



Indian Health Service  
 Division of Epidemiology & Disease Prevention  
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<http://www.ihs.gov/epi/>

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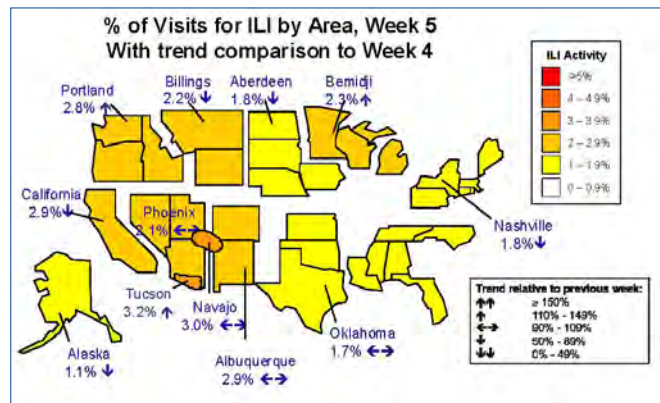
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## RESPONDING TO A PUBLIC HEALTH THREAT: 2009 PANDEMIC INFLUENZA A (H1N1)

During the first week of the pandemic, in April 2009, IHS developed a new, secure system for the daily export of anonymous clinical data on influenza-like illness (ILI), temperature, and risk factors for H1N1 influenza such as asthma, pregnancy, obesity, and diabetes from RPMS, the IHS' electronic health record system. The system is called the IHS Influenza Awareness System (IIAS). The export was designed, tested, and released to the field over an eight day period, and immediately began returning important epidemiologic data to the Division of Epidemiology and Disease Prevention. Since that time, the IIAS has added information on vaccine delivery (both seasonal influenza and H1N1), possible adverse events to influenza vaccination, and hospitalizations. The use of the IIAS to make epidemiological decisions on a national scale helps IHS lead the nation in use of EMR data as the United States moves forward with health reform.

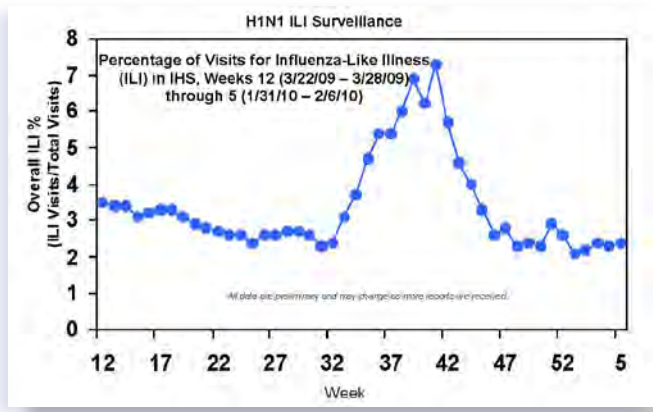
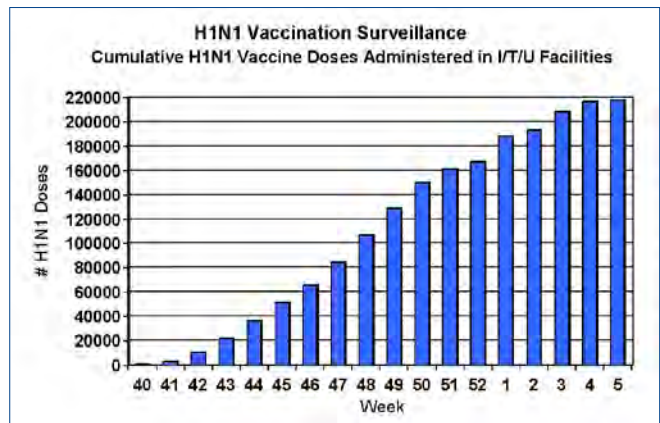
This graph represents the percentage of all outpatient visits to IHS facilities participating in the IIAS (about 60%) that were for ILI. In addition, the IIAS allows IHS DEDP to analyze data by IHS Area, which helped us make decisions about distribution of H1N1 vaccine:



Please see the Weekly IHS 2009 Influenza A (H1N1) Surveillance Reports at <http://www.ihs.gov/h1n1>. The graphs and tables included in this article are as of Saturday, February 6, 2010.

We have also been able to follow distribution of H1N1 vaccine:

The definition of influenza-like illness (ILI) used in the IIAS is based on measured temperature and recorded ICD-9 codes: [influenza-specific ICD-9 code] or [measured temp > 100F and presence of at least 1 of 24 ILI ICD-9 codes]. This definition has helped us track the progress of the H1N1 pandemic in Indian Country:



### Message from Dr. James Cheek, DEDP Director:

Little did I know, as I chatted in between sessions at the Annual Epidemic Intelligence Service Conference last spring, that the vague rumors of swine flu in Mexico would lead to an all-consuming marathon for public health workers across the country. Needless to say, as we all pause to catch our breaths, the H1N1 influenza pandemic has been an extraordinary event that has the potential to shape and enhance the practice of public health for several years. Luckily, the disease itself is nothing like the 1918 Great Influenza. Instead, it provides us with the opportunity to reflect on our roles, individually and collectively, in a defining public health activity.

Did we rise to the occasion and shift our energies toward controlling this old nemesis? Did our systems and planning work as we expected? Were we able to prevent people from dying? What would have been the outcome if this influenza virus had been as lethal as that of 1918? Each of us in public health should be asking ourselves and those around us these questions. In this age of specialization, it's not enough to say "that's not my job, or interest, or training..." We cannot lose sight of our overall goal to "raise the health status of the American Indian and Alaska Native people to the highest level possible," especially in the midst of a pandemic.

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### RESPONDING TO A PUBLIC HEALTH THREAT: 2009 PANDEMIC INFLUENZA A (H1N1)

And to give vaccination data by area:

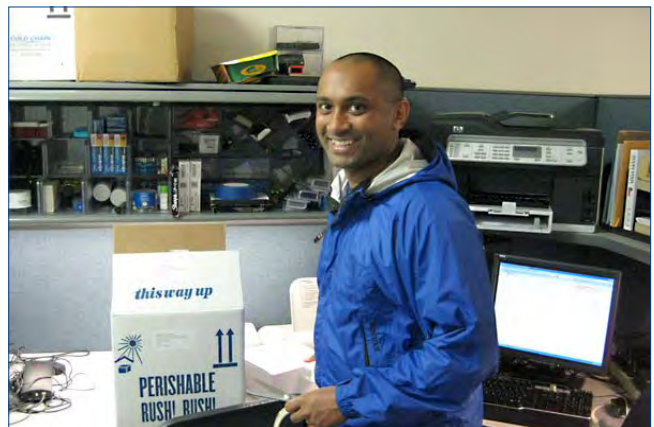
IHS Area	#H1N1 doses
Aberdeen	16,596
Alaska	19,982
Albuquerque	9,951
Bemidji	5,105
Billings	16,689
California	9,707
Nashville	5,204
Navajo	62,412
Oklahoma	30,987
Phoenix	18,959
Portland	14,798
Tucson	7,334
Unknown	4
<b>Total Number of Doses</b>	<b>217,728</b>

And by risk group:

Age Group	# H1N1 doses
< 5 years	40,962
5-24 years	79,306
25-64 years high risk	29,916
25-64 no high risk condition	52,582
65+ years	14,962
<b>Total Number of Doses</b>	<b>217,728</b>

The system has begun to track potential adverse reactions to the H1N1 vaccine in IHS, helping us to ensure the well being of our patients.

The IIAS has helped IHS to respond quickly to the H1N1 situation in different IHS Areas, to coordinate vaccine distribution, and to make informed decisions about antiviral medications, personal protective equipment, and other mitigation efforts.



LCDR Anil Suryaprasad, Epidemic Intelligence Service Officer, packs samples during his field work for the 2009 Pandemic Influenza A (H1N1) outbreak.

## TRIBAL COMMUNITY COLORECTAL HEALTH EDUCATION & NAVIGATION PROJECT

Colorectal cancer (CRC) is the second most frequently diagnosed cancer among American Indian men and women in the Southwest. At the same time, recent studies have demonstrated that the prevalence of timely, age-appropriate colorectal cancer screening is significantly lower among American Indians than other groups in the United States. Therefore, there is an urgent need to strengthen colorectal cancer awareness, education and early detection in American Indians communities in order to reduce these existing disparities.

One promising approach for addressing disparities in access to and utilization of recommended cancer screening services in tribal communities entails the use of community health representatives (CHRs) to provide education, outreach and navigational services to community members. In fact, both the Institute of Medicine (IOM) and the Centers for Disease Control and prevention (CDC) have identified community health worker interventions as a proven strategy and best practice for elevating access to cancer early detection exams. Since 2002, the Albuquerque Area Indian Health Board (AAIHB) has been collaborating with CHRs in the seven consortium tribes its serves to build knowledge and capacity in providing breast and cervical cancer education, outreach and navigational services. In an effort to expand this initiative to include colorectal cancer, the AAIHB has partnered with the National Indian Health Service Division of Epidemiology and Disease Prevention to develop and implement a one year demonstration project entitled the Tribal Community Colorectal Health Education & Navigation Project.

This project has two main objectives which are to:

1. Build knowledge and skills among community health representatives (CHRs) to bolster their involvement in colorectal cancer specific education, outreach and navigational services in the seven AAIHB consortium tribes
2. Develop multidisciplinary colorectal health workgroups in participating AAIHB communities to strengthen relationships between CHRs and other community health providers/programs, and expand community education, outreach and navigational services to improve community colorectal cancer control.

In order to strengthen the colorectal cancer specific capacity of CHRs, a series of three, two-day training workshops will be conducted over the one year course of the project. At a minimum, curriculum content will include: 1) colorectal cancer 101, 2) anatomy of the colon & rectum, 3) screening exams for colorectal cancer (stool card tests, flexible sigmoidoscopy, and colonoscopy), 4) bowel preparation procedures, 5) risk factors for colorectal cancer, 6) participation/recruitment strategies, 7) theories of health behavior change, and 8) strategies for addressing sensitive and/or stigmatized health issues. A mix of didactic

and interactive teaching strategies will be utilized, including role playing, interactive educational games, videos, anatomical models, survivor stories and field trips to observe sigmoidoscopy/colonoscopy equipment and procedures. Participants will also work together to develop several culturally appropriate colorectal health educational materials for use in community education and outreach (e.g. brochure(s), flipchart, radio public service announcements, etc.). All training materials developed through this initiative will be integrated into a tool kit and shared with tribal communities and tribal health boards throughout the country.

Because CHRs cannot be expected to work in isolation of the local health care system, the project will also strive to establish multidisciplinary colorectal health task forces in each of the participating communities. Initial project orientation meetings have been held to bring together community health providers/programs to discuss current efforts related to community colorectal cancer control, and to explore the feasibility of implementing and/or strengthening local navigational system(s) to enhance community participation in colorectal cancer early detection services. Invited individuals/groups have included: medical providers, health administrators, CHRs, tribal leaders, behavioral health, pharmacy, contract health, and cancer survivors. Quarterly meetings with the local colorectal health taskforce in each participating community will be conducted throughout the project year. These meetings will provide a forum for participating communities to 1) develop local action plans to strengthen local educational, outreach and navigational services related to colorectal cancer, 2) identify & address facilitating and constraining factors related to community colorectal cancer control, and 3) monitor progress in achieving proposed tasks/objectives. It is also anticipated that the establishment of multidisciplinary task forces will also strengthen collaboration between CHR programs and other health providers/programs in the participating communities.

For further information regarding this colorectal health initiative, please contact:

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Funding for this project was supplied by CDC, via the Indian Health Service, Office of Public Health Support, Division of Epidemiology and Disease Prevention.

## INDIAN HEALTH SERVICE TOBACCO CONTROL TASK FORCE

The IHS Tobacco Control Task Force has teamed up with the Office of Women's Health and the Health Resources and Services Administration in an effort to develop best practices to reduce tobacco use in young low SES women.

The Federal Collaboration to Make a Difference is a group of Federal agencies working in partnership to address issues related to tobacco use in young low socio-economic status (LSES) women, ages 18 to 35 years old, and their families. The Tobacco Collaborative has identified the clinical systems of the Indian Health Service and The Health Resources and Services Administration (HRSA). Selected pilot sites within these two systems will have two objectives;

Objective 1: Increase patients' (a) awareness of the dangers of tobacco use and second and third hand tobacco exposure, and (b) access to tobacco cessation interventions

Objective 2: Increase provider and health center competencies and capabilities in (a) engaging in dialogue to prevent and reduce patient tobacco use, (b) tracking patient tobacco use, and (c) reducing patient tobacco use.

A multi-site demonstration project is the first phase in the project. The tobacco collaborative team has identified settings for its efforts that include both medical/clinical (i.e., in a health center) and socio-ecological (i.e., where women live, work, play, and pray) approaches. 13 IHS/Tribal/Urban sites will be participating in the project.

For more information, contact Megan Woehr, Tobacco Control Specialist, at (602) 400-0850, or [megan.woehr@ihs.gov](mailto:megan.woehr@ihs.gov)



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INDIAN HEALTH SERVICE



DIVISION OF EPIDEMIOLOGY  
& DISEASE PREVENTION

## SOUTH DAKOTA TRIBAL PRAMS PROJECT

The Northern Plains Tribal Epidemiology Center (NPTEC) initiated collaboration with the Yankton Sioux Tribe, all South Dakota tribes, and South Dakota Department of Health to conduct the South Dakota Tribal Pregnancy Risk Assessment Monitoring System (SDT PRAMS). SDT PRAMS is the first tribal-specific and tribally-led CDC-funded PRAMS project; Yankton Sioux Tribe was the grant recipient of the SDT PRAMS.

The project began in April 2006. NPTEC assembled a Tribal Oversight Committee, which helped make decisions regarding project policies and procedures. In addition, a Steering Committee provided guidance on the survey instrument, project promotional materials, and data collection operational procedures. During the first year of funding, planning activities included protocol development, tribal consultation and approvals, and collaboration development with SD and ND Departments of Health. In 2007, project staff were hired and trained, including staff on all participating reservations. IRB approvals were obtained from AAIHS and CDC IRB. Data collection began in September 2007 and ended in June 2008. There were 1,299 women eligible to participate, and the project had an overall response rate of 72.9%. All data was turned into the CDC in summer of 2008 for cleaning, weighting and preparation for analysis. In late September 2008, SDT PRAMS received a weighted data set back from CDC and began analysis.

Preliminary results showed that 82% of women surveyed indicated they entered prenatal care within the first 13 weeks of pregnancy. As for breastfeeding practices, 67% reported breastfeeding or pumping breast milk at any point after delivery. Maternal tobacco use was also a topic of the survey, and 31% of participants indicated that they smoked at some time during the last three months of pregnancy.

To learn more about the results of the South Dakota Tribal PRAMS survey, please contact Jennifer S. Irving, MCH Epi Program Manager at (605) 721-1922 ext. 120, or by e-mail at [jirving@aatchb.org](mailto:jirving@aatchb.org)