CM). Cases with ICD-9-CM E-codes E878-E879 were not included. These codes refer to abnormal reactions or complication of surgical and medical procedures (such as rejection of a transplanted organ or malfunctions of prosthetic devices).⁹ The target population was American Indians living within the boundaries of three service units of the Eastern Arizona District (EAD), Phoenix Area. The EAD FY08 user population was 33,572.

Severe injury surveillance was conducted at the three IHS service units using current methods (the IHS SISS). ER logs were reviewed at the local IHS hospitals to identify potential injury cases. Medical records were then reviewed to confirm injury cases and obtain additional relevant data (e.g., demographics, circumstances of injury). Persons hospitalized at referral facilities were included if a discharge summary appeared in their IHS medical record. The names of patients were not recorded.

The IHS SISS data were compared with two data sources from the Arizona Department of Health Services (ADHS): injury hospitalization data from the Hospital Discharge Data (HDD) system; and mortality data from the ADHS Bureau of Public Health Statistics, Health Status and Vital Statistics Section (ADHS HDD + VS). We compared data for the months of January, June, and September 2006.

Arizona's vital statistics data are compiled every year based on information from death certificates. The HDD receives standardized medical and financial data, as well as data concerning external causes of injury, from Arizona hospitals. All licensed hospitals in Arizona are required to report discharge data to ADHS twice a year, with the important exclusion of federal hospitals (IHS, military, Veterans Affairs) and psychiatric hospitals.¹⁰ Diagnostic groupings and code numbers are based on the ICD-9-CM. No hospital in Arizona is allowed to report more than 3% of N-Codes (diagnostic, nature of injury codes) without E-Codes (external causes of injury codes) (Alana J. Shacter, ADHS, personal communication, October 2010).

The ADHS injury data were provided to the authors in a Microsoft Excel database. Patient identifiers were not included. The data were first sorted by E-Code and days of

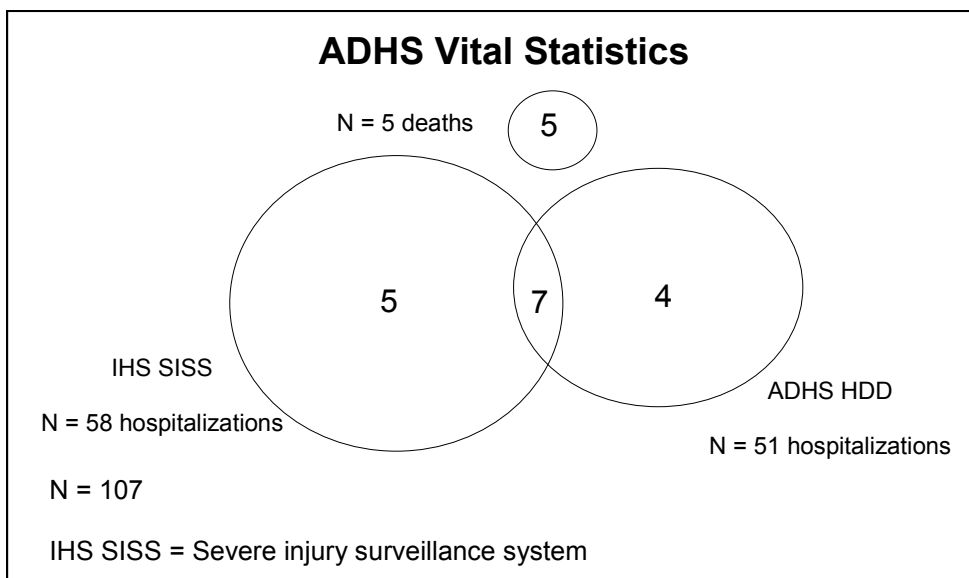
hospitalization; then filtered by patient's city of residence, zip code, tribe, and race. Only American Indian injury cases that resided on a reservation were included in the analysis. Probabilistic record linkage was used to eliminate duplicate records. The variables used to link records were age, gender, name of receiving hospital, date of injury, time of injury, E-codes, and days of hospitalization.

Permission to publish this study was obtained from the Phoenix Area Institutional Review Board.

Results

Together, the IHS SISS and the ADHS data collection systems identified 107 non-duplicated, severe injury cases from the three service units (Figure 1). Fifty-eight injury hospitalizations and no fatalities were identified by the SISS; 51 injury hospitalizations and five fatalities were identified by the ADHS HDD and VS data. Based on our probabilistic linkage, seven (7%) of the 102 unduplicated hospitalized cases were identified by both systems.

Figure 1. Venn diagram of three injury surveillance sources. American Indian Arizona residents with injuries resulting in hospitalization or death, January, June, and September 2006.



The distribution of severe injury cases by external cause of injury appears in Table 1. The leading categories of total, unduplicated cases were assaults (31%), falls (30%), "all other causes" (17%), and motor vehicle crashes (13%). While these were also the four leading categories for the IHS SISS and ADHS data systems, there were clear differences as well. For example, falls accounted for 40% of the injuries identified by the IHS SISS, but only 20% in the ADHS data. Conversely, motor vehicle crashes, suicides/suicide attempts, and other causes were higher in the ADHS data.

Table 1. Distribution of severe injury cases by external cause and data system. American Indian residents of three service units in Arizona; January, June, and September 2006.

	IHS SISS* (All Cases)		ADHS HDD + VS** (All Cases)		TOTAL SISS + ADHS (Unduplicated Cases)	
Assault	19	32.8%	18	32.1%	33	30.8%
Drowning	0	0.0%	0	0.0%	0	0.0%
Fall	23	39.7%	11	19.6%	32	29.9%
Fire/Burn	1	1.7%	2	3.6%	3	2.8%
MVC	6	10.3%	9	16.1%	14	13.1%
Suicide	2	3.4%	5	8.9%	7	6.5%
Other	7	12.1%	11	19.6%	18	16.8%
Total	58	100.0%	56	100.0%	107	100.0%

* IHS SISS = Severe Injury Surveillance System

** ADHS HDD + VS = Arizona Department of Health Services Hospital Discharge Data and Vital Statistics mortality data

Surprisingly, 27 (53%) of the 51 cases identified by the IHS SISS (but absent from the ADHS data) were treated at seven non-IHS, state-licensed hospitals.

More than 100 person-hours were required to complete the SISS-based work for this project; 20 person-hours were needed to complete the ADHS-based work.

Discussion

This study answered both of our original questions, at least as far as these three service units are concerned: 1) statewide severe injury data did not duplicate data obtained from local injury surveillance based on ER logs; and 2) currently, state HDD and VS cannot be considered a substitute for the local SISS. State hospitalization and mortality data do, however, greatly expand the number of cases identified, alter the distribution of injury causes, and help identify the most severe injuries (fatalities). We recommend both local SISS and state data be utilized for injury surveillance.

However, local SISS is very labor-intensive; 100 hours were required to collect the three months of IHS SISS data summarized in Table 1, compared to 20 hours for the ADHS data. The most cost-effective approach to severe injury surveillance would be to have Arizona IHS hospitals submit their hospitalization data to the ADHS HDD, even though they are not currently required to do so. Until that is implemented, some service units might consider omitting a local SISS and using only the state HDD and VS data for surveillance. This could be a reasonable choice if, for example, their primary goal is to identify the leading three to four causes of serious injury, their environmental health

workforce is deeply understaffed, or the majority of injury cases are transported to referral hospitals. A shift to more efficient data collection methods has potential to improve overall injury prevention program outcomes by allowing limited resources previously spent on data collection to be utilized for the implementation of evidence-based interventions.

It is important to determine why 27 injury cases identified by the IHS SISS were treated at state-licensed hospitals, but did not appear in the state HDD. There might be weaknesses in our method of probabilistic linkage; non-reporting of patient hospitalization data when facilities are reimbursed via contract health services; or other reasons.

There were several limitations of this study. First, the data fields from the three data sources were not identical, resulting in minor differences in the injury case definitions. For example, injury cases identified in the ADHS datasets resided on a reservation, while the SISS captured only injury cases initially triaged at an IHS hospital. Second, identification of hospitalized referrals for injury care was incomplete due to vacancies in discharge planning offices and recordkeeping issues. Third, in the absence of patient identifiers, we could not verify the reliability of our record linkage procedure to identify duplicate records. Fourth, utilizing a case definition of severe injury that requires a hospitalization omits the many cases with serious injuries that are treated as outpatients. For example, cases of intimate partner violence and individuals who attempt suicide are frequently treated in emergency rooms but not hospitalized. Fifth, neither IHS nor state HDD and VS would capture cases receiving care at a facility outside

Arizona. Finally, the exclusion of specific types of hospitals from mandatory HDD reporting requirements leads to under-reporting of certain conditions. For example, exclusion of psychiatric hospitals means suicide attempts are likely to be under-reported. Similarly, non-reporting of hospitalizations at VA hospitals means an unknown number of adult injury cases will be missing in the database.

Conclusion

Approaches to injury surveillance must be tailored to local needs and resources. Local surveillance alone can be feasible and reliable in smaller or more rural communities where a very large proportion of injury cases are treated at a single facility. Medical records can be supplemented by additional data sources from tribal, state, and federal entities, such as law enforcement agencies and emergency transport services.⁶

Expanded opportunities for injury surveillance include development of the IHS electronic health record¹¹ and the electronic ER log; state trauma registries and state hospital reporting systems;^{12,13} using narrative text from computerized electronic records;¹⁴ clipping newspaper articles;¹⁵ obtaining diagnostic codes (N codes) from local Resource and Patient Management Systems (RPMS) to identify injury cases;^{16,17} and querying the Notifiable Disease and External Cause of Injury (NDECI) datamart. NDECI is a web-based system that retrieves data from the (RPMS) National Data Warehouse. With appropriate approvals, NDECI data can be obtained by the national, area, service unit, facility, and community level.^{18,19}

The ADHS Hospital Discharge Data system and Vital Statistics Section are valuable injury surveillance resources for service units in Arizona. Combining the hospitalization data from IHS and tribal facilities with Arizona hospitalization and mortality data provides a unique opportunity to improve the health and safety of AI/AN residents and to enhance the state's capacity to optimally allocate resources and implement programs for all its citizens.

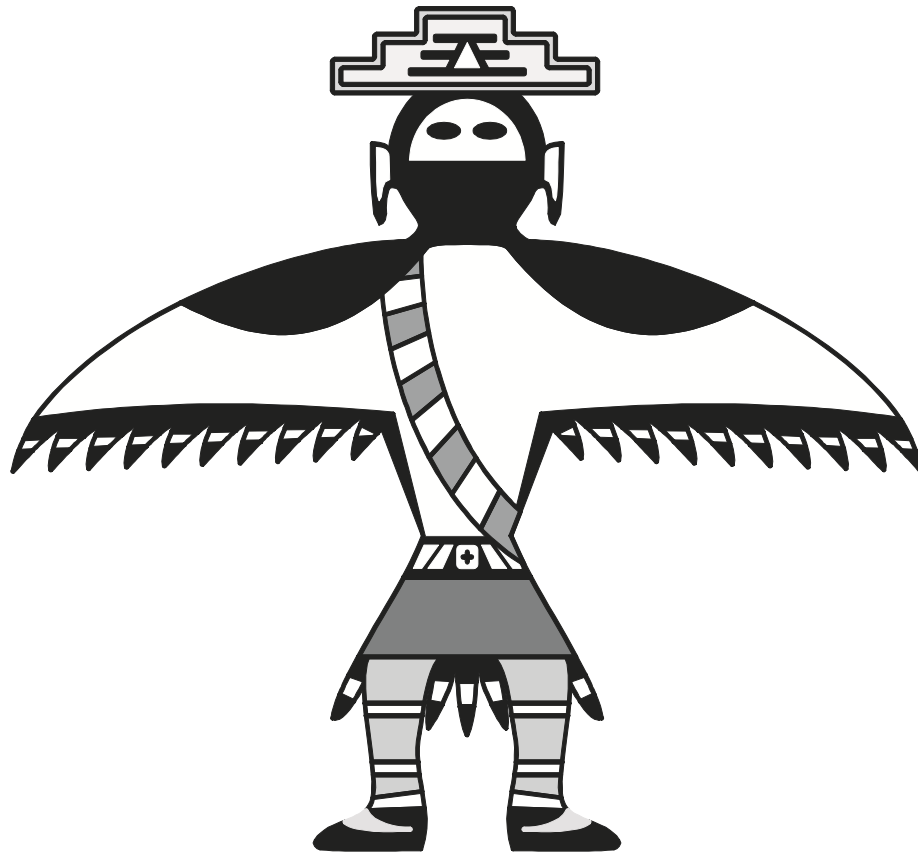
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The Emerging Nuisance of Bedbugs

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They're small. They're fast. They only come out at night, and they want to suck your blood. No, it's not vampires, it's *Cimex lectularius*, commonly known as the bedbug (or bed bug). These tiny pests have been making big headlines the last few years, and no place is immune, including health care facilities. This article covers the basics about infestation, the public health significance of bed bugs, and general guidelines for how to address an infestation. Since it appears that bedbugs aren't going away any time soon, your facility should consider a proactive strategy to manage a bedbug infestation.

Why the Resurgence of Bedbugs?

Bed bugs were a common problem in the United States until in the 1950s when prodigious use of dichlorodiphenyl-trichloro-ethane ("DDT") all but wiped them out. "Sleep tight, don't let the bed bugs bite," became a quaint saying, and gradually stories of bedbugs became akin to urban legends. Then, about five years ago, reports began surfacing of a resurgence of infestations. There are several theories concerning their return; some think increased international and domestic travel is likely responsible; others believe residual effects of DDT and other pesticide resistances have led to the comeback.

Bedbug infestations are found at all socioeconomic levels. Bedbugs have been identified in numerous hospitals, upscale movie theaters, limosines, shopping malls, hotels, as well as homeless shelters. In fact, the Parklawn Building in Rockville, Maryland, headquarters to the US Public Health Service, recently reported treating for bedbugs.

What They Look Like and How to Find Them

- Adult bed bugs are about the size of a tick or a watermelon seed. They are reddish brown and flat. Immature bugs, called nymphs, are no bigger than the head of a pin.
- They favor dark hiding spaces in crevices of any size or material, although they do have a

preference for wood.

- They are nocturnal feeders, attracted by body heat, and they can consume up to three blood meals a night. Each blood meal typically lasts about ten minutes, and the bite is painless. They prefer to stay close to their hosts, which is why they are most frequently found living in the seams of mattresses, headboards, bedding materials, and in cracks in walls and furniture in bedrooms.
- Bed bugs are great hitchhikers and can be transported to a new location in suitcases, boxes, shoes and clothing, secondhand furniture, and even rental equipment.

Public Health Significance

The good news is that bedbugs have not been found to transmit pathogenic organisms; however, many people have allergic reactions to the bites, ranging from mild to severe. Also, complications may result from secondary infections if the bites are scratched.

For hospitals and clinics, the bedbug problem is largely about quality customer service and public perception. Patients are naturally distressed by tiny bugs that hide in crevices and crawl out at night to suck blood, and while bed bugs can be found in the cleanest of environments, they are often associated with poor sanitation. Therefore, it's critical to get in front of this issue before it becomes a public relations disaster.

The Key to Avoiding an Infestation is Prevention

A proactive approach to this nuisance is the key to success. The Veterans Administration (VA) has been a leading voice in the problem of bedbugs. In 2009 the VA published a comprehensive guideline for bedbug prevention and management. The VA recommends the following strategy:

- Update your policies and procedures to include bedbug prevention.
- Conduct a risk assessment of your facility to identify areas that are likely susceptible to an infestation. Inpatient areas or residential programs where clients bring their own luggage are particularly vulnerable.
- Develop factsheets to distribute to patients and staff detailing the health risks and how to prevent them at home.
 - Train your clinical staff to pay particular attention to patients reporting itching and bites.
 - Train housekeeping to be vigilant during

- routine and terminal cleaning of patient rooms.
- Reduce hiding places by sealing crevices in patient rooms and eliminating clutter.
- Use plastic mattress covers or consider seamless rubber mattresses. Avoid box springs and head boards. If the beds already have head boards, keep them away from direct contact with the wall.
- Perform routine inspections of linens, beds, and furniture for the presence of bugs. Signs of infestation include dark brown or reddish spot stains from dried excrement and the presence of eggs, eggshells, and molted skins.
- Inspect all rental equipment carefully before accepting it into your facility.

What to Do If Bedbugs Are Reported in Your Facility

If bedbugs are reported at your facility, quick action is essential. Again the VA provides specific guidance on how best to manage an incident.

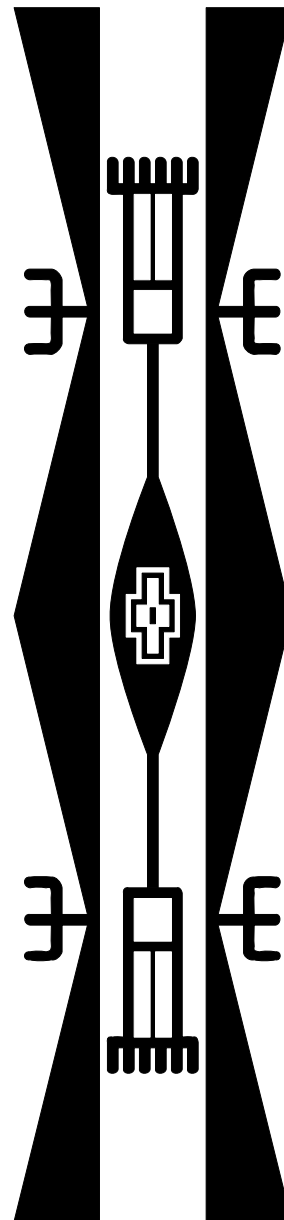
- The room or area should be sealed from use and proper signage posted; all items should remain in place to prevent the further spread of bugs to other areas.
- Immediately contact a licensed pest management contractor.
- If possible, capture a bug and place it in a sealable container for positive identification.
- Inspect adjacent rooms to determine the extent of the infestation.
- Bag all suspected items, including clothing, linens, and curtains, and launder at 120° F minimum. Bed bugs are temperature sensitive, and anything 120° or hotter will kill all bedbug life stages.
- Items such as toys, shoes, and backpacks can be placed in the dryer on high heat for 10 - 20 minutes. Larger items can be de-infested by enclosing them in plastic and setting them out in the sun. If this option is used, it's a good idea to use a thermometer to ensure the temperature inside the plastic reaches at least 120° F.
- Steam heat is also effective, but be mindful that moisture can also lead to mold issues.

Rapid Response Contains Bed Bug Infestation

Should bedbugs be spotted within the facility, a rapid response can prevent widespread infestation. In late September 2010, an IHS hospital in the southwest spotted a bedbug in the Emergency Department. The housekeeping staff immediately called in a pest management contractor. All curtains and linens were removed and wrapped in plastic; the walls and plastic furniture were thoroughly cleaned with sanitizing solution; and the bed was sealed in plastic and moved outside into the hot sun. Since then, all housekeeping

personnel have received training on bedbug identification and managing potential threats. Treatment for bedbugs has been added to the pest management contract. In addition, the infection control department developed a fact sheet for distribution to staff and patients.

The key to managing bedbugs is preparation. Training clinical staff to be on the lookout for signs of bedbugs and advising housekeeping personnel on procedures to follow if bedbugs are reported are critical to effectively managing an infestation. It appears that health care facilities are in for a long haul on this issue.



SAVE THE DATE



- * Challenges in Indian Health Care ***
- * Health Care Budgets & Financing ***
- * Data and Information Technology ***
- * Law ***
- * Integrity and Ethics ***
- * Negotiation ***

Session One: April 11-15, 2011

Session Two: May 16-20, 2011

Session Three: June 6-10, 2011

**You can be a part of the 2011 Class
of the Executive Leadership Development Program (ELDP)!**

The purpose of the Executive Leadership Development Program is to provide a forum where participants learn new skills and encounter different approaches to reduce barriers, increase innovation, ensure a better flow of information and ideas, and lead change. The goal is to provide essential leadership training and support for Indian health care executives, whether they work in Federal, tribal, or urban settings.

**Look for the registration material in January on
<http://www.ihs.gov/nonmedicalprograms/eldp/> .**

ELDP Coordinators:

gigi.holmes@ihs.gov and wesley.picciotti@ihs.gov

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

IHS Child Health Notes

Quote of the month

“Without fear and illness, I could never have accomplished all I have.”

Edvard Munch (Painter of “The Scream”)

Editor’s Note

This entire Child Health Notes is devoted to the use of antiviral medication in the treatment of influenza. During the H1N1 influenza pandemic of 2009 it became apparent that American Indian/Alaska Native people overall had a four-fold higher rate of influenza-like illnesses, influenza hospitalizations, and mortality from influenza, even in the absence of known risk factors. We need to use antiviral medications for influenza when indicated but also be mindful that the supply of antiviral medications may be limited.

For children, it is also important to recognize that the majority of wintertime viral illnesses are not influenza but other pathogens. Close attention to whether influenza is circulating in your area can help target the use of antiviral medications to appropriate patients.

Infectious Disease Updates

Rosalyn Singelton, MD, MPH

New Influenza Antiviral Recommendations from the Centers for Disease Control and Prevention

On November 23, 2010, the CDC published new guidelines on influenza antiviral use. Taken along with the American Committee on Immunization Practice’s (ACIP) recommendation that AI/AN people be considered a priority group for influenza vaccination, these new guidelines represent a strong recognition of the impact of influenza disease in our patient population. **It is crucial for IHS providers to continue to prevent influenza through the universal use of influenza vaccine in all patients aged six months and older, and to consider use of antiviral medications when indicated.** Decisions regarding antiviral treatment should take into account information on influenza virus circulation in the community.

Antiviral treatment with oseltamivir (Tamiflu®) or zanamivir (Relenza®) is recommended as early as possible (preferably within 48 hours) for any patient with confirmed or suspected influenza who:

1. Has severe, complicated, or progressive illness

2. Is hospitalized
3. Is at higher risk for influenza complications as follows:
 - a. Children younger than two years old
 - b. Adults 65 years and older
 - c. Persons with the following conditions: chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, hematological (including sickle cell disease), neurological and neurodevelopmental conditions, or metabolic disorders (including diabetes mellitus)
 - d. Persons with immunosuppression, including that caused by medications or by HIV infection
 - e. Women who are pregnant or post-partum (within two weeks after delivery)
 - f. Persons younger than 19 years of age who are receiving long-term aspirin therapy
 - g. American Indians and Alaska Natives
 - h. Persons who are morbidly obese (body mass index ≥ 40)
 - i. Residents of nursing homes and other chronic-care facilities

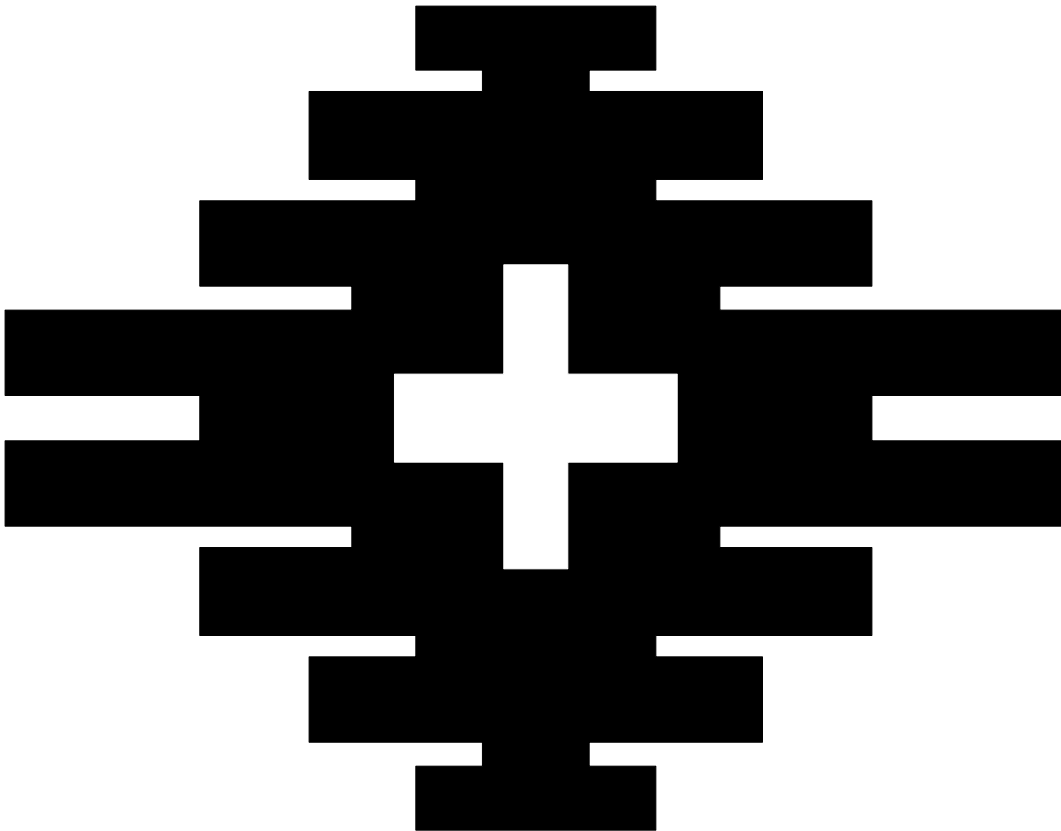
The recommendations also state that “Clinical judgment, based on the patient's disease severity and progression, age, underlying medical conditions, likelihood of influenza, and time since onset of symptoms, is important to consider when making antiviral treatment decisions for high-risk outpatients. When indicated, antiviral treatment should be started as soon as possible after illness onset.

- The greatest benefit is when antiviral treatment is started within 48 hours of influenza illness onset.
- Antiviral treatment may still be beneficial in patients with severe, complicated, or progressive illness, and in hospitalized patients when administered more than 48 hours from illness onset.

Antiviral treatment also can be considered for any previously healthy, non-high risk, symptomatic outpatient with confirmed or suspected influenza based upon clinical judgment, if treatment can be initiated within 48 hours of illness onset.”

Comments

1. Newly included in the groups at higher risk for complications (3.g.) is AI/ANs. This inclusion is based on epidemiologic studies showing increased hospitalization and death rates among AI/AN people.
2. Many AI/AN are already high-risk because of the presence of underlying medical conditions.
3. Among children, the risk is highest among young infants aged <6 months old. Oseltamivir (Tamiflu®) is not licensed for children <1 year of age, although its use was allowed during the H1N1 pandemic under an FDA Emergency Use Authorization.
4. Because many people with mild febrile respiratory illness may have other viral infections, knowledge about local influenza virus circulation is important for treatment decisions.
5. Providers should always use their clinical judgment regarding the likelihood of influenza infection, the amount of time that has passed since disease onset, and the presence of risk factors, including AI/AN race, in individual patients when making a decision regarding use of antiviral medications.
6. Prevention of influenza through universal vaccination of all of our patients aged six months or older, as per ACIP recommendations, is the preferred means of reducing the impact of influenza in AI/AN communities.
7. Check with your pharmacy re: antiviral supply. The IHS National Supply Service Center currently has Tamiflu available. If needed, the NSSC can procure additional supplies of antivirals.



Support the 2011 GYT Campaign: Get Your Patients Talking and Tested!

Colleen Kapsimalis, MPH, CPH, Public Health Prevention Specialist, Division of STD Prevention, Centers for Disease Control and Prevention, Atlanta, Georgia; and Scott Tulloch, BS, Public Health Advisor, Division of STD Prevention, CDC, assigned to the IHS National STD Program, Albuquerque, New Mexico

Half of sexually active young people will get a sexually transmitted disease (STD) by the time they are 25, and because STDs are often asymptomatic, many who are infected will go undiagnosed. Untreated STDs can cause severe health consequences in women, including pelvic inflammatory disease and long-term complications like chronic pelvic pain, ectopic pregnancy, and infertility. Lack of information, misconceptions, fear, and social stigma related to STDs keep many people from getting tested.

To help address high rates of STDs in youth (ages 15 to 24 years), the IHS National STD Program is collaborating with CDC, MTV Networks, Kaiser Family Foundation, and Planned Parenthood Federation of America to promote the **GYT: Get Yourself Tested** campaign (www.GYTNOW.org). GYT began in 2009 as a youth social movement to promote STD testing and treatment as needed. The campaign's presence online, on air (through MTV), and in the community aims to remove taboos around STD testing, encouraging youth conversations about it with their partners, parents, and **healthcare providers**.

GYT 2011 will mark the second year that IHS is partnering with GYT to help young people across Indian Country make responsible decisions about their sexual health. Although race and ethnicity alone are not risk factors for getting an STD, American Indian and Alaskan Native (AI/AN) people are disproportionately impacted by high rates of HIV and common STDs, including chlamydia, gonorrhea, and syphilis. According to the 2007 IHS STD surveillance report, young AI/AN are impacted by STDs, especially Chlamydia (2,547.7 per 100,000 ages 15 - 19 and 2,866 per 100,000 ages 20 - 24).¹ Promoting sexual responsibility and the diagnosis and treatment of STDs is critical for the personal health of our youth and for

addressing the wider STD epidemic.

Last year, IHS and GYT worked together to reach Native youth through online and on-the-ground strategies, including banner ads on frequently visited Native-specific websites, such as Native Times, Indian Country Today, and *Indianz.com*; a Native-specific clinic locator widget (available as a free download at <http://www.cdcnpin.org/stdawareness>); campus activities; and promotional materials in local clinics. IHS and GYT hope to expand the 2011 campaign by reaching out early to potential partners and Native media sources, adopting social networking strategies (through Facebook and Twitter), and increasing visibility at the campuses of tribal colleges and universities (TCUs).

Although the GYT campaign runs year-round, its heaviest promotion period is in April, during National STD Awareness Month, an annual observance to raise public awareness about the impact of STDs on the lives of Americans. You can visit www.GYTNOW.org to prepare for STD Awareness Month 2011 and access a wide selection of free materials to promote STD testing.

This year, the GYT campaign will launch a new **provider website** (<http://provider.gytnow.org>), which includes a wide range of resources, including how to talk with patients about STD testing. Also, by becoming a fan of the GYT Facebook page (<http://www.facebook.com/GYTnow>), you can get updates about the campaign throughout the year.

If you would like to receive a GYT tool kit to promote the campaign or conduct an STD/HIV screening event, contact Scott Tulloch, scott.tulloch@ihs.gov; telephone (505) 248-4344 for more information.

¹Centers for Disease Control and Prevention, & Indian Health Service. (2009). *Indian health surveillance report—Sexually transmitted diseases 2007*. Atlanta, GA: US Department of Health and Human Services

Advancements in Diabetes Seminars

Join us monthly for a series of one-hour live WebEx seminars for health care professionals who work with patients who have diabetes or are at-risk for diabetes.

- Seminars are generally held at 1:00 pm Mountain Time.
- Presented by experts in the field, these seminars will discuss what's new, update your knowledge and skills, and describe practical tools you can use to improve care for people with diabetes.
- No cost CME/CE credit is available for every seminar. **Accredited Sponsors:** IHS Clinical Support Center, the IHS Nutrition and Dietetics Training Program and the IHS Division of Oral Health
- Registration for each of the seminars starts approximately two weeks prior to the seminar and goes all the way up until the start of the seminar. Registration and seminar information, including handouts, is available via the following link: <http://www.diabetes.ihs.gov/index.cfm?module=trainingSeminars>
- Upcoming seminars include:
 - February 15, 2011: Update: Pediatric Obesity and Diabetes, by Diana Hu, MD
 - March 2011: Healthy Weight for Life, by Judith Thierry, MD and Tammy Brown, MPH, RD, BC-ADM, CDE

Wed-Based Diabetes Trainings

CME/CE trainings, available 24/7 at no cost. Some of these trainings, based on the live WebEx seminars, include:

- Physical Activity and Cardiovascular Risk Reduction, by Ralph LaForge, MSc, Exercise Physiologist
- Prenatal and Early Life Risk Factors, by Ann Bullock, MD
- Diabetes Foot Care, by Stephen Rith Najarian, MD
- Obstructive Sleep Apnea: New Links to Diabetes and Home Sleep Testing, by Kelly Acton, MD, MPH, FACP, and Teresa Green, MD

These trainings and others are located at: <http://www.diabetes.ihs.gov/index.cfm?module=trainingWebBased>

The 16th Annual Elders Issue

The May 2011 issue of THE IHS PROVIDER, to be published on the occasion of National Older Americans Month, will be the sixteenth 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

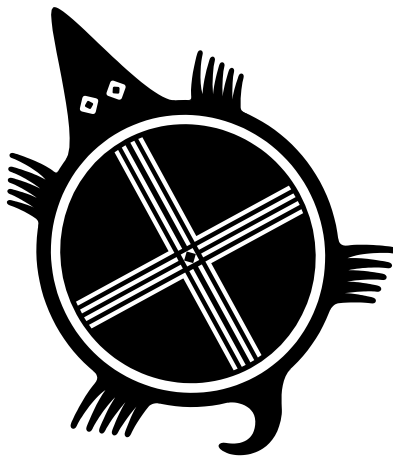
their health and health care. We are also interested in articles written by Indian elders themselves giving their perspective on health and health care issues. Inquiries or submissions can be addressed to the attention of the editor at the address on the back page of this issue.

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MEETINGS OF INTEREST

Advancements in Diabetes Seminars

Monthly; WebEx

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

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

Available EHR Courses

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

Honor our children.



Give them a healthy smile.

Make an appointment
for yourself to protect
your baby's teeth.

February is Children's
Dental Health Month

Albuquerque Area
Dental Support Center
A program of



MEETINGS OF INTEREST

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 Medicine, Internal Medicine, Emergency Medicine Physicians

Family/Pediatric Nurse Practitioner for School Health Program

Family Nurse Practitioner for Sells Indian Hospital Sells Service Unit; Sells, Arizona

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

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

of natural splendor.

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

Mid-Level Practitioner Pediatrician

St. Regis Mohawk Health Service; Akwesasne, New York

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

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

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

Family Practice Physician

Family Nurse Practitioner

Physician Assistant

Psychiatrist

Bay Mills Health Center/Bay Mills Indian Community; Brimley Michigan

The Bay Mills Health Center is seeking a family practice physician (MD or DO; board certified). Must have completed a residency program and have a Michigan license or be able to obtain one. New Graduates are welcome to apply!

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

We are in need of a certified mid-level practitioner, a

FNP or a PA, with a background in Family Practice.

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

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

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

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

Medical Director

Emergency Room Physicians

Emergency Medicine PA-Cs/Nurse Practitioners

Family Practice PA-Cs/Family Nurse Practitioners

OB/GYN Physician

Nurse Mid-Wives

Family Practice Physicians

Rosebud Comprehensive Health Care Facility; Rosebud, South Dakota

The Rosebud Comprehensive Health Care Facility in Rosebud, South Dakota is seeking board eligible/board certified physicians and mid-levels with at least 2 - 3 years post-residency experience. We are also in need of ER PA-Cs, family practice PA-Cs, and family nurse practitioners. Rosebud is located in rural south central South Dakota, west of the Missouri River on the Rosebud Indian Reservation and is approximately 30 miles from the Nebraska border. We are a 35-bed facility that has a 24-hour emergency department, and a busy clinic that offers the following services: family practice, internal medicine, ob/gyn, pediatrics, general surgery, optometry, dentistry, physical therapy, dietary counseling, and behavioral health. Our staff is devoted to providing quality patient care, and we have several medical staff members who have been employed here ten or more years. The beautiful Black Hills, Badlands, Custer State Park, Mount Rushmore, and Crazy Horse Memorial are just 2 - 3 hours away. South Dakota is an outdoorsman's paradise with plenty of sites for skiing, hiking, hunting, fishing,

boating, and horseback riding. Steeped in western folklore, Lakota cultural history, and the lands of such famous movies as "Dances with Wolves" and "Into the West," there is plenty for the history buff to explore. If you are interested in applying for a position, please contact Kevin Stiffarm, Chief Executive Officer, at (605) 747-3111, (605) 517-1283; or e-mail him at kevin.stiffarm@ihs.gov. (11/10)

Family Practice Physician

Warm Springs Health and Wellness Center; Warm Springs, Oregon

The Warm Springs Health and Wellness Center has an opening for a board certified/eligible family physician. Located in the high desert of central Oregon, we have a clinic that we are very proud of and a local community that has much to offer in recreational opportunities and livability. Our facility has been known for innovation and providing high quality care and has received numerous awards over the past ten years. We have positions for five family physicians, one created by a physician who recently retired after 27 years of service. Our remaining four doctors have a combined 62 years of experience in Warm Springs. This makes us one of the most stable physician staffs in IHS. Our clinic primarily serves the Confederate Tribes of Warm Springs. We have a moderately busy outpatient practice with our doctors seeing about 15 - 18 patients per day under an open access appointment system. We were a pilot site for the IHS Innovations in Planned Care (IPC) project and continue to make advances in how we provide care to our patients. We fully utilize the IHS-Electronic Health Record, having been an alpha test site for the program when it was created. We provide hospital care, including obstetrics and a small nursing home practice, at Mountain View Hospital, a community hospital in Madras, Oregon. Our call averages 1 in 5 when fully staffed. For more information, please call our Clinical Director, Miles Rudd, MD, at (541) 553-1196, ext 4626, or e-mail stephen.rudd@ihs.gov. (10/10)

Dentist

Family Practice Physician

Consolidated Tribal Health Project; Redwood Valley, California

The Consolidated Tribal Health Project in Redwood Valley, California is recruiting for a dentist and a family practice physician. These positions are full-time with benefits; salary DOE. All applicants will be considered; Native American preference applies. Visit www.cthp.org for an application and job description. Send application and resume to HR Department by fax at (707) 485-7837. ADA/EEO. (10/10)

Family Practice Physician

Menominee Tribal Clinic; Keshena, Wisconsin

Join seven experienced primary care physicians in beautiful north central Wisconsin 45 miles from Green Bay.

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

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

SEARHC invites registered dietitians to apply for a community dietitian opening on the SEARHC Health Promotion Team. The baseline qualifications are a BS in community nutrition/dietetics or a nutrition-related field. Two years clinical nutrition and/or community nutrition work experience are required, with specific experience in management and prevention of diabetes, heart disease, and other chronic diseases. Must be a registered dietitian and eligible for dietetic licensure in the State of Alaska.

The dietitian will assess, plan, implement, and evaluate community nutrition programming focused on diabetes prevention. Additionally, the community dietitian offers medical nutrition therapy to clients living with diabetes and pre-diabetes on an on-site, outpatient basis as well as using distance delivery via Polycom. These services are provided to individuals, small groups, and communities in Juneau and the northern SEARHC region. SEARHC is a non-profit

tribal health consortium of 18 Native communities, which serves the health interests of the Tlingit, Haida, Tsimshian, and other Native people of southeast Alaska. Residents of southeast Alaska towns share a strong sense of community. Residents take full advantage of the excellent opportunities for fishing, boating, skiing, hiking, and other outdoor activities. Applications are available on-line at www.searhc.org, or please contact Human Resources at (907) 463-6693. (10/10)

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

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

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

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



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THE IHS PRIMARY CARE PROVIDER

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



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