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Introduction to the July 2011 Special Issue on Injury Prevention

Lawrence R. Berger, MD, MPH, Academic Director, IHS Injury Prevention Specialist Fellowship Program, and Clinical Assistant Professor of Pediatrics, University of New Mexico School of Medicine, Albuquerque, New Mexico

At first glance, you would think the three articles featured in this special issue have little in common. However, they all address vitally important topics in the field of injury prevention: motor vehicle crashes, the leading cause of death for American Indians and Alaska Natives from the ages of 1 to 44 years; falls, the leading cause of nonfatal injuries, hospitalizations, and injury-related deaths for individuals aged 65 and older; and focus groups, a social marketing tool that can greatly improve the likelihood that interventions will be successful. Another marked similarity is that the articles emphasize “lessons learned” about how to skillfully conduct three specific activities: a collaborative tribal motor vehicle injury prevention program, an assessment of prescribing practices involving potentially inappropriate medications, and focus groups to design and evaluate local prevention efforts. These articles explore the value and limitations of a specific data source (the IHS National Data Warehouse), factors that either limit or contribute to successful program implementation, and aspects of focus group structure and process that mitigate or advance one’s ability to obtain in-depth information about a target audience. Clinicians, public health practitioners, advocates for community health and safety, and program administrators will all find a great deal of useful information in these insightful articles.

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Applying Funding Agency Lessons Learned to Enhance Motor Vehicle Injury Prevention in American Indian/Alaska Native Communities

Robert J. Letourneau, MPH, Research Associate, Department of Health Behavior and Health Education, The University of North Carolina at Chapel Hill Gillings School of Global Public Health, Chapel Hill, North Carolina; Carolyn E. Crump, PhD, Research Associate Professor, Department of Health Behavior and Health Education, The University of North Carolina at Chapel Hill Gillings School of Global Public Health; and Holly Billie, RS, MPH, Injury Prevention Specialist, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Atlanta, Georgia

Background/Purpose

Public health interventions including injury prevention (IP) programs in American Indian/Alaska Native (AI/AN) communities must consider a community's unique cultural, political, and historical factors (e.g., tribal sovereignty) and the use of effective strategies based on sound data and community identified concerns.¹ Also important to establishing effective tribal IP programs is the provision of tailored technical assistance² and the emphasis on continuity, commitment, and contributions when developing and nurturing IP partnerships.³ Successful motor vehicle IP program efforts describe adapting educational, enforcement, and evaluation activities to address local conditions^{4,5} and the need for law enforcement-based interventions to be combined with public education or mass media and policy change interventions.^{6,7} This article summarizes how a federal agency is building on lessons learned about program administration, partnerships/collaboration, tailoring evidenced-based strategies, and data collection and evaluation to ensure that elements critical to program success are present for eight tribes/tribal organizations currently receiving four-year motor vehicle IP funding.

The Centers for Disease Control and Prevention's (CDC) National Center for Injury Prevention and Control awarded four AI tribes approximately \$75,000 per year from 2004 - 2009 to plan, implement, and evaluate tribal motor vehicle injury prevention programs (TMVIPP). The CDC encouraged funded tribes to use "best practices" for three traffic safety issues: 1) increasing seatbelt use; 2) increasing child safety seat (CSS) use; and/or 3) reducing driving under the influence (DUI). The CDC referred tribes to the *Guide to Community*

*Preventive Services*⁸ as a resource to identify interventions. In addition, the CDC required each TMVIPP to devote approximately 15% of annual program budgets to hire external evaluators to provide program planning and evaluation assistance.

The four pilot TMVIPP projects achieved varying types of success. One tribe passed a tribal primary enforcement seatbelt law and increased seatbelt use from 47 to 62 percent from 2005 to 2008.⁹ Another tribe saw driver seat belt use increase 38 percent, passenger seat belt use increase 94 percent, and child safety seat use increase from a baseline of 26 percent to 76 percent between 2005 and 2009.⁴ In 2008 alone, another tribe conducted 24 sobriety checkpoints and stopped 13,408 vehicles.⁹ Compared with data from 2001 - 2004, another tribe saw a 17 percent decrease in motor vehicle crashes (MVCs) and 4.3 and 8.5 percent reductions in fatal MVCs and total MVCs with injuries, respectively, during the 2004 - 2009 funding period.¹⁰

To increase effectiveness of the TMVIPP, at the end of the pilot funding cycle the lead authors reviewed the implementation process for the 2004 - 2009 cycle.¹¹ This article summarizes selected results from the review, emphasizing successes, challenges, and recommendations related to program administration, partnerships and collaboration, tailoring effective strategies, and data collection and evaluation.

Methods

To complete the review of the TMVIPP implementation process, primary data sources included: 1) project funding applications (submitted annually); 2) TMVIPP workshops and evaluation summaries (conducted annually in Years I - IV); 3) discussions with CDC staff and TMVIPP Coordinators (completed during annual site visits and regular conference calls); 4) project progress reports (submitted three times annually); and 5) multi-year data collection summaries. Data reviewed from these sources were combined with in-depth discussions with project coordinators and team members during the final year of the pilot cycle (2008 - 2009).

Review of data sources enabled the authors to identify factors contributing to project success and challenges. Success factors were identified when present for at least two funded

tribes. Limitation factors were noted when relevant for at least one funded tribe. The lead authors identified recommendations from a synthesis of available data sources, careful study of the success and limitation factors, and prior experience working with the TMVIPP and other IP funded programs in AI/AN communities.

Results

We identified project success factors (n = 17) and project limitation factors (n = 15) organized by four components associated with TMVIPP project implementation and evaluation: 1) *Program Administration*; 2) *Partnerships/Collaboration*; 3) *Tailoring Effective Strategies within American Indian Communities*; and 4) *Data Collection and Evaluation*. Nearly all of the success factors were present for all four tribes. There was greater variation in the number of limitations relevant across tribes (8 - 15 per tribe), with a greater number of limitations present for two tribes (13 or more).

We identified a total of 24 recommendations, with four to eight per component. The majority of recommendations for 1) *Program Administration* were derived from a mixture of success and limitations, whereas recommendations for 2) *Partnerships and Collaboration* and 3) *Tailoring Effective Strategies* were derived primarily from success factors, with the majority of recommendations for 4) *Data Collection and Evaluation* being derived from limitation factors.

For 1) *Program Administration*, success factors included low coordinator turnover during the cycle; annual site visits from CDC and evaluators; coordinator experience in IP or working with law enforcement; and staff training obtained by coordinators prior to or during the cycle. Limitation factors included inadequate infrastructure to manage a cooperative agreement; staffing requirements that did not mandate a full-time TMVIPP coordinator; miscommunication among team members about TMVIPP project goals, objectives, and roles and responsibilities; inconsistent progress reporting quality; challenging tribal accounting approval processes; and administrative burdens of tribal sub-contracting. Recommendations for *Program Administration*, based on a combination of success and limitation factors identified in the pilot cycle, included:

1. Ensure commitment from tribe to provide the TMVIPP coordinator access to an adequate office, computer, e-mail, Internet, phone, and administrative support for accounting and travel.
2. Require projects to have one full-time staff person in the TMVIPP coordinator position.
3. Continue annual site visits by CDC staff and external evaluator.
4. Require attendance at annual in-person coordinator meetings.
5. Encourage or require coordinators to attend and/or

submit presentation abstracts to national conferences and to obtain additional training.

6. Provide consistent external evaluation and technical assistance for tribes by contracting with one organization/entity.
7. Provide enhanced progress reporting templates and increased oversight by providing specific feedback on reports.
8. Develop a TMVIPP manual that outlines a) project staff roles and responsibilities; b) agency and partner roles and responsibilities and contact information; c) reporting requirements and tips for writing effective progress reports; d) summary of evidence-based implementation strategies for traffic safety; and e) summary of traffic safety policy change strategies.

For 2) *Partnerships and Collaboration*, success factors included integration within the tribe's police department (PD); in-kind, paid, and incentive-based police department contributions; coordinator involvement with a coalition; support of tribal leaders; teamwork with tribal and non-tribal staff; cross-tribal resource exchange; and assistance from IHS staff. One limitation factor included limited project integration within the tribe's PD. Recommendations for *Partnerships and Collaboration*, based primarily on success factors identified in the pilot cycle, included:

1. Ensure that TMVIPP Coordinators understand how to integrate program implementation and evaluation activities with local law enforcement entities (e.g., tribal, municipal).
2. Allow TMVIPP project funds to support in-kind, paid, and incentive-based contributions of PD personnel.
3. Encourage and provide training and technical assistance to support coalition building (to foster tribal and non-tribal partnerships).
4. Foster partnerships among TMVIPP Coordinators and with local IHS IP staff.

For 3) *Tailoring Effective Strategies in American Indian Communities*, success factors included use of Native language in educational and media activities; project access to free and paid media; and tribal passage of enhanced traffic safety laws or policies. Limitation factors included competing priorities and politics affecting the ability of law enforcement to fully implement enforcement activities; chronic PD understaffing; turnover in PD or tribal leadership; and over-emphasis on education-only activities. Recommendations for *Tailoring Effective Strategies*, based primarily on success factors identified in the pilot cycle, included:

1. Provide suggestions for tailoring effective strategies using Native language and brands (e.g., logos).
2. Continue to encourage the use of paid and/or free media (e.g., radio, newspapers) by providing tips and guidance for how to develop and report reach of press

releases, public service announcements, and advertisements.

3. Emphasize the importance of learning and understanding tribal policies and procedures to pass new or enhanced traffic safety laws or policies and encourage sites to develop multi-year action plans that include traffic safety policy change activities.
4. Encourage TMVIPP sites to describe project accomplishments to tribal councils so that traffic safety remains a high priority among tribal leaders.
5. Provide advice to TMVIPP coordinators on how to handle staff turnover, understaffing, and politics.

For 4) *Data Collection and Evaluation*, success factors included requirement to budget for program evaluation services to collect, interpret, and summarize data; and access to secondary data sources. Limitation factors included inconsistent collection or summary of primary and secondary data; limited summarization of paid enforcement-based activities; and judicial system functioning that limited tracking of traffic safety violation or arrest prosecutions. Recommendations for Data Collection and Evaluation, based primarily on limitation factors identified in the pilot cycle, included:

1. Specify required evidence-based strategies and appropriate evaluation measures to be included in tribal workplans.
2. Emphasize and provide technical assistance and training for conducting evaluation.
3. Provide early guidance to identify tribal-specific data collection sources, methodologies, and summary templates.
4. Require TMVIPP sites to document formative, process, impact, and outcome evaluation in a timely and consistent manner.
5. Provide guidance, tools, and strategies for how to summarize on-going enforcement of traffic safety laws.
6. Assist coordinators in meeting requirements of tribe-specific Institutional Review Board policies.
7. Outline the following in a TMVIPP manual: a) data collection methods for evidence-based effective strategies for traffic safety; b) data collection

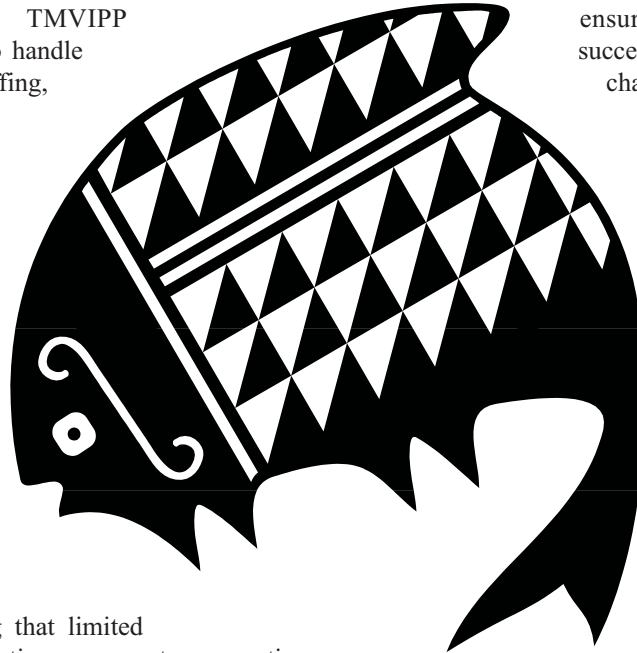
instruments (e.g., observational surveys, checkpoint summaries); c) data entry/summary tools (e.g., templates for summarizing data); and d) tips for summarizing project success (e.g., writing success stories, submitting abstracts for presentations at conferences, promoting successes).

Discussion/Conclusions

The review of the 2004 - 2009 TMVIPP was conducted, primarily, to ensure elements critical to program success and lessons learned from program challenges would be addressed to better support tribes/tribal organizations participating in the 2010 - 2014 TMVIPP. By building on project successes, and seeking to address project limitations, all but one of the recommendations provided (a requirement for a full-time TMVIPP Coordinator) are being applied during the current CDC TMVIPP funding cycle. While tribes have been encouraged to have a full-time coordinator, the funding amount (\$70,000 annually) may limit the ability of tribes located in some geographic areas (e.g., with higher salary/benefit requirements or indirect costs rates) to provide

adequate funds for both personnel and non-salary project expenses. At the start of the current TMVIPP cycle, the CDC developed and distributed a comprehensive *TMVIPP Administration, Implementation, and Evaluation Manual* designed to enhance the ability of funded tribes to administer, plan/implement, and evaluate project activities.¹² Program administration tools in the manual include information from CDC's Procurement and Grants Office (PGO), such as a TMVIPP roles and responsibilities summary; key staff contact information; a summary of important PGO-related events/due dates; and progress reporting requirements, tips, and templates. Program planning and implementation tools include detailed summary of motor vehicle injury prevention evidenced-based interventions, strategies, and activities; guidelines and tools for building and maintaining coalitions; a summary of how to work with media (including project branding examples); and description of steps needed and resources available to use policy change as a public health strategy.

Program evaluation tools and resources in the manual include overview of the four stages of evaluation (i.e.,



formative, process, impact, and outcome); summary of the data collection measures needed to assess effectiveness of motor vehicle IP programs; and list of the ways in which program success can be shared publically (e.g., in progress reports, at presentations to tribal council, or at conferences). To standardized data collection procedures, several sample data collection tools are in the manual, including community member knowledge, attitude, skill survey examples; observational survey protocols and guidelines to assess occupant restraint use; program implementation summary tools to document restraint use and DUI enforcement and child safety seat activities; and secondary data abstraction forms to summarize law enforcement citation/arrest and motor vehicle crash, crash injury, and crash fatality data. Future additions to the manual's resources will include site-specific data entry files (so tribes can consistently communicate evaluation results to tribal leaders, program partners, and community members), answers to frequently asked questions, and additional PGO information.

The TMVIPP has contracted with one organization for the 2010 - 2014 funding cycle to provide external technical consultation for program implementation and evaluation to CDC staff and funded tribes. Technical assistance activities include workplan development, progress report review, conference calls, site visits, annual workshop, and on-going technical assistance. Several funded sites were required to revise workplans based on weaknesses identified by the proposal review panel.

Through the use of a cooperative agreement funding mechanism, the provision of a comprehensive *TMVIPP Manual*, and simultaneous provision of on-going technical assistance from a single external group, the CDC is seeking to ensure that the elements critical to AI/AN motor vehicle injury prevention – administration, partnerships and collaboration, tailoring effective strategies, and data collection and evaluation – will be realized in the 2010 - 2014 TMVIPP cycle. Recommendations provided for the latter three categories are consistent with critical elements identified by other IP practitioners working in AI/AN communities.^{1,3,5-6} More resources are available to tribes to assist with developing partnerships and collaboration and tailoring effective strategies, compared to those available for data collection and evaluation. Given that the majority of limitations associated with data collection and evaluation were relevant for all four tribes, the need for enhanced technical assistance to collect and summarize data warrants further development. Tools and methods to increase tribal data collection and evaluation capacity are emphasized in several of the recommendations for the 2009 - 2014 TMVIPP funding cycle.

The recommendations provided for program administration are based primarily on the authors' expert opinion obtained from prior experiences working in AI/AN communities² and in-depth discussions with TMVIPP staff in the final year of funding. The lead authors were involved with

the TMVIPP throughout the pilot-cycle, serving initially as external consultant for one funded tribe and ending the cycle serving all four tribes. As part of this work, they conducted annual site visits, regular conference calls, and worked with CDC staff to facilitate four annual workshops at which training and technical assistance was provided to TMVIPP Coordinators.

Recommendations provided to CDC for the 2010 - 2014 TMVIPP are being reviewed by additional experts, agency administrators, and tribal program staff brought together as part of a CDC-led effort to confirm a set of 'critical factors' needed in tribal motor vehicle injury prevention programs. This effort is occurring concurrently with administrators from multiple federal agencies, including the CDC, IHS, National Highway Traffic Safety Administration, and Bureau of Indian Affairs, who are working together to identify opportunities to streamline and coordinate federal programs that support traffic safety for tribes and tribal organizations across the country (e.g., funding, technical assistance).

Based on the experiences from the prior TMVIPP funding cycle, those to be identified during the current cycle, and as part of inter-agency collaborative efforts also underway, the CDC plans to develop a comprehensive "Best Practices Manual" to enable additional AI/AN tribes and tribal organizations to effectively address the disproportionate burden of motor vehicle crash injuries and fatalities faced in their communities.

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Potentially Inappropriate Medications (PIMs) and Falls Risk in Older American Indians and Alaska Native Adults: A Pilot Study

LT J. Garrett Sims, PharmD, BCPS, Clinical Pharmacist, US Public Health Service Northern Navajo Medical Center, Shiprock, New Mexico; Lawrence Berger, MD, MPH, Clinical Assistant Professor of Pediatrics, University of New Mexico, Albuquerque, New Mexico; LCDR Clint Krestel, PharmD, Assistant Chief of Pharmacy (Inpatient), US Public Health Service Northern Navajo Medical Center, Shiprock; Bruce Finke, MD, IHS Elder Health Consultant, Northampton, Massachusetts; and Orlando Correa, Systems Development Manager, Indian Health Performance Evaluation System (IHPES) Program, Albuquerque

Introduction

Each year in the United States, one in three older adults experiences a fall. Falls are the leading cause of nonfatal injuries, hospitalizations, and injury-related deaths for individuals aged 65 and older.^{1,2}

The association between medications and increased risk of falls applies to both the number of medications used currently (polypharmacy); and to specific medications and medication classes. In a previous article, we called attention to the frequency of “polypharmacy” (concurrent use of multiple medications) among older American Indians and Alaska Natives (AI/AN) represented in the IHS National Data Warehouse (NDW) data.³ Polypharmacy increases the risk of falls by increasing the risk of medication compliance errors, adverse events, and drug-drug interactions.⁴

Specific medications and medication classes are independent risk factors for falls in the elderly.^{4,5} For example, neuroleptics, benzodiazepines, and antidepressants are noted by the American Geriatric Society to increase the risk of falls, especially in high-risk patients (e.g., those with previous falls or dementia).^{6,7} In a 2005 study, the relative risk for falls among users of olanzapine and other psychotropics was 3.25 (95% CI 1.96 – 5.40).⁸ A 2009 study found the relative risk of falling for users of long-acting benzodiazepines was 1.46 (95% CI 1.23 – 1.74).⁹

There are numerous mechanisms by which specific medications can contribute to an increased risk of falls. They include impairment of balance, lowered reaction times, sedation, dizziness, hypoglycemia, orthostatic hypotension, cardiac arrhythmias, and gait disturbances. Medications with

anticholinergic properties can predispose the elderly to falls through multiple mechanisms, such as blurred vision, arrhythmias, impaired cognition, and unsteady gait.¹⁰ Anticholinergic medications are additive in their adverse effects.¹¹

In this pilot study, we explored the value and limitations of National Data Warehouse data to identify prescribing practices for older AI/AN that are potentially inappropriate due to falls risk.

Methods

To create our list of potentially inappropriate medications (PIMS) related to falls risk, we first conducted a literature review of medications associated with an increased risk of falls. Based on this review, we chose two categories with a strong evidence base for falls risk: medications with anticholinergic properties and medications associated with cognitive impairment (dizziness, confusion, sedation). Medications in these classes typically have safer alternatives to substitute.

We then referred to two sources of information that are commonly used to avoid prescribing potentially inappropriate medications for the elderly: the “2003 Beers list”¹² and the Health Plan Employer Data and Information Set (HEDIS).¹³ The Beers list was developed using Delphi methods to obtain consensus among content experts. “The criteria covered two types of statements: 1) medications or medication classes that *should generally be avoided* in persons 65 years or older because they are either ineffective or they pose unnecessarily high risk for older persons and a safer alternative is available; and 2) medications that should not be used in older persons known to have *specific medical conditions*.”¹⁴

HEDIS measures are widely used to assess the quality of managed care plans and federal health care programs, such as Medicare and the Veterans Administration.¹⁵ We included medications on the most recent HEDIS lists, as well as proposed changes for HEDIS 2012.¹⁶ The HEDIS lists are from two categories, “Use of High Risk Medications in the Elderly”; and “Potentially Harmful Drug-Disease Interactions in the Elderly” (anticholinergic agents, antipsychotics and sleep agents, tricyclic antidepressants).

To create our PIMS list, we identified ten medications/

Table 1. Selected medications presenting a potential falls risk for older adults

(1) Name of drug or class	(2) VA Classification Code(s)	(3) Examples*	(4) Common reasons for prescribing	(5) Falls risk	(6) Comments	(7) % of population receiving a prescription
Propoxyphene	Searched by name	Darvon™	Pain relief	Cognitive impairment, Confusion, Sedation	Ordered removed from the market in November 2010	2.3%
Antihistamines	AH100, AH102, AH104, AH105, AH107, AH200	diphenhydramine (Benadryl™), chlorpheniramine (Chlor-Trimeton™), hydroxyzine (Atarax™), promethazine (Phenergan™)	Allergies, insomnia, nausea, urticaria.	Anti-cholinergic	Excluded “non-sedating” histamines such as loratadine (AH109) and fexofenadine (AH106).	11.2%
Parasympatholytics/GI antispasmodics	AU350	dicyclomine (Bentyl™), hyoscyamine, propantheline Treat irritable	bowel syndrome.	Anti-cholinergic	Excluded benzotropine (indicated for treatment of certain neurologic disorders) and glycopyrrrolate (indicated for ulcer treatment).	0.8%
Tricyclic antidepressants	CN601	amitriptyline (Elavil™), imipramine, doxepin	Depression, fibromyalgia, neuropathic pain, insomnia	Anti-cholinergic, sedative	Excluded nortriptyline and desipramine. Desipramine was specifically excluded in Beers 2003. Nortriptyline has far less anticholinergic properties than amitriptyline, and is proposed for exclusion in HEDIS 2012.	2%
Phenothiazine/related anti-psychotics	CN701	thioridazine (Mellaril™)	Anti-psychotic.	Cognitive impairment, confusion, Sedation,	FDA Black Box Warning (FDA's highest level of warning) for treating dementia in the elderly	< 0.1%
Other anti-psychotics	CN709	clozapine (Clozaril™), aripiprazole, haloperidol	Anti-psychotic	Cognitive impairment, Confusion, Sedation	FDA Black Box Warning for treating dementia in the elderly.	0.4%
Barbiturates	CN301	phenobarbital, secobarbital, pentobarbital	Sedative/ hypnotics, pain relief, phenobarbital for seizures	Cognitive impairment, Confusion, Sedation	Beers 2003 excludes phenobarbital for use in seizures, HEDIS includes phenobarbital.	0.1%
Benzodiazepine derivatives and clonazepam	CN302 + clonazepam (searched by name)	diazepam (Valium™), chlordiazepoxide (Librium)	Sedative/ hypnotic, anxiolytic, anti-epileptic.	Cognitive impairment, Confusion, sedation	Beers 2003 includes all benzodiazepines when an individual is at risk for falls.	2.8%
Antispasmodics, urinary	GU201	oxybutynin (Ditropan™)	Urinary incontinence	Anti-cholinergic	Beers 2003 specifically excluded oxybutynin extended release.	1.3%
Skeletal muscle relaxants	MS200	cyclobenzaprine (Flexeril™), methocarbamol (Robaxin™), metaxalone (Skelaxin™), orphenadrine (Norflex™)	Muscle Spasm	Anti-cholinergic	Excluded baclofen tizanidine and dantrolene – not on Beers 2003.	3.5%

medication classes that are associated with the two categories of falls risk and that are potentially inappropriate for elders in general or who have a history of falls according to Beers 2003 criteria and/or HEDIS lists. These are shown in Table 1, along

with the Veterans Administration (VA) classification for each medication class.

We then submitted our PIMs list to the NDECI Data Mart to determine how many patients 65 years and older were

prescribed one of the focus medications or medication classes in FY 2008. We described the NDECI data mart in our previous publication.³ Briefly, IHS Environmental Health Division's Notifiable Disease and External Cause of Injury (NDECI) data mart contains data and analytical information derived from the National Data Warehouse (NDW). The latter is a national repository of health care information, over 90% of which comes from local IHS and tribal sites that use RPMS (Resource and Patient Management System) as their information technology system. NDW data includes demographic data, third-party eligibility information, and clinical data. Prescription information in the NDW includes the medication name, National Drug Code (NDC) code, and VA drug class code. We chose the VA drug class codes for our search because they are broader than the NDC codes. The latter are especially cumbersome because for the same medication, there are separate codes for each manufacturer, strength, dosage form, and package size.

We searched the NDW data for all patients age 65 years and older receiving one or more of the targeted medications in fiscal year 2008. All the counts were based on distinct integrity identity numbers, which refer to distinct patients. Two medications, propoxyphene and clonazepam, were searched by

name rather than by drug class. The age and gender of each patient was recorded; no patient identifiers were collected. Permission to publish this manuscript was obtained from the National IHS Publication and Review Committee.

Results

Overall, nearly one in five older adults (19%) in the NDW database received a potentially inappropriate medication associated with increased falls risk due to central nervous system effects or anticholinergic properties (Table 2). There was a clear male/female disparity: 15.3% of males were prescribed a PIM compared to 22% of females. For both males and females, the percentage of individuals receiving a PIM declined with increasing age. About a fourth (24%) of women 65 - 74 years of age, and 16% of men, received one or more PIMs, compared to 16% of women and 12% of men 85 years and older.

As shown in Table 1, the most frequently-prescribed PIM was a sedating antihistamine: 11% of patients 65 years and older received a prescription for a sedating antihistamine during FY 2008. Other medications prescribed to 2% or more of the target population were skeletal muscle relaxants (4%), benzodiazepines (3%), propoxyphene (2%) and tricyclic

Table 2. National Data Warehouse: Patients 65 years and older receiving one or more selected potentially inappropriate medications for falls risk FY 2008

	User Pop	# Receiving One or More Meds	% Receiving One or More Meds
MALES			
Males 65–74	17,154	2,706	15.8%
Males 75–84	7,460	1,115	14.9%
Males 85+	1,875	233	12.4%
Subtotal	26,489	4,054	15.3%
FEMALES			
Females 65–74	24,107	5,791	24.0%
Females 75–84	11,647	2,396	20.6%
Females 85+	3,763	595	15.8%
Subtotal	39,517	8,782	22.2%
TOTAL			
All 65–74	41,261	8,497	20.6%
All 75–84	19,107	3,511	18.4%
All 85+	6,638	828	14.7%
Subtotal	66,006	12,836	19.4%

antidepressants (2%). Medications prescribed to 1% or less of the target population were urinary antispasmodics (excluding extended release forms of oxybutynin), parasympatholytics/GI antispasmodics, phenothiazines, other anti-psychotics, and barbiturates.

Discussion

Medication therapy in the elderly is always a balancing act, requiring assessment of the benefit for a specific medication against potential risks.^{14,17} This pilot study focused on medications for which there is strong evidence for potential increased risk of falls and published expert recommendations for avoidance of use in older adults (2003 Beers list and HEDIS tables).

The percent of individuals who received prescriptions for PIMs decreased from 20.6% in the 65 - 74 age group, to 18.4% in the 75 - 84 age group, to 14.7% in the 85+ age group. This may represent an awareness by prescribers of both the increased likelihood of falls and the increased risk of these medications in the elderly; or may represent a general pattern of declining medication use in the older cohorts.

Antipsychotics are among the most consistently-cited class of medications that are potentially inappropriate for the elderly, especially those with pre-existing risks for falls.^{4,7,18,19} We found that antipsychotics (both typical and atypical) are rarely prescribed to the NDW older population, with less than 0.5% of this population receiving prescriptions in 2008. Prescriptions for barbiturates were also very infrequent (0.1%).

A relatively large

percentage (11%) of patients received first generation antihistamines such as diphenhydramine, chlorpheniramine, or hydroxyzine. These may cause somnolence, central nervous (CNS) system dysfunction, and other anticholinergic side effects. Except to treat severe allergic reactions, a first generation antihistamine should rarely be used, given that safer alternatives are available for all other indications (e.g., loratadine for allergies and ondansetron for nausea).²⁰

Two percent of the elderly were being prescribed propoxyphene during FY 2008. This was in spite of the substantial evidence that propoxyphene was no better than

Table 3. PIM prescription rates: Guidelines for local RPMS services

Item	Comments
Determine the goal of the search	Determine the goal of this search. For example: publication, support for policy & procedure change, education of clinical staff, falls program development, measurement of programmatic success, etc.
Determine what data will be collected	Depending on what the goal of the search, you may need chart numbers for chart review, ages for stratification, medications of concern for quantification/comparison by medication or class, dates for discovering trends over time, other prescribed medications for polypharmacy identification, prescribing physician for targeted education, etc.
IHS & Local Data Collection Rules	Determine what type of permission from what authority (IHS – National and/or local, tribal, or other) must be obtained. Typically, the wider the distribution more permission needed.
Drug(s)/medication list(s) used to guide search	Determine what medications are to be searched by using Beer’s List, HEDIS, other lists, and/or a selection of these lists based on local formulary as a guide and combine facility specific information such as falls report trends, incident reports, adverse reactions reported or other mechanisms that may be in place.
Searching by drug	Searching by NDC may be appropriate for a local search with a small number of medications for the search over a short period of time. Searching by drug name or VA drug class is more efficient than obtaining individual NDC numbers for reasons discussed in the text. Most RPMS systems are automatically downloaded with this information; however, drug file patches may require some VA classes to be entered manually.
RPMS Search Methods	Multiple search methods are available in RPMS to extract the necessary data. VGEN and QMAN are two such searches. If unfamiliar with VGEN and QMAN, the RPMS Site Manager may be able to run the report if provided the proper information. Some other positions within most facilities that use VGEN and QMAN frequently are the HIM Director, PQS Director, Infection Control Officer, and Utilization Review Officer. Parameters for the search that will provide the most complete and accurate data will be dictated by the topics mentioned above. Tips: These searches will include all patients unless otherwise stated. Reduce the number of results by searching living patients only. When building searches it will be helpful to answer yes when asked to include all drugs in similar classes. Results for these searches can be exported into Excel® where they can be further manipulated.
Review Results	Data may be missing, or unnecessary data may be included in the results due to improper search parameters, wrong or outdated VA class codes in drug file, missing VA class codes in drug file, or drugs with multiple possible VA class codes. Therefore, verification of search results is recommended to assure all appropriate drugs are included in the RPMS search and to eliminate unnecessary data captured in error.

acetaminophen for pain relief, caused sedation, and was associated with an increased risk of fractures in the elderly. The FDA requested that manufacturers voluntarily remove all propoxyphene-containing products from the market in November 2010.²¹

Comparing the rate of use of PIMs in different studies is problematic because there are numerous, differing lists of what constitutes a PIM,²²⁻²⁶ specific medications are sometimes not identified, and study populations differ by age, presence of comorbidities, and other variables. Nevertheless, two studies involving Veterans Administration (VA) populations are relevant to our study. A 2006 study of inappropriate prescribing in a VA population of older adults utilized the 2006 HEDIS list. In that study, 20% of patients were prescribed a PIM, very similar to the 19% that we identified.¹⁵ Another VA study examined gender differences in rates of PIM prescribing.²⁷ Utilizing the Beers criteria in FY 2000, the study documented that “analgesic, psychotropic, and anticholinergic medications that should be avoided contributed to higher rates of inappropriate drug use among older women than among older men.” The disparity remained even after controlling socio-demographic characteristics, number of medications, and care characteristics. These findings are consistent with our results of a higher percentage of women than men receiving PIMs (22% vs. 15%).

Strategies to improve pharmaceutical care quality in ambulatory older adults using multiple medications include pharmacist-centered interventions (such as face-to-face consultations with patients), multidisciplinary teams, and computer feedback.^{17,28} Several studies have explored the role of pharmacists in helping to reduce PIMs in the elderly.²⁹⁻³² In fact, The Patient Protection and Affordable Care Act states that Medicare Part D beneficiaries should, at a minimum, have “an annual comprehensive medication review furnished person-to-person or using telehealth technologies . . . by a licensed pharmacist or other qualified provider.”³³ The CDC includes education programs for older adults and their caregivers and medication review and management as two of the five building blocks of effective community-based fall prevention programs.² The American Geriatrics Society Clinical Practice Guideline for Prevention of Falls in Older Persons suggests withdrawal or minimization of psychoactive medications and other medications as part of a comprehensive, evidence-based strategy.⁶ A recent Cochrane meta-analysis showed that prescribing modification programs can decrease the risk of falling in the community dwelling elderly (RR = 0.61).³⁴

Conclusions

The National Data Warehouse is a rich source of prescribing information for IHS and tribal health facilities. Our methods for extracting and analyzing data can be generalized and used locally to assess prescribing practices for both individual medications and entire medication classes; and to serve as a baseline for interventions to reduce inappropriate

prescriptions and subsequent adverse outcomes, such as falls (Table 3). The literature supports specific clinical-, community-, and pharmacy-based interventions to reduce prescribing of potentially inappropriate medications.

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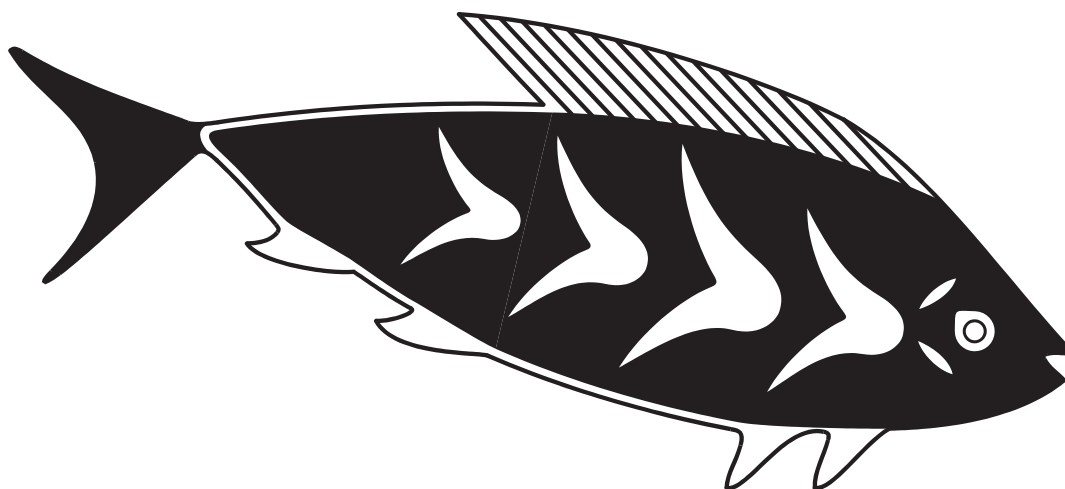
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Focus Groups for Injury Prevention: A Primer

Lawrence Berger, MD, MPH, Clinical Assistant Professor of Pediatrics, University of New Mexico School of Medicine, Albuquerque, New Mexico; and Stephen R. Piontkowski, MSEH District Environmental Health Officer, Phoenix Area IHS Office of Environmental Health and Engineering, Lakeside, Arizona

Focus groups are a powerful tool for planning and evaluation. Originally designed as a marketing tool for the business world, focus groups are now widely used in diverse arenas, from clinical practice,¹⁻⁵ to public health initiatives,⁶⁻¹⁰ to law and politics.^{11,12} The goal of this primer is to demonstrate how focus groups can facilitate community-based services and interventions, using examples from the field of injury prevention.

What Are Focus Groups?

A focus group is a well-planned, structured event in which invited participants provide ideas, perspectives, and insights on a specific program-related topic.

When Are Focus Groups Useful?

Among other things, focus groups can help develop a work plan for an intervention or program; craft specific messages (slogans, themes, logos); determine the best channels for dissemination of information (newspapers, radio, word-of-mouth); and identify key stakeholders, role models, target audiences, and potential obstacles. They are also invaluable to assess proposed materials (such as posters, PSAs, and handouts) for content, cultural appropriateness, and appeal, and to obtain feedback on current program activities (See Table 1).

How Do Focus Groups Differ From Other Types of Meetings?

There are several key elements that make focus groups very different from other types of meetings (Table 2). The goal of a focus group is to elicit attitudes, perceptions, ideas, beliefs, and suggestions on specific topics.

In place of an agenda, focus groups utilize a thoughtfully-crafted “moderator’s guide” (Table 3). The guide is essential for the trained moderator to cover the important questions, but also for the designated note-taker(s) to closely follow the proceedings and the group’s relevant comments for each question. The moderator’s guide should address no more than three or four key issues related to the topic. Each issue will have one or more open-ended questions, often followed by

several probing questions. The guide should begin with questions that are non-controversial and aimed at putting the participants at ease. More sensitive or controversial questions should appear later, when trust has been established among participants and with the moderator. Take time to pilot the guide with one or two people representative of the target audience to ensure they understand what the moderator is asking for, you are receiving the desired feedback, questions are unambiguous and easily understandable, and conversation flows well. For example, the use of “child occupant restraint” may be the most accurate phrase in public health circles, but with the target audience, “car seat” might be a better term to use. Piloting the guide will also ensure you meet your goal within the allotted time.

A focus group session usually involves eight to twelve people. Having fewer than eight people reduces the likelihood of obtaining an adequate spectrum of opinions. Having more than 12 participants makes full participation by each individual less likely and can actually reduce the amount of interaction. They are strictly time-limited, usually lasting no more than one to two hours, with one hour preferred.

Participants should be representative of the target group or “audience segment” for the planned program or draft media item. A focus group to help plan a seat belt campaign targeting male drivers ages 16-24 years, for example, should obviously recruit males in this age group. If the planned approach involves a school-based component, a separate focus group of high school teachers would also be valuable. Ideally, participants should not know each other, so they can offer unique perspectives and not be constrained by consideration of personal relationships. In small communities, however, recruiting residents who don’t know each other may not be feasible.

What Are the Advantages and Limitations of Focus Groups?

Focus groups have a number of advantages over other forms of information gathering. In addition to obtaining facts about a topic, focus groups can reveal perceptions, attitudes, beliefs, and feelings of the target audience. In-depth feedback about a topic is promoted by the flexible format. The moderator can ask additional probing questions when unanticipated aspects of an issue arise or clarification is needed. The interactive nature of focus groups promotes more expansive thinking among participants, as one participant’s idea can trigger additional suggestions from others in the group. Compared to large-scale written or interview surveys,

Table 1. Examples of the Usefulness of Injury Prevention Focus Groups

<p>Purpose: Identify extent of support and reasons for support and opposition to a law.</p> <p>Participants: Adult tribal members.</p>	<ul style="list-style-type: none"> • There should be a warning period and a media campaign first, to let people know about the law; • Fines should be \$25–50 • People with certain medical conditions should be excluded from the law.
<p>Topic: Smoke alarm distribution program.</p> <p>Purpose: Identify reasons why many installed smoke alarms are not functioning after one year.</p> <p>Participants: Adults in households who received smoke alarms.</p>	<ul style="list-style-type: none"> • People don't know whether they have an ionization or photoelectric smoke detector installed in their home; • Nuisance alarms happen most often with smoke from frying in the kitchen or steam from taking a shower; • Hush buttons don't work well—often need to pull out the batteries to stop a nuisance alarm.
<p>Topic: Head Start child car safety seat program.</p> <p>Purpose: Identify how to increase car seat usage rates.</p> <p>Participants: 1) Parents whose children attend the local Head Start program; 2) Head Start program staff.</p>	<ul style="list-style-type: none"> • Staff need hands-on training to help parents feel comfortable using the car safety seats correctly; • Have an incentive program, e.g., a lottery for a prize, to encourage parents to use the car seats; • Make extra car seats available to grandparents and others who transport children; • Have a tribal law requiring that children be transported in car safety seats.
<p>Topic: Draft brochure on fall prevention among elders.</p> <p>Purpose: Assess the readability, acceptability, and likely effectiveness of the brochure.</p> <p>Participants: Adult members of the community.</p>	<ul style="list-style-type: none"> • Too much text; • Too much jargon; • Photos should have local people; • Include a phone number so people can get more information.
<p>Topic: Community seat belt media campaign.</p> <p>Purpose: Identify logo, messages, venues for marketing the campaign.</p>	<ul style="list-style-type: none"> • Have a tribal artist design the campaign logo; • Include messages that tribal law enforcement takes seat belt enforcement seriously.

focus groups are relatively inexpensive, require minimal resources, and provide rapid feedback.

One major limitation of focus groups is that the information gathered from them is not quantitative. One cannot conclude, for example, that 80% of the community would favor implementation of a certain program simply because eight out of the ten participants in a focus group favors it. There is also no guarantee that the participants in a specific focus group are representative of the target population. Despite your best efforts to recruit a diverse group of individuals, the majority may share a particular background or perspective that skews the feedback they provide. Because participants are answering “face-to-face”, they may avoid vital, but sensitive, issues. Furthermore, an unskilled moderator may influence the responses of participants or not elicit responses from all the individuals.

What Are the Steps in Organizing Focus Groups?

The first step is to clearly define the purpose of the focus group and the essential questions that need to be addressed. Although it is often tempting to want to answer many questions, narrowing the focus to one topic and three or four key issues is a necessity.

When planning the focus group, seek the assistance of individuals familiar with the target audience and the topic of the focus group to decide:

- How best to recruit participants (ads in newspapers, word-of-mouth, appearances at community events, mailings to individuals are commonly-used methods)
- What potential barriers need to be addressed, such as language issues requiring a translator, or scheduling conflicts (consider the best time of day for participants)

Table 2. Focus Group vs. Committee/Working Group

Focus Group	Committee or Working Group
1. Goal: Elicit attitudes, perceptions, ideas, beliefs, and suggestions	1. Goal: Make decisions, solve problems
2. Structured moderator’s guide with specific questions	1. Meeting agenda
3. Moderator is trained to conduct focus groups	2. Chairperson usually moderates
4. Designated note-taker to record comments and observations	3. Minutes taken to record votes, summarize the discussion items
5. Optimal to have 8–12 participants and limit the focus group session to about one hour	4. No standard limits on the number of participants or length of meeting
6. Participants are members of a target audience	5. Participants are often decision-makers
7. Participants are preferably strangers and do not meet as a group after the focus group session	6. Participants often know each other and meet on a regular basis

- Where the focus group might be held (ensure a quiet location with limited distractions)
- What incentives might be appropriate (e.g., certificates of participation, reimbursement for travel expenses, gift cards of \$10 - \$25, and child care for parents of young children)
- Appropriate content of the moderator’s guide
- What participant demographics (gender, age, clarifying that they indeed represent your target audience, years lived in the community, etc.) you wish to collect and how to collect them (written questionnaire) while they arrive to the session
- If a “privacy pledge” for team members and/or an “informed consent form” for participants are needed
- Whether the note-taker should use a paper and pad or a laptop, and whether additional recording devices (e.g., voice or video recorder) would be acceptable.

Pilot test your moderator’s guide with colleagues and/or members of the target audience. Arrive at the focus group site early to arrange seating, set up any equipment, and prepare the refreshments. Make sure the room is comfortable and has few distractions. Arrange the seating so participants have eye contact with each other and with the moderator (usually, a horse-shoe or circular arrangement). Distribute “name tent” cards or name badges for participants (first names only).

How Are Focus Groups Conducted?

A basic focus group “team” consists of the participants, a moderator, note-taker, and session facilitator. The moderator guides the session through the following elements: welcome and introduction, ground rules and instructions for participants, optional collection of anonymous demographic information, facilitated discussion based on the moderator’s guide, and

closing (Table 4). During the discussion, the moderator’s primary job is to elicit as many ideas and perspectives as possible from all the participants on each of the major questions contained in the moderator’s guide. A skilled moderator will be able to create a relaxed and friendly atmosphere, clearly establish and enforce the ground rules, encourage participation by every person, and guide the discussion in a way that balances flexibility (e.g., pursuing unanticipated issues or insights that arise, asking additional probing questions when necessary) and adherence to the moderator’s guide and time constraints.

It is extraordinarily difficult, if not impossible, for a moderator to both successfully conduct a focus group *and* take adequate notes of the proceedings. A note-taker is therefore essential for most focus groups. The notes can be handwritten, or typed into a laptop computer. The note-taker sits away from the participants, so they are not distracted. A voice or video recorder can be used as a complement to notes, but shouldn’t substitute for notes entered during the session; trying to reconstruct a session if the recording apparatus fails is a very difficult task. Successful note-taking requires skill in deciding when to record a participant’s exact words vs. key points; following the flow of conversation as the moderator often jumps from one item to another or omits certain questions altogether; and making observations about individuals and group dynamics. Consider designating a second note-taker dedicated to recording observations about individuals (e.g., body language) and group dynamics.

A session facilitator can have a number of roles. He or she help greet the participants, address potential distractions (such as unexpected visitors, phones ringing in the session room), ensure the refreshments are well-stocked, adjust the room lighting and temperature, and distribute the incentives at the end of the focus group.

Table 3. Sample Moderator's Guide for a Tribal Housing Safety Focus Group

<p>A. Safety concerns</p> <ol style="list-style-type: none">1. In your neighborhood, what do you feel are the most common causes for people to be hurt or have accidents inside their home or apartment?2. In your neighborhood, what do you feel are the most common causes for people to be hurt or have accidents outside the home?3. What are some ways those injuries or accidents might be prevented? <p>B. Safety brochure</p> <p>Here's a brochure about home safety. Please take 5 minutes to look it over.</p> <ol style="list-style-type: none">4. What do you like about this brochure?5. How could it be improved?6. How else might this information be given to residents of Tribal housing? <i>Probes:</i> Would the tribal newspaper be a good way? Why or why not? What about radio or television? Any other ways to get the information across?7. What other comments do you have about this brochure? <p>C. Home safety training</p> <ol style="list-style-type: none">8. What are some things you wish someone had told you about before you moved into your house/apartment?9. If you attended the training session given by the housing authority for new renters, what do you remember about it? <i>Probes:</i> What topics were discussed at the training session? What was useful? What might be changed or added?10. If you did not attend the training session, why didn't you?11. What is the best way to provide training to new renters? <i>Probes:</i> Would you rather have a group session with other renters, or a visit to your home? Would a video be better? If so, do most people own a videotape or DVD player? Why do you prefer one or another approach? <p>D. Violence</p> <p>Violence and violent behaviors are a problem in many communities around the country.</p> <ol style="list-style-type: none">12. Is violence a problem in your community? <i>Probes:</i> What kind of violence is common here? Is there domestic violence a problem? Gang violence?13. Why do you think these kinds of violence happen in your community?14. What are some ways these kinds of violence might be reduced? <i>Probes:</i> What could the tribal police be doing to reduce violence? What might the schools do? How else could violence be reduced?

How Are the Results of a Focus Group Summarized and Reported?

A debriefing session among the focus group team members should occur immediately after the session concludes and participants leave. The moderator, note-taker, and other observers should consider these questions:

- How do you think the focus group went?
- Did the moderator elicit all the information desired?
- Was participation adequate?
- What could have been done differently?
- What struck you most about the participants' comments?

These immediate responses often prove invaluable in analyzing and summarizing the results of the focus group.

The goal of the written summary is to provide insight into major themes and specific items that warrant attention. The summary can be as simple as grouping comments under the essential questions (Table 5) or can involve sophisticated, software-assisted narrative analysis.^{13,14} The latter approach is especially useful for large-scale initiatives involving multiple focus groups at multiple sites. We have not needed software to analyze results from our community-based focus groups.

How Many Focus Groups Should Be Held For a Given Topic?

The number of focus groups to hold depends on several factors:

- How much staff time and money is available to conduct the focus groups?
- What is the project timeline? Does a project need to end in the next month, or is there an extended planning period built in?
- How many audience segments need to be addressed?

Will program elements be targeting different age groups, one or both genders, providers and consumers? Are there unique geographic considerations, such as urban and rural populations?

Ideally, multiple focus groups are held for each audience segment until no new ideas or themes emerge. In practice, many topics are satisfactorily addressed by a single focus group, especially when a single audience segment is targeted and the topic is narrowly defined.

What Are Other Approaches to Obtaining In-Depth, Qualitative Data?

Focus groups are often used in conjunction with other approaches to obtaining qualitative data.¹⁵ These include key informant interviews, questionnaire surveys, and community observations. Included in the last category is a technique called “participant observations” where researchers directly participate in the activities they wish to learn more about. For example, a member of a violence prevention coalition volunteers to work as a classroom aide in order to gain insights into school bullying; or a pediatrician with anthropology training conducts extended interviews with adolescents in his practice who attempt suicide.¹⁶ An adaptation of focus groups that is based on the “Sharing Circles” of First Nations communities has been used by injury prevention advocates in Canada.¹⁷ The Healthy Native Communities Partnership (HNCP), a non-profit organization that “helps communities realize their own vision of wellness,” has been promoting community dialogue through several innovative avenues, including “Café,” Open Space, blogs, and wiki sites.¹⁸

How Can I Learn More About Focus Groups?

There are numerous publications and websites addressing all aspects of focus groups.¹⁹⁻²⁵ Perhaps the best single reference is a concise paperback entitled, “The Wilder Nonprofit Field Guide to Conducting Successful Focus Groups.”¹⁹ Reading is no substitute for practical experience, however. Consider serving as a participant in one or more focus groups that might be hosted by agencies in your community. To receive moderator training, invite a skilled moderator to conduct a focus group for your program and discuss how you might co-moderate some or all of the session. The IHS Area Injury Prevention Specialists and non-profit organizations that serve American Indian/Alaska Native communities (such as the HNCP, Inter Tribal Council of Arizona, and others) can recommend experienced moderators. You can also contact your local college or university to see if they offer courses on focus groups or have faculty members with skills in moderating them.

Final Thoughts

Most community-targeted focus groups require only a meeting space, some refreshments, a trained moderator, a note-taker, and 8 - 12 participants. A single focus group can provide vital feedback for a proposal, project, program, or media activity. Organizing a focus group to obtain feedback from members of your target audience before you launch an activity or intervention can help you avoid embarrassing and costly mistakes and greatly enhance the likelihood that your activity or materials will be well-received and effective.

Table 4. Format for a Focus Group

Welcome/Introduction

- Good morning and welcome everyone.
- My name is . . .
- Thank you all for coming this morning.
- As you know, we are part of a group of people who work for tribes or the Indian Health Service from all over the country. We are here to learn about . . .
- Your participation is very important in helping us learn about what people think about these issues. Please help yourself to refreshments at any time. Please be sure you have a name tag.

Instructions and guidelines for participants

Our meeting today will work in the following way:

- In the next hour, I am going to be asking a series of questions designed to collect your ideas on . . .
- The people sitting outside the table will be taking notes about what you say. No names will be used in our report. All of the comments that you make today will be summarized so that your privacy will be completely protected. No names will ever be reported.
- When answering these questions, please speak one at a time.
- Please raise your hand to speak if several people want to speak at the same time.
- Say what you think, not what you think someone wants to hear. Your honest impressions are what is important.
- Remember that there are no right or wrong answers! We are here to gather information and ideas, not to come up with any decisions.

Optional

Let's have you take a minute or two to fill out this short form. Do not write your name on it. It's just for us to have some basic information about your age and so forth.

Distribute forms, collect them when completed.

Conduct the focus group using the moderator's guide (Table 3)

Closing

Are there any other thoughts or comments anyone would like to make before we close?

Thank you all for your participation today. Your comments will be very helpful in our work. Please accept this token of our appreciation for your help (e.g., envelopes with financial incentive, thank you letter).

Table 5. Summary of Comments: Focus Group on Cultural Aspects of Injury Control

1. What does it mean to have a “culturally competent” program?

- Use of local language, not exclusive use of English language, in written materials, media campaigns.
- Involvement of elders.
- Personnel learn about sensitive issues regarding interactions with community people, such as touching, eye contact, personal space, how to show respect for elders.
- Absence of stereotyping and derogatory comments.
- Written materials, such as textbooks, include local statistics and information about the community (history, geography, demographics, etc.).
- The program hires people from the community.
- Illustrations for program activities incorporate local people and practices, traditional images.

2. How can programs become more culturally-competent?

- Provide a mandatory orientation for all staff on reservation life and cultural issues.
- Strike a balance between cultural aspects and strictly professional roles.
- Strike a balance between socializing and professional roles.
- Provide on-going feedback to staff on cultural issues as they arise.
- Allow individuals to choose whether they will make use of or avoid traditional approaches (such as herbs or sweat lodges).
- Emphasize positive values and strengths of the community, such as respect for elders and love of children.
- Involve elders in decision-making, such as through focus groups, community meetings, or as an advisory committee.
- Conduct focus groups to get feedback on program plans and materials.
- Start from a foundation of mutual respect, care and concern for the community and all people.

3. What are some cultural issues that make injury prevention efforts particularly challenging?

- Bringing a family member on the job may violate confidentiality.
- Working with multiple tribes may lead to conflicts about symbols, language, and practices.
- Local beliefs, such as discussing death and injury may bring on adverse events.
- Tension among different clans or other kinship groups may complicate working relationships.
- Even within a community there may be differences in cultural beliefs and approaches, such as among different healers, Christians/non-Christians.

4. What are some aspects of culture that can be incorporated into prevention efforts, such as brochures, billboards, PSAs and videos?

- Using the Native language.
- Symbols: e.g., feathers, colors, circle, medicine wheel, four directions.
- Music.
- Involve community members, respected tribal leaders and celebrities.
- Photos of local vehicles, locations, and community members.
- Traditional crafts.

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Acknowledgements

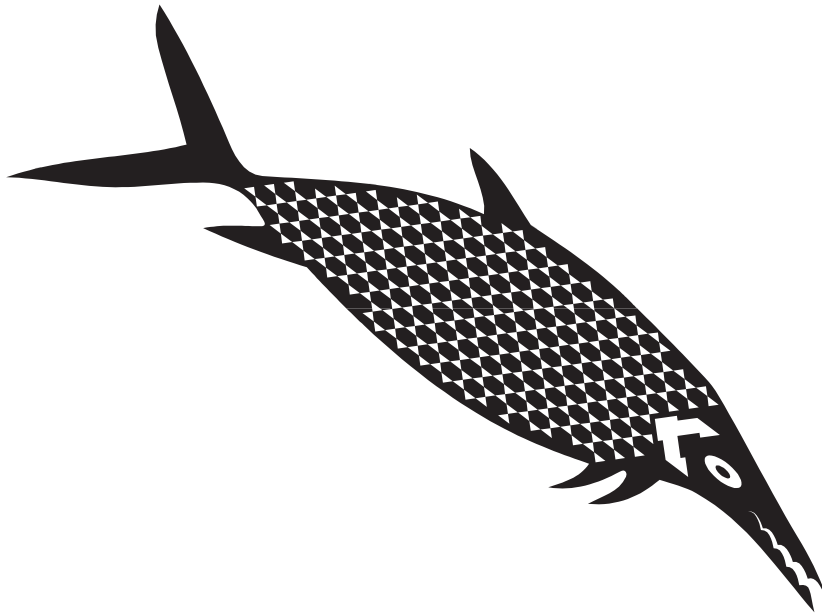
We are grateful to Carolyn Crump and Robert Letourneau of the University of North Carolina, who helped develop focus group materials for the IHS Injury Prevention Fellowship Program; and to many individuals who contributed to our knowledge and experience with focus groups, including Gordon Tsatoke, Amanda Parris, Jon Peabody, the Inter Tribal Council of Arizona, and the San Carlos Apache Police Department.

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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

“It takes a long time to become young.”

Pablo Picasso

Articles of Interest

ACIP Provisional Recommendations for Health Care Personnel on use of Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine (Tdap) and use of Postexposure Antimicrobial Prophylaxis. Date of posting of provisional recommendations: April 4, 2011; scheduled date of publication of recommendations in *CDC Morbidity and Mortality Weekly Report*: fall 2011.

On February 23, 2011 the ACIP approved revised recommendations for health care personnel for use of tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine (Tdap) and use of postexposure antimicrobial prophylaxis. Revised recommendations on use of Tdap in health care personnel incorporate the changes made by ACIP at the October 2010 meeting and support direct language to remove barriers to facilitate the uptake of Tdap.

Use of Tdap in health care personnel:

- The ACIP recommends that all health care personnel (HCP), regardless of age, should receive a single dose of Tdap as soon as feasible if they have not previously received Tdap and regardless of the time since last Td dose.
- Tdap is not currently licensed for multiple administrations. After receipt of Tdap, HCP should receive routine booster immunization against tetanus and diphtheria according to previously published guidelines.
- Hospitals and ambulatory-care facilities should provide Tdap for HCP and use approaches that maximize vaccination rates (e.g., education about the benefits of vaccination, convenient access, and the provision of Tdap at no charge).

Postexposure antimicrobial prophylaxis in healthcare personnel:

- Health care facilities should maximize efforts to prevent transmission of *Bordetella pertussis*. Respiratory precautions should be taken to prevent

unprotected exposure to pertussis.

- Data on the need for postexposure antimicrobial prophylaxis in Tdap-vaccinated HCP are inconclusive. Some vaccinated HCP are still at risk for *B. pertussis*. Tdap may not preclude the need for postexposure antimicrobial prophylaxis.
- Postexposure antimicrobial prophylaxis is recommend for all HCP who have unprotected exposure to pertussis and are likely to expose a patient at risk for severe pertussis (e.g., hospitalized neonates and pregnant women). Other HCP should either receive postexposure antimicrobial prophylaxis or be monitored daily for 21 days after pertussis exposure and treated at the onset of signs and symptoms of pertussis.

Editorial Comment

Pertussis has not gone away. The least we can do as HCP is make sure we do not transmit illness to our patients. Get a jump on this ahead of the fall 2011 publication. Encourage all staff to be vaccinated with Tdap.

Infectious Disease Updates

Rosalyn Singelton, MD, MPH

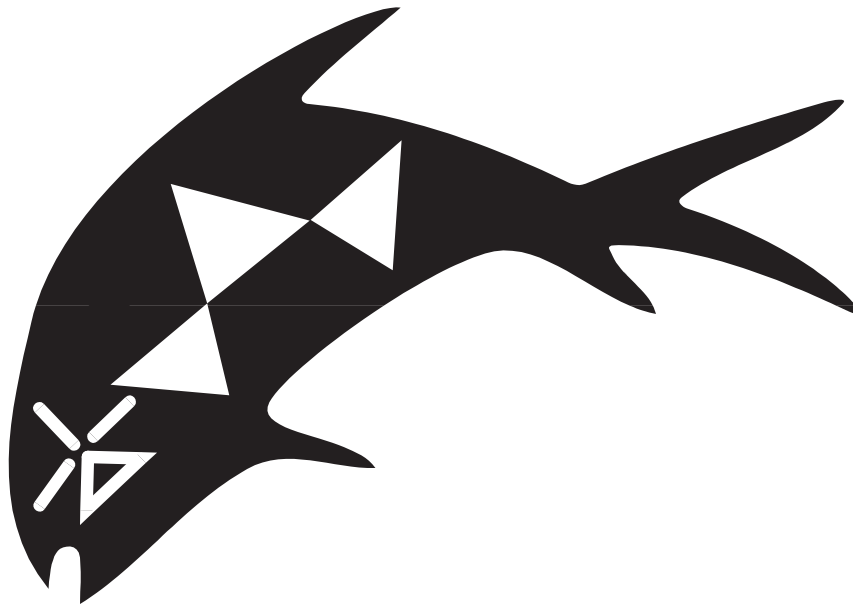
Think TB! Tuberculosis outbreaks have recently surged. The Southwest, Alaska, and other IHS Areas are experiencing a surge in tuberculosis outbreaks. In a Southwest hospital, two patients admitted with fever, cough, and pneumonia were eventually diagnosed with TB. One hundred individuals were exposed, and 15 converted their PPD. In Alaska, in the wake of numerous outbreaks since January 2011, the state is reporting five young children with TB – four Alaska Native and one foreign born. Three children were diagnosed with pulmonary TB, one with TB meningitis and one with scrofula.

Pulmonary TB cases were diagnosed based on positive TB skin test (TST), chest x-ray, and clinical impression. The scrofula diagnosis was based on clinical impression (TST), and biopsy results. TB meningitis was suspected on clinical presentation and CT imaging studies. TB was later confirmed by CSF culture, but the child died prior to lab confirmation.

The take home message from these and numerous other TB outbreaks is “Think TB.” Children with TB are usually asymptomatic, but can progress rapidly from initial infection to full blown disease. The Curry International TB Center provides a warmline (not hotline) for clinical TB consultation;

telephone (877) 390-6682 or go to <http://www.nationaltbcenter.edu/medconsult/index.cfm>.

Control of TB requires diligence and collaboration between IHS, regional tribal corporations, public health officers, and private providers.



In a Dental Emergency...

Care for the child first.

Call the parent/caregiver and encourage them to call their dentist.

Follow the instructions below.

Knocked Out Tooth

- Have the child rinse mouth with water.
- Baby tooth: Place baby tooth in cool milk—do not try to put it back in the mouth.
- Permanent tooth: If possible, gently put it back in the socket; otherwise put the tooth in cool milk.
- Take the child and tooth to the dental clinic ASAP.

Broken Tooth

- Have the child rinse mouth with water.
- Put cold compresses on the face, in the area of the injured tooth.
- If the injured area is bleeding, apply direct pressure using a clean cloth.

Bitten Lip or Tongue

- Put direct pressure to the bleeding area with a clean cloth.
- If there is swelling, put cold compresses directly on the swollen area.

Object Stuck Between Teeth

- Try to remove object with dental floss. Be careful not to cut the gums.
- Do NOT try to remove the object with a sharp or pointed tool.
- If unable to remove object, take the child to dental clinic.

If the Emergency Is More Severe

Call 911.



Community Transformation Grants Are Coming Soon...

The Affordable Care Act includes funding to support new Community Transformation Grants (CTGs) for purposes of implementation, evaluation, and dissemination of evidence-based community preventive health activities. This grant program is designed to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming.

Who is Eligible?

- Indian tribes or tribal organization
- State and local governmental agencies
- Territories
- National networks of community based organizations
- State and local non-profit organizations

What Type of Activities Will Be Funded?

Applicants must devise a plan that lays out changes in policies, programs, environment, and infrastructure to promote healthy living and reduce disparities. Specific activities suggest providing sustained investments to

- Reduce tobacco use
- Reduce obesity (BMI)
- Increase physical activity
- Increase healthy nutrition (such as consumption of fruits and vegetables, increases in low-fat milk consumption, and reductions in salt consumption)
- Reduce the severity and impact of chronic diseases and associated risk factors

Activities within the plan may focus on (but are not limited to):

- Creating healthier school environments, including increasing healthy food options, physical activity opportunities, promotion of healthy lifestyle, emotional wellness, and prevention curricula, and activities to prevent chronic diseases
- Creating the infrastructure to support active living and access to nutritious foods in a safe environment
- Developing and promoting programs targeting a variety of age levels to increase access to nutrition,

physical activity and smoking cessation, improve social and emotional wellness, enhance safety in a community, or address any other chronic disease priority area identified by the grantee

- Assessing and implementing worksite wellness programming and incentives
- Working to highlight healthy options at restaurants and other food venues
- Prioritizing strategies to reduce racial and ethnic disparities, including social, economic, and geographic determinants of health
- Addressing special populations needs, including all age groups and individuals with disabilities, and individuals in urban, rural, and frontier areas

How Will National Organizations Be Involved in CTGs Program?

National organizations will be funded to provide training and technical assistance to funded communities to effectively plan, develop, implement, and evaluate community-based interventions to reduce the risk factors that influence the burden of chronic disease and associated risk factors in communities.

How Much Money is Available?

The Centers for Disease Control and Prevention's (CDC) Fiscal Year 2012 request of \$221,061,000 from the Affordable Care Act Prevention and Public Health Fund will support CTGs.

Who Oversees the CTGs?

The CDC will award the grants, help develop community transformation plans, and provide training on effective strategies for the prevention and control of chronic disease and the link between physical, emotional, and social well-being.

How Will CTGs be Evaluated?

In general, funded programs will conduct activities to measure changes in the prevalence of chronic disease risk

factors among community members participating in preventive health activities. In addition, the CDC will help devise a structure for evaluating programs.

Why Are CTGs Important?

Awarding CTGs will allow communities to focus on advancing state, local, tribal, and territorial policies and systems to reduce the leading causes of death, associated risk factors, and health disparities.

Where Can I Obtain More Information?

During 2011, CDC will announce the Funding Opportunity Announcement for the CTGs on www.grants.gov. For more details about CTGs, please see section 4201 of the Patient Protection and Affordable Care Act. For more information about the Affordable Care Act and Public Health Fund, visit www.healthcare.gov. Additional information will not be available until the Funding Opportunity Announcement is announced on www.grants.gov.





The Mayo Clinic and the Indian Health Service
proudly announce



Save the Date!

“Intensive Case-Based Training in Palliative Care”

October 17-20, 2011

Rochester, Minnesota

This evolving and innovative program will include hands-on training using palliative care scenarios with live actors in the state-of-the-art Mayo Clinic Simulation Center, clinical rounds with Mayo Clinic staff in palliative care, pain management, and other teams, real-life case studies, and the opportunity to tailor training in specific areas of palliative care to meet your team or individual needs. The course is designed for those who wish to further their skills in clinical practice and program development in palliative care for their communities.

Participants: We can accept a total of 24 participants in teams of 2-4 individuals from an IHS, Tribal or Urban Indian Health program. Send the team that will be building or furthering your palliative care program. The most common teams include a physician, PA or NP, a nurse, and a social worker. Other members of a team could be a pharmacist, administrator, public health nurse, or CHR. More than one team may come from an Area.

Prerequisites: This is an intensive course, designed to build on existing knowledge and experience in providing palliative care. Applicants should have attended a previous EPEC-O for Indian Health training or have comparable experience in palliative care. EPEC-O for Indian Health training is available this year in a multiple-session palliative care track at the *Advances in Indian Health* conference in Albuquerque, NM, May 3-6, 2011. We will consider individuals or teams without those prerequisites on an individual basis.

Cost: The course itself is at no cost to the participant/team. Travel and per diem is the responsibility of the IHS, Tribal or Urban Indian health program. This remains an outstanding opportunity to receive world-class training in palliative care at relatively little cost. Travel dates will be Oct 16 & 21.

The deadline for applications is July 1, 2011. Applications will be accepted on a first-apply, first-approved basis. Selected team members will receive confirmation letters by email. Do not make travel arrangements without a confirmation letter from the Clinical Support Center indicating you were selected to attend. Register on line at <http://www.csc.ihs.gov> “Event Calendar.”

For more information, please contact: Bret Benally Thompson, MD at Bret.BenallyThompson@ihs.gov

ACCREDITATION

The Indian Health Service (IHS) Clinical Support Center is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

The IHS Clinical Support Center is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

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.

Medical Director American Indian Health and Family Services of Southeastern Michigan, Inc. (AIHFS); Detroit, Michigan

AIHFS is looking for a qualified candidate for the medical director position at our health center in Detroit, Michigan. A summary of the position is as follows: general professional guidance of primary care staff; collaborates with fellow physicians and executive director on administrative operations of the medical, dental, and behavioral health services; responsibilities for management of all aspects of the program including accreditation, infection prevention and control, patient safety risk management, and emergency preparedness. This position will report to the executive director. We are seeking someone with completion of an accredited medical school, internship, and completion of the certification examination by the medical board of examiners; a permanent current full and unrestricted license to practice medicine or osteopathy in Michigan; board certified or eligible in family practice. If board eligible, must be AAFP or AOA certified within six months from the date of hire. Current medication dispensing license (DEA). Experience and training must have been progressive and responsible, demonstrating good knowledge of current principles, practices, methods, and techniques in the field of medicine. Medical experience in an outpatient family medical clinic including pediatrics, obstetrical/gynecological, medical care, and non-emergency care. Possess current and valid Michigan driver's license with no DUI/DWI or reckless driving convictions in the last five years, having no more than two at-fault accidents in the last three years, and maintain a valid driver license during employment. Must pass a criminal background check with a Class I Fingerprint Clearance Card within the initial ninety days of employment. Must have updated Immunization record. Must have a tuberculosis test upon employment and

employee health profile updated on an annual basis. Must obtain/maintain CPR certification and a valid card during employment. Please send a cover letter with resume and references to AIHFS, PO Box 810, Dearborn, Michigan 48121, Attn: Jackie Allison, Administrative Assistant. You can also fax to (313) 846-0150. (7/11)

Mid-Level Providers: Nurse Practitioners/Physician Assistant Aleutian Pribilof Islands Association (APIA); St. Paul and Unalaska, Alaska

This is a renowned bird watcher's paradise! Provide health care services to multiple generations of families. We are recruiting for mid-level providers for both sites: St. Paul and Unalaska, Alaska. Duties include primary care, walk-in urgent care, and emergency services; treatment and management of diabetes a plus. Must have the ability to make independent clinical decisions and work in a team setting in collaboration with referral physicians and onsite Community Health Aide/Practitioners. Sub-regional travel to other APIA clinics based on need or request. Graduate of an accredited NP or PA program. Requires a registration/license to practice in the State of Alaska and current ACLS and PALs. Minimum experience: 2-3 years in a remote clinical setting to include emergency care services and supervisory experience. Indian Health Service experience a plus. Will be credentialed through Southcentral Foundation. Positions available immediately. Clinic hours 8 am-4:30 pm, Monday through Friday, and rotations scheduled and/or shared for on-call during evenings and weekends. Salary DOE, plus benefits. Contractual two-year commitment with hiring bonus, housing allowance, and continuing education to keep license current. Job description available upon request. Please send your curriculum vitae to Nancy Bonin, Human Resources Director, via e-mail to nancyb@apiai.org. (7/11)

Registered Nurse Wassaja Memorial Health Center; Fort McDowell Yavapai Nation, Arizona

The Wassaja Memorial Health Center is currently seeking a registered nurse with a pay rate of \$43,766 to \$52,519 per annum (DOE). The registered nurse will provide direct patient care to patients of the Wassaja Memorial Health Center, an outpatient facility. This position requires a current active license as a registered nurse in the state of Arizona with at least two years experience in a clinical environment. Current Arizona driver's license and meet FMYN insurance standards.

The Wassaja Memorial Health Center is an outpatient facility located on the Fort McDowell Yavapai Nation in

Arizona. Fort McDowell Yavapai Nation is located within Maricopa County about twenty-three miles northeast of Phoenix. The Wassaja Memorial Health Center provides care to all IHS eligible patients with proof of membership. The clinic operates Monday through Thursday from 7:30 am to 5:30 pm. The full-time medical staff includes a physician, a nurse practitioner, a physical fitness specialist, and a pharmacist. The facility offers the following clinical services: family medicine, dietician, podiatry, eye, community health, and on-site pharmacy.

The Fort McDowell Yavapai Nation offers a highly competitive compensation program ranging from medical and life insurance to disability and retirement plans. Some benefit programs require contributions from the employee, but most are fully paid by the company. If you are interested in applying, please contact Sarah Gonzales, HR, at (480) 789-7219; e-mail sgonzales@ftmcdowell.org, or submit application/resume to recruiter@ftmcdowell.org. To view the job description and print the application, please visit www.ftmcdowell.org. (7/11)

Family Practice Physician (4)

Physician Assistant (1)

Dentist (2)

Pharmacist (2)

Nurse (4)

Standing Rock Service Unit; Fort Yates, North Dakota

The Standing Rock Service Unit is a fully accredited 12-bed hospital and outpatient services facility located along the Missouri River in Fort Yates, North Dakota. In addition to inpatient, outpatient, emergency, dental, behavioral health, and optometry services, a dialysis unit (eight stations) is also available to serve our patients' needs. Indeed, through strong partnerships with health care providers in nearby Bismarck, North Dakota (approximately 60 miles away) and extension outpatient centers in Cannonball, North Dakota, McLaughlin, South Dakota, Bullhead, South Dakota, and Wakpala, South Dakota, the Standing Rock Service Unit provides comprehensive services to over 9,000 American Indians in North and South Dakota. If you are interested in a position or would like more information, please contact Kim Lawrence at (605) 226-7532; e-mail kim.lawrence@ihs.gov or Kara Todd-Iwen at (605) 226-7808; e-mail kara.todd-iwen@ihs.gov. (7/11)

Family Practice Physician (2)

Physician Assistant (1)

Pharmacist (2)

Nurse (4)

Cheyenne River Service Unit; Eagle Butte, South Dakota

Inpatient, emergency room and outpatient services including specialty care for obstetrics, physical therapy, and optometry services are provided. Hospital and emergency room services are the only services within 90 miles of Eagle

Butte. A new six-bed short stay facility is under construction and due for completion in 2011. Five providers staff this 13-bed unit. The Cheyenne River Service Unit provides comprehensive services to over 9,000 American Indians in South Dakota. If you are interested in a position or would like more information, please contact Kim Lawrence at (605) 226-7532; e-mail kim.lawrence@ihs.gov or Kara Todd-Iwen at (605) 226-7808; e-mail kara.todd-iwen@ihs.gov. (7/11)

Family Practice Physician (2)

Pharmacist (1)

Spirit Lake Service Unit; Fort Totten, North Dakota

The Spirit Lake Nation in North Dakota is served by a four-physician ambulatory care facility as well as a dental clinic and a diabetes program, a pharmacy with three pharmacists, a radiology department with state-of-the-art ultrasound imaging, a complete clinical laboratory, in addition to a mental health department. The Spirit Lake Service Unit provides comprehensive services to over 6,000 American Indians in North Dakota. If you are interested in a position or would like more information, please contact Kim Lawrence at (605) 226-7532; e-mail kim.lawrence@ihs.gov or Kara Todd-Iwen at (605) 226-7808; e-mail kara.todd-iwen@ihs.gov. (7/11)

Family Medicine Physician

Internal Medicine Physician

Emergency Medicine Physician

Nurse Practitioner

Physician Assistant

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. We are also looking for a family/pediatric nurse practitioner or physician assistant for our school health program, and a family nurse practitioner for the Sells Hospital outpatient department.

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. (7/11)

Associate Director for Tribal Support, Office for State, Tribal, Local, and Territorial Support Centers for Disease Control and Prevention; Atlanta, Georgia

The Office for State, Tribal, Local, and Territorial Support (OSTLTS) is currently seeking exceptional candidates for the position of Associate Director of Tribal Support. The position requires knowledge of the unique cultural, environmental, social, economic, political, and other interrelated factors that impact the health of American Indian/Alaska Native (AI/AN) populations. The salary range is \$118,846 to \$154,501 per year.

The OSTLTS serves as the primary link between the Centers for Disease Control and Prevention (CDC), the Agency for Toxic Substances and Disease Registry (ATSDR), and Tribal governments. OSTLTS has responsibility for coordinating public health programs and policies that focus on AI/AN communities.

To apply, visit www.usajobs.gov. Candidates external to the federal government may apply to job announcement HHS-CDC-DE-11-487758. Federal government merit promotion job announcement number is HHS-CDC-MP-11-487665. The closing date for this job announcement is Wednesday, July 20, 2011. Questions may be directed to Dr. Melanie Duckworth at (404) 498-0300 or mhd1@cdc.gov. Please do not submit resumes to this e-mail address. (7/11)

**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/DO, board certified. Must have completed a residency program and have a Michigan license or able to obtain one. New graduates are welcome to apply. We are also seeking a full time psychiatrist who is board certified, able to obtain a Michigan license and who 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, an FNP or a PA-C 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 are rich in culture. The area is the outdoor enthusiast's dream.

We are an outpatient facility open 8 am to 4:30 pm, Monday through Friday. We have an onsite laboratory, pharmacy, x-ray, behavioral health, dental, community health, and social service departments. Physicians see between 18 - 21 patients per day, with adequate time to be acclimated to the facility and procedures. There are no nights or weekends on call. The Bay Mills Health Center was established in 1976 and is a Federally Qualified Health Center. The health 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. We offer a competitive salary, student loan repayments options, CME leave and allowance, a generous leave policy, and comprehensive benefits. If you are interested, please contact Audrey Breakie at (906) 248-8327 daytime, (906) 437-5557 evenings, or e-mail abreakie@baymills.org. (7/11)

**Family Practice Physician
Menominee Tribal Clinic; Keshena, Wisconsin**

Join seven experienced primary care physicians in beautiful wooded 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 pristine Wolf River. Practice in an efficient setting with committed colleagues, your own nurse, and a robust electronic health record. Inpatient and obstetrical care is 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 8,000 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. (7/11)

**WIC Coordinator
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. Four years clinical nutrition and/or community nutrition work experience with progressive experiences in maternal/child nutrition, outpatient medical nutrition therapy, and program planning and administration. Must be a registered dietitian and eligible for dietetic licensure in the State of 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.

SEARHC is a nonprofit 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 online at www.searhc.org, or contact our Human Resources Office at (907) 966-8311 or send an e-mail to hr-web@searhc.org. (06/11)

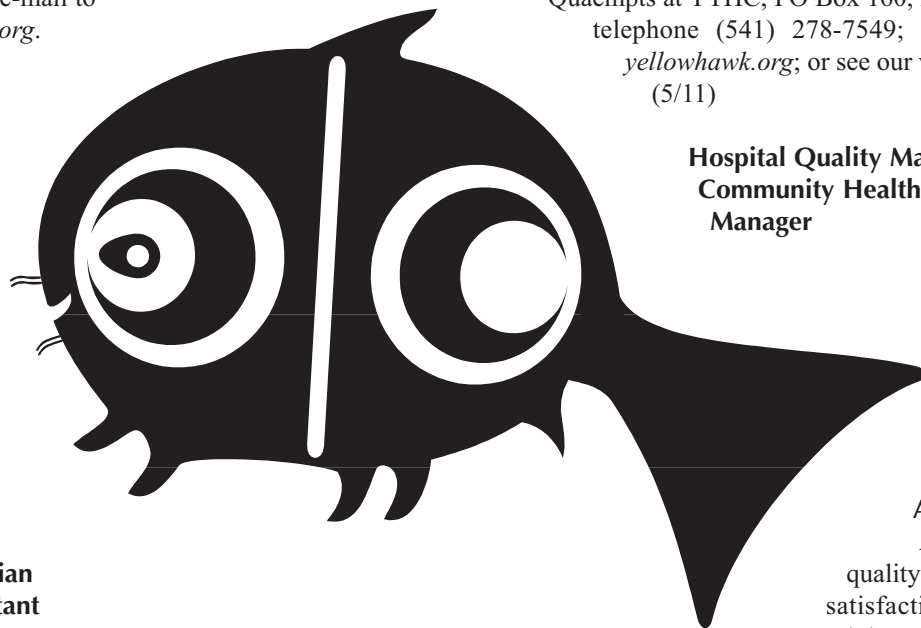
- Family Nurse Practitioner**
- Family Practice Physician**
- Physician Assistant**
- Pharmacist**
- Dentist**
- Clinical Social Worker (3)**
- School Social Worker**
- Behavioral Coordinator**
- Child Adolescent BHS Coordinator**
- Substance Abuse Treatment Coordinator**
- Alamo Navajo School Board, Inc.; Alamo, New Mexico**

The Alamo Navajo Health Services is seeking applicants to fill numerous positions. Our organization requires background investigation as required by law. ANSB, Inc. offers a benefits package including medical, dental, vision, life, and disability insurance, and a 403B retirement plan. ANSB, Inc. gives Navajo/Indian Preference to qualified applicants. For information about qualifications and requirements, and to request for a position description or application, please call the

Personnel Office at (575) 854-2543 ext. 1309 or 1304; or e-mail rkelly@ansbi.org. (5/11)

**Clinical Director
Confederated Tribes of the Umatilla Indian Reservation;
Pendleton, Oregon**

Yellowhawk Tribal Health Center houses a fully accredited, primary care medical facility located on the Confederated Tribes of the Umatilla Indian Reservation. We are looking for a highly motivated, dedicated clinical director to join our already established two-provider practice. We offer excellent hours in a team environment, a well-funded and well-equipped clinic, a competitive salary, and an outstanding benefits package with relocation assistance, and signing bonus. Yellowhawk is located 10 minutes from Pendleton, Oregon, in the foothills of the beautiful Blue Mountains. Come and experience our culture and a rewarding practice where the focus is on quality patient care. Please contact Janyce Quaempts at YTHC, PO Box 160, Pendleton, Oregon 97801; telephone (541) 278-7549; e-mail janycequaempts@yellowhawk.org; or see our website at Yellowhawk.org. (5/11)



**Hospital Quality Manager
Community Health Services Quality
Manager**

**Safety and Infection
Control Officer
Data Specialist
SouthEast
Alaska Regional
Health
Consortium
(SEARHC); Sitka,
Alaska**

Are you passionate about quality improvement and patient satisfaction? Do you enjoy applying new approaches to difficult problems? Do you have a positive attitude and desire to succeed? If so, an exciting opportunity awaits you in scenic Sitka, Alaska. SEARHC recently created a Performance Improvement Division and is recruiting for the following positions:

Performance Improvement Director: a new position responsible for management of all aspects of the program including customer service, accreditation, infection prevention and control, and patient safety. Position reports directly to the COO and works closely with other division directors in managing and directing the health programs of SEARHC.

Hospital Quality Manager: responsible for infection control, patient safety activities, patient satisfaction, risk management, hospital accreditation through the Joint Commission, and data management.

Community Health Services Quality Manager: responsible for infection control, patient safety activities, patient satisfaction, risk management, accreditation through AAAHC, and data management.

Safety and Infection Control Officer: responsible for infection control, emergency preparedness, risk assessments, and safety surveys.

Data Specialist: Part-time position responsible for data management, analysis, and reporting used to improved quality of care and customer satisfaction.

Native American preference applies. Apply online at www.searhc.org. For more information e-mail Connie Goldhahn at connieg@searhc.org; telephone (907) 966-8629. (4/11)

Family Practice PA-C

Family Nurse Practitioners

Family Practice Physicians

Fort Thompson Health Center; Fort Thompson, South Dakota

The Ft. Thompson Health Center in Ft. Thompson, South Dakota is seeking board eligible/board certified physicians and mid-levels with at least 1 - 2 years post-residency experience. We are also in need of family practice physician assistants and family nurse practitioners. Ft. Thompson is located in rural south central South Dakota, east of the Missouri River on the Crow Creek Indian Reservation, and is approximately 80 miles from the Nebraska border. We are a busy clinic that offers the following services: family practice, ob/gyn, pediatrics, optometry, dentistry, dietary counseling, and behavioral health. Our staff is dedicated and devoted to providing quality patient care. 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, Sioux cultural history, and land 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 Mr. Robert Douville, Clinical Services Administrator at (605)245-1514; e-mail him at robert.douville@ihs.gov; or Diana Rodriguez, MD, Medical Director at (605) 245-1516; e-mail her at diana.rodriguez@ihs.gov. (4/11)

Internist

Family Practice Physician

Family Practice Nurse Practitioner

Internal Medicine Nurse Practitioner

Oklahoma City Indian Clinic; Oklahoma City, Oklahoma

The Oklahoma City Indian Clinic is a comprehensive ambulatory health care facility located in the Oklahoma City metropolitan area. The clinic is a non-profit Urban Indian health facility. From its beginning in 1974 as a volunteer, after hours clinic, it has grown to serve over 16,000 patients. Clinical services offered on-site include Family Medicine, Internal Medicine, Podiatry, Pediatrics, Dental, Optometry, Radiology, Public Health, Behavioral Health and WIC. The clinic also has a Laboratory and Pharmacy.

The full-time medical staff includes two family physicians, a pediatrician, two physician assistants and a pediatric nurse practitioner. We are currently recruiting for a board certified/board eligible family medicine physician and an internal medicine physician for our growing clinic. Operating hours for the clinic are 8:00 am – 5:00 pm Monday through Friday; no nights, weekends, or on-call. The clinic offers competitive salary, excellent benefits, retirement, and holidays off. The clinic pays 100% of premiums for medical and dental insurance for employee and family. The clinic also pays for licensures, liability insurance, and CME.

The Oklahoma City Indian Clinic is located in the heart of Oklahoma City and offers limitless entertainment, cultural, and recreational opportunities. Enjoy shopping, fine dining, downtown night life, museums, NBA basketball, Division I college football, professional baseball, and hockey. There are also major universities and colleges close by for continuing education opportunities. Oklahoma City's economy continues to grow. As reported in USA Today and Newsweek, Oklahoma City has proven to be one of the most recession-proof places to live in the United States.

For more information, inquiries, or if interested, please contact Dr. Mark James, Medical Director, at (405) 948-4900 ext. 238 or by e-mail at mark.j@okcic.com; or Monica Tippit, Director of Human Resources at (405) 948-4900 ext. 214 or by e-mail at monica.t@okcic.com. (4/11)

MEETINGS OF INTEREST

Advancements in Diabetes Seminars Monthly; WebEx

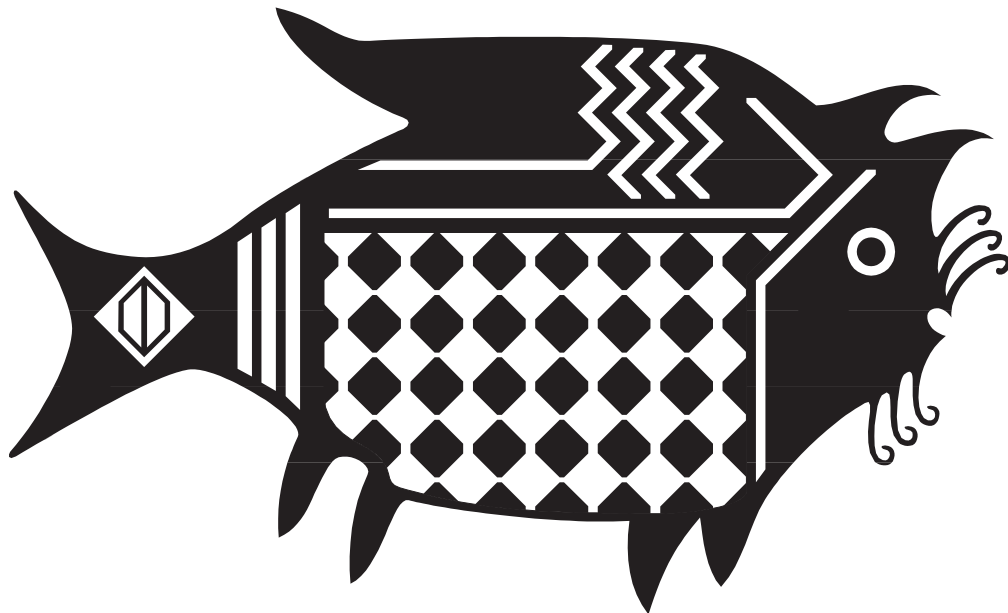
Join us monthly for a series of one-hour WebEx seminars for health care program professionals who work with patients who have diabetes or are at risk for diabetes. Presented by experts in the field, these seminars will discuss what's new, update your knowledge and skills, and describe practical tools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

For information on upcoming seminars and/or previous seminars, including the recordings and handouts, click on this

link and see Diabetes Seminar Resources: <http://www.diabetes.ihs.gov/index.cfm?module=trainingSeminars>

Available EHR Courses

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



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THE IHS PRIMARY CARE PROVIDER

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

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Wesley J. Picciotti, MPADirector, CSC
John F. Saari, MDEditor
Cheryl BegayProduction Assistant
Theodora R. Bradley, RN, MPHDirector, OCE
Linda Trujillo, RN, MSNNursing Consultant
Erma J. Casuse, CDADental Assisting Training Coordinator
Edward J. Stein, PharmDPharmacy Consultant

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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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