OIT Newsletter

INDIAN HEALTH SERVICE ✛ OFFICE OF INFORMATION TECHNOLOGY

SEPTEMBER 2012

What's Inside

About This Issue

This issue provides updates on several major healthcare-related initiatives at IHS—MU, ICD-10, VistA Imaging. It includes the second article in the series on Telemedicine at IHS, this time focusing on trauma treatment.

On the technology side, read about how IHS is using social media—in this case, Facebook—and how mapping technology is arriving at IHS to help support healthcare services.

And, as always, get training updates from the OIT Training Coordinator.

Happy reading!

Hot Topic

Eligible Professionals and Meaningful Use

by JoAnne Hawkins, Sr. Healthcare Policy Analyst

Across the Indian healthcare system, the buzz has been about Meaningful Use: Have Eligible Professionals (EPs) met patient volume? Are they meeting their measures?

Congratulations to all the providers who have worked hard to participate in the CMS EHR Incentive program. I am pleased to say that 1700 Eligible Professionals have registered to participate in Meaningful Use, and 438 EPs at IHS/Tribal/Urban (I/T/U) facilities have received payments thus far of $8,947,070. There are EP payments still on the way.

For those who began participation, it is not over. In order to continue to receive payments, you must continue to demonstrate Meaningful Use. Here is what an EP needs to do in order to continue to receive incentive payments:

♦ If an EP participated in Medicaid for CY 2011, all they had to do was adopt, implement, and/or upgrade to a Certified Electronic Health Record (CEHR) and meet patient volume thresholds. For CY 2012, they will still need to meet patient volume thresholds, and will also need to *demonstrate Meaningful Use for a 90-day period*. The 90-day period can be any consecutive 90 days in CY 2012. *The latest date that the 90-day reporting period can start is October 3, 2012.*

♦ EPs who participated in Medicare for CY 2011 demonstrated Meaningful Use for a 90-day period. For CY 2012, they will need to *demonstrate Meaningful Use for a full 365-day period, starting on January 1, 2012 and ending on December 31, 2012.*

In order for Eligible Professionals to demonstrate Meaningful Use, they will need to meet or exceed the targets established for MU Performance Measures and Clinical Quality Measures utilizing a Certified EHR. There are 20 MU Performance Measures and 6 Clinical Quality Measures that must be reported on for EPs.

> NOTE: It is very important that EPs monitor their performance throughout their reporting period to ensure that they are meeting or exceeding the MU Performance Measure thresholds and to make any adjustment to workflow if needed to improve patient care and meet all targets.

For more information on how to demonstrate Meaningful Use, please go to http://www.ihs.gov/meaningfuluse/index.cfm?module=toolkit or contact your Area Meaningful Use Coordinator.

If you are an Eligible Professional who has not yet started to participate in Meaningful Use, please contact your Area Meaningful Use Coordinator for guidance or the Meaningful Use National Team at meaningfulteam@ihs.gov.

As a reminder, there are three stages to Meaningful Use: We are in Stage 1; Stage 2 is on the horizon, and targets and performance measures are increasing. Please keep an eye out for Stage 2 updates. Information is regularly distributed on the MU ListServ. Sign up for the ListServ at http://www.ihs.gov/listserver/index.cfm?module=signUpForm&list_id=168.

Hot Topic

ICD-10 RPMS Software Testing

by Catherine Holck, ICD-10 Test Manager
(with the assistance of Kathleen Keats, Janice Chase, Denise Grenier, and Catherine Moore)

The Indian Health Service (IHS) is one of many organizations that must transition from ICD-9 to ICD-10 by the recently published compliance date of October 1, 2014. ICD-10 is the latest revision of the International Classification of Diseases, first developed by the World Health Organization. ICD codes are used to classify disease and other health problems. The 10th revision is more granular than its predecessor, leading to a much greater ability to analyze health data.

The majority of Resource and Patient Management System (RPMS) modules will be affected by the transition to ICD-10. High-level requirements have been gathered, and design is underway. ICD-10-related development in RPMS is on an aggressive schedule; the new compliance date will allow additional time for changes and thorough testing. It will also allow for some adjustment in schedule if needed to accomplish other key initiatives, such as 2014 Certification for Stage 2 Meaningful Use.

A crucial part of the transition effort will be the effective testing of the modified RPMS software applications. First, the modules will be individually tested in a controlled OIT test area. Second, OIT will conduct internal end-to-end testing that will test software changes across the modules. Alpha testing in a test environment at selected sites will be followed by beta and user acceptance testing.

The complexity and reach of the ICD-10 transition across multiple RPMS applications will require intensive testing. However, OIT is prepared to assist beta test sites throughout the entire process by providing testing orientation, detailed test scripts and on-going guidance and support.

OIT is recruiting test sites, and at a minimum needs three hospitals and three clinics. Requirements for test sites include:

- Active use of major RPMS applications including the Electronic Health Record and iCare
- Use of both clinical and financial applications
- Use of both ICD-10-CM and ICD-10-PCS (at least one hospital site)
- An up-to-date RPMS database with the latest patches, including Code Set Versioning and the ICD-9 Dictionary patch
- Approval for participation by facility and Area leadership
- Commitment to attend alpha/beta test meetings

Testing is a critical step in software development. Beta test sites will have the opportunity to play an important role in this exciting and challenging effort and contribute to the successful delivery of ICD-10 ready RPMS software.

If you are interested in participating as an individual module tester or as an alpha/beta test site, please contact the ICD-10 Test Manager, Katy Holck, at Catherine.Holck@ihs.gov, or the Federal Lead, Jan Chase, at Janice.Chase@ihs.gov.

Hot Topic

VistA Imaging – Beyond Document Scanning

*by Carolyn Rhodes, IHS VistA Imaging Technical Consultant*

When you hear "VistA Imaging," do you think "Scanned Documents"? No wonder! The American Reinvestment and Recovery Act of 2009 (ARRA) provided an opportunity to accelerate the deployment of VistA Imaging across Indian Health Service, Tribal, and Urban Tribal (I/T/U) facilities through the centralized acquisition of hardware. VistA Imaging has now been implemented in all 12 Areas with more than 146 sites using VistA Imaging's Clinical Capture and Clinical Display software to store and display scanned documents. Image storage and provider access to those images are key components of the second stage of Meaningful Use, helping drive an increase in VistA Imaging implementation requests.
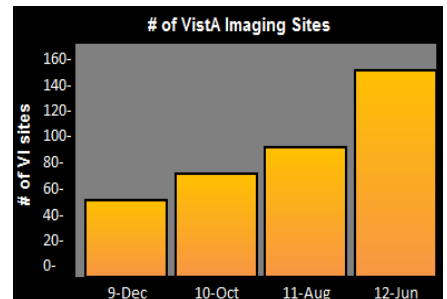
However, VistA Imaging is much more than a scanned document storage system. Developed by the Veterans Administration (VA) and distributed by IHS as its multimedia component for the RPMS EHR, VistA Imaging is an FDA-regulated medical device primarily developed as a Radiology PACS (Picture Archive and Communication System). A VistA Imaging system is capable of storing a wide variety of images from many different clinical and administrative sources. With proper configuration, hardware, and support, VistA Imaging will store and display Diagnostic Radiology, Dental, Ophthalmology, Endoscopy, Lab, Wound Care, Photo ID images, and more.

There are currently more than 30 facilities using VistA Imaging for Radiology image storage. Many of these facilities forward their studies to outside reading services. Several facilities, though, have onsite or offsite radiologists using VistA Imaging's VistARad Diagnostic Display software for primary interpretation. In addition to Radiology use, some facilities are taking advantage of VistA Imaging for Ophthalmology image storage and display, Patient Photo ID programs, and when interfaced with GE Muse, to display EKG tracings.
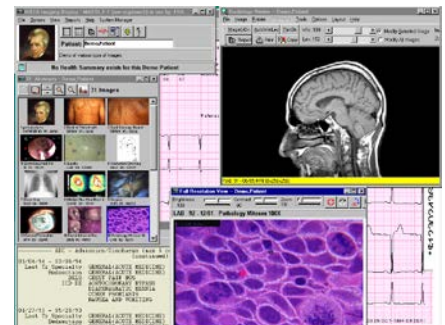
In the past, IHS deployment of VistA Imaging and its many functions has been about two years behind VA due to the need to recode the software to fit IHS use. We are currently working with VA Development to close that gap. MAG Patch 123 will give IHS the ability to test new patches concurrently with VA sites and release those patches on the same schedule. MAG Patch 123 is currently being tested at several IHS and Tribal sites and is expected to be released to all sites in the first quarter of FY2013.

VistA Imaging - Beyond Document Scanning *continued*

The IHS VistA Imaging Program Office continues to support the deployment of VistA Imaging throughout I/T/U facilities. Once the software gap between VA and IHS is closed and the MPIF is in place, we look forward to the many uses of VistA Imaging as yet untapped.

So, when you think of VistA Imaging in the future, think "Possibilities"!

Hot Topic

Patient Education Protocols and Codes (PEPC) for 2013

by Mary Wachacha, IHS Health Education Program

In May 2012, Dr. Dominique Toedt, Chair, convened the annual meeting of the Patient Education Protocols and Code Committee to revise and add new 2012 education protocols to RPMS. These new protocols and codes will be released for 2013. Ten new topics join the PEPC developed in previous years. (See the lists below for new topics.) As always, the Committee welcomes suggestions for new topics.

After two years of extensive work between the IHS Health Education Program and OIT, the IHS has partnered with the Tanana Chiefs Conference, Fairbanks, Alaska, to incorporate the documentation of health education offered by the Community Health Aide (CHA) and Community Health Practitioners (CHP) into RPMS and the National Data Warehouse. This education is reflective of the Community Health Aide program manual. As needed, the Tanana Chiefs Conference will now be able to report to governing bodies on the education provided by the CHA/CHPs within their area. This combined effort affects the future for the rest of the CHA/CHPs programs throughout Alaska Native Country. The Community Health Aide Program Patient Education Codes and Protocols will now be deployed to multiple Tribes/Tribal clinics throughout Alaska, thus improving patient care and helping to unify the patient record.

New EHR enhancements for health education include the development of an **Info** button for a direct link to Medline Plus. This enhancement enables the healthcare provider to highlight a medication, lab result, or problem from the patient's medical record and retrieve a patient education handout. After reviewing the handout with the patient, the provider is prompted to document the education. This helps to increase patient knowledge as well as assist providers in meeting the Meaningful Use performance measure for patient specific education.

New Clinical Patient Education Protocols and Codes

- Infertility
- Polycystic Ovary Syndrome (PCOS)
- Erectile Dysfunction
- Diabetes-related sexual dysfunction
- Multiple Sclerosis
- New Optometry protocols
- Infection Prevention
- Emergency Contraception
- Diarrhea

New Behavioral Health Protocols and Codes

- Selective Mutism
- Communication Disorders

Contact Information

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Tele-health

Tele-Trauma in Indian Country

by David R. Boyd MDCM, FACS; Jacqueline M. Dowell MD; and Mark Carroll MD

Dr. David R. Boyd,
"the Father of Trauma and
Emergency Medical Services
(EMS) Systems"

Editor's Note: This is the second in a series of articles adapted from the *Tele-Trauma and Tele-Acute Care Medicine* manual created by the IHS Trauma Care and Injury Prevention Program (TCIPP).

Trauma is unpredictable. Consequently, it is critical that trauma systems of care select the best enabling innovation and tools to meet the needs of diverse and difficult situations. The telephone is insufficient. One can imagine how poorly a consult may transpire when a trauma surgeon on the other end of the phone is currently in the operating room treating a completely different patient. Clamping one vessel while discussing the CT of another patient hundreds of miles away is a less than ideal consultation format. In addition, in IHS Tribal hospitals, trauma typically occurs when ED staffing is limited. The unpredictable nature of Nature, coupled with variations in staffing and trauma skills, necessitates a fresh review of telemedicine tools so that better system designs can improve patient outcomes. Previously purchased Tele-Trauma video equipment is often unused or forgotten in a closet, while the trauma patients are stabilized and transferred to the regional trauma center.[1] Advanced telemedicine and telecommunication technology must be readily available when needed, and staff must be familiar with its use. Recent experience and trauma-specific infrastructure development now make telemedicine particularly beneficial to trauma care.

One approach is to expand to "scale" some of the currently available Tele-Trauma applications. Such applications learn from and inform experiences in stroke management and other subspecialty care. An infrastructure of people, hardware, and software—built to support trauma care— can be adapted to many locations and other applications to improve the care of American Indians and Alaska Natives.[2] Exquisite, timely, accurate, and cost-effective diagnosis and care in remote locations is enhanced through the use of this infrastructure and system design.

Rapid connectivity is needed for accurate early diagnosis and treatment decisions. Patients can now be co-managed via local and distant medical staff to a degree not permitted in the past. The old image of bedside consultation with a specialist and the patient's primary physician can now be performed with the medical team hundreds to thousands of miles apart. Medical professionals can discuss the interpretation of the exact same images, physical exams and treatment options as if present together at the patient's bedside. This history of consultation within the medical field is "business as usual" since consultants have for years provided consultations based on, at least in part, review of medical images forwarded to them. Image review that formerly took days (e.g., x-ray films or CDs sent via UPS, courier, and other means) can now be securely and reliably accomplished in minutes.[3] Improved patient care, improved triage, improved outcomes, and subsequently improved cost-effectiveness have been demonstrated in the examples found below.

[1] Boyd, David. ""Smart Phones and Tele-Trauma" September 8, 2011 Chief Medical Officer's Rounds." Message to LISTSERV-Trauma, Emergency Medicine, and Emergency Medical Services. 30 August. 2011. E-mail.
[2] Carroll, Mark. "RE: MORE GLORY FOR YOU." Message to David Boyd. 16 Nov. 2011. E-mail.
[3] Boyd, David. "IMEDON." Message to Jackie McDowell. 7 Nov. 2011. E-mail. Specific File: Indian Country - UNM IMEDCON Connectivity.doc.

Tele-Trauma in Indian Country continued

Trauma efforts throughout Indian Country are founded on the basis of the successful national Trauma and Emergency Medical Services System (EMSS). From this foundation comes the concept of **Regionalization** which applies to the Tele-Trauma organization.[4] Regionalization of trauma care is the resolution of two immutable facts that make trauma care unique and challenging; i.e.:

- ◆ Trauma or injury is a time-dependent disease.
- ◆ Trauma care is geographically determined.

The best possible response to this conundrum is to develop plans and implement programs that take into account and mitigate the inevitable tension while maximizing the available and upgradeable local resources internally within a designated geographic region. Trauma/EMSS are built today for tomorrow's injuries. Regional Trauma and EMS Systems are the proven method for providing expert response, field care, and transport to hospitals and allowing for secondary transfer to pre-designated advanced Regional Trauma Centers (RTC). Semi-random behavior and guess-working the system are dangerous, ineffective, inefficient, and discouraging.   A recent Institute of Medicine (IOM) study on the "Future of Emergency Care in the U.S. Health System" (2007) outlined the many current and obvious problems in our nation's emergency medical systems. The IOM importantly recommended "Regionalization" for the Nation's Crisis in Emergency Medical Care.[5]

IHS Providers are well aware of and experience most of these "lack of consistent regionalization" problems on a daily basis. These seemingly intractable issues in Indian Country reflect national findings, but local circumstances are typically worse. Many of the AI/AN trauma problems are obvious and well known: They are not, however, well understood. Trauma care disparities issues do exist, persist, and are documented. Unfortunately prior to TCIPP they were not correctly or strategically analyzed with a goal of tactical resolution. Without a new paradigm, these problems will continue, at high costs and with excessive drain on limited resources and capabilities. Native American community expectations of appropriate EMS response and sophisticated definitive care, however, are justifiably in line with those of the general and rural population. This old problem demands new thinking.

Trauma care has improved over the past 40 years in all regions, communities, and sectors. IHS has the talent and expertise and can improve trauma capabilities throughout the entire system—the pre-hospital, hospital, and advanced care components. Trauma system enhancements will also improve surgery, medicine, and primary care. Hospitals should strive to improve their trauma capacity and actively participate in their Regional Trauma/EMS System. The medical staff needs to identify a "First Option" Regional Trauma Center (FORTC) and establish dependable inter-hospital Transfer Agreements (TA). Our limited TCIPP project funding and programs are dependent on establishing that inter-hospital relationship. From this, all involved can work towards perfecting a 24/7 dependable "Seamless Operation" for the many essential operating components that need improvement and support.

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[4] Boyd, David. "FW: TRAUMA, EM, EMS LIST-SERVE #2 TRIAGE AND TRANSFER." Message to Avery, Charlene; Karol, Susan; Hunt, Richard; Elizabeth Holguin; J. L. Green MD; et al. 23 Nov. 2011. E-mail.
[5] Consensus Report: Hospital-Based Emergency Care: At the Breaking Point. Institute of Medicine. Web. 13 Jun 2006.

Tele-Trauma in Indian Country continued

Once identified and incorporated, these selected FORTCs have responded and are now committing their talent and resources with technical assistance to common problems. This includes:

- Regional team and co-managed patient care
- Transfer acceptance
- Transport and communications guidance
- Professional education and training
- Administrative support for improved trauma care
- Systems operations in their regions

In several areas, these relationships are further enhanced with Tele-Radiology and Smart Phone technology. Ideally, these lessons from trauma care can be applied to the use of telemedicine regarding spine injury, stroke management, general torso trauma, and other medical specialties with essentially the same models of referral.[6]

Major trauma is not a single disease but a spectrum of injury producing effects causing death and disability. Leading clinical patterns are:

- Central nervous system injuries to the brain and spinal cord
- Thoraco-abdominal visceral injuries
- Crippling orthopedic injuries.

These present in a variety of complex multi-injury patterns and occur in all ages, but are most damaging to the young. Increasing numbers of critical trauma patients with greater magnitudes of injury can have a negative impact and destabilizing effect on our hospitals and medical staffs. In addition, inadequate regional support, limited ongoing training, and the lack of currently available diagnostic technologies (e.g., CT scanners) have negative consequences on patient care and on medical and nursing staff retention and recruitment.

Despite these challenges, the recognized issues of the rural setting, poverty, and delayed access to regionalized trauma care are not insurmountable. Volumes of scientific documentation now exist and studies have shown that regionalized trauma care saves lives and decreases morbidity for all clinical injury patterns. Integrated regional trauma systems can also control ill-advised, expensive, and risky behavior like unnecessary secondary helicopter transports. The geographic basis for successful regional trauma care utilized in the national Trauma/EMSS program (1974-83) will be detailed in the next article in this series. These patterns and arrangements have remained operational to current times.

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[6] Boyd, David. "More stuff." Message to Jackie McDowell. 7 Nov. 2011. E-mail. Specific File: TCIPP FOR UNM TELE-RADIOLGY CONFERENCE 16 SEPT 11 .ppt.

News to Use

Facebook – Media for the Masses: How does IHS use it?

by Denean Standing-Ojo, Assistant Web Services Manager

If you are anything like me, you have a personal love-hate relationship with the world's most popular social networking site. But with 955 million monthly *active* users as of June 2012, it is difficult to ignore the ability that Facebook holds to reach people, and how much it is incorporated into people's daily lives. For the Indian Health Service (IHS), Facebook provides a unique opportunity to extend our digital reach beyond **IHS.gov** and e-mail LISTSERVs. Facebook pages allow us to reach patients, prospective health professionals, and the tribal communities we serve at a place they are already comfortable going.

Since the release of the *Standard Operating Procedure (SOP) for Facebook* in December of 2010, IHS Facebook pages have been slowly gaining momentum. Areas, Service Units, and agency-wide programs use Facebook to share:

♦ Events
♦ Public health information
♦ Recruitment activities
♦ Emergency response information
♦ Agency-wide messages
♦ Pictures

The current reach of our IHS pages is over 2,100 people, with many of our pages having well over 100 "likes." Some of our most popular pages are at the Service Unit level, where they are able to post relevant real-time information and interact directly with people in their communities. Area pages are a great venue for sharing job postings, overarching public health messages, and emergency response information. Our agency-wide programs are able to transcend some of the locality-based information and share overarching events, job postings, and IHS-wide activities. Our Facebook pages include:

♦ Billings Area
♦ Catawba Service Unit
♦ Chinle Service Unit
♦ Fort Peck Service Unit
♦ Health Promotion Disease Prevention
♦ IHS Health Professions Recruitment
♦ IHS Pharmacists

♦ Nashville Area
♦ Oklahoma City Area
♦ Passamoquaddy Indian Health Township
♦ Warms Springs Service Unit
♦ Whiteriver Service Unit
♦ Yakama Service Unit

If you are interested in starting a Facebook page, the first step is to read the requirements in the SOP, and then you can submit a *Request for Social Media*. Questions and comments about Facebook or social media in general can be emailed to socialmedia@ihs.gov.

Technology Update

Mapping Our Way to Improve Tribal Health Services

by Larry Layne, Division of Epidemiology & Disease Prevention

If a picture is worth a thousand words, then a map must be worth hundreds of thousands, because a map is a picture that is designed to speak. A map is built from real-world data, and its primary intent is to convey that real-world information. This is the real strength of a map—that it can convey a lot of information at one time to a lot of different people with differing viewpoints, because everyone understands a map.

Most people have seen the Culture of Caring map created by Michael Durkin, formerly in Public Affairs. This map was created in 2006 and has been very helpful for visualizing several key geographic features important in IHS. These include IHS Administrative Areas, IHS Area Office locations, Health Facilities (broken down by hospital, health center, and health station), Tribal Epidemiology Centers, and the relationship of all of these to U.S. states. Although quite useful, the Culture of Caring map is limited because it's a static map printed on paper, and if you want to update this map with 2012 information or see what an IHS map would look like from 1996, then you'd have to re-draw this map and print the new one.

Mapping Our Way to Improve Tribal Health Services continued

The more contemporary approach for storing and visualizing information of a geographical nature is to use **Geographic Information Systems** (GIS). What is a Geographic Information System? A simple definition would be that it's an electronic mapping tool, used, for example, to show what health facilities are found in a specific Service Unit and what communities are near them; to show where position vacancies are the most prevalent and the most critical; or to easily identify locations of healthcare resources for emergency preparedness planning. These examples demonstrate how things can be mapped and easily visualized rather than making one cross-eyed, trying to glean the same information from a table. But a GIS can do a lot more than just make maps because of all the analytical tools available in the software. For instance, the question, "What is the total amount of IHS ARRA funds spent in my congressional district?" can be very easily answered using a GIS. Another useful analytical application is to compute and display 30, 60, and 90-minute drive-times around health facilities.

Creating a GIS and maintaining data that feeds it is no simple task, especially at an agency level. This is why a group of enthusiastic and dedicated individuals from three different offices (OPHS, OEHE, OIT) got together and formed a GIS working group. This group has developed and implemented an agency-wide GIS for IHS. To start, the GIS working group determined two primary purposes for establishing an agency level, or enterprise, GIS. The first was that a few carefully selected layers would be created and maintained in a centralized location, which would then become a one-stop shopping place for geographic data. That way, users can be assured of a consistent and reliable data source. The second purpose was to ensure that everyone in IHS, as well as its tribal partners, had access to the geographic layers. These centralized geographic data layers are not limited to any specific project or group. They are available to everyone.

The first application arising from this enterprise GIS effort was the Find Health Care web application (http://www.ihs.gov/findhealthcare/) accessed from the IHS home page. Another application recently launched contains more GIS functionality and can be seen at http://www.ihs.gov/maps/. The GIS working group invites you to take a look at both of these web sites, look around a bit to see what's there, and imagine how you can begin integrating maps into your work.

News to Use

RPMS & EHR Training Update
By Kimberlee Crespin-Richards, Training Coordinator

Completed Training

During the past quarter (April – June 2012), the Office of Information Technology (OIT) sponsored and completed the following training for the Resource and Patient Management System (RPMS) and the Electronic Health Record (EHR):

AREA	SESSIONS	EST. PARTICIPANTS
Aberdeen	7	55
Albuquerque	10	136
Alaska	7	50
Bemidji	10	120
Billings	7	78
California	10	95
Nashville	11	112
Navajo	8	201
Oklahoma City	10	122
Phoenix	4	41
Portland	7	57
Tucson	3	38
eLearning	43	735
TOTALS	137	1840

Scheduled Training and Registration

To register for OIT sponsored RPMS and EHR training, please visit the following link:

http://www.ihs.gov/RPMS/index.cfm?module=Training&option=index&sortChoice=Title&newquery=1

Contributors

- **Dr. David R. Boyd** recently retired as the IHS National Trauma Systems Coordinator in the Office of Emergency Services (ES). He was the COTR of the IHS-UNM Tele-Radiology project, Co-Innovator of the IHS-UAZ "Smart Phone" project, and the IHS representative to the Federal Inter Agency Committee for Emergency Medical Services (FICEMS) and Council on Emergency Medical Care (CEMC). Today, he serves as an Advisor to the Executive Director of the National Accreditation Alliance of Medical Transport Applications (NAAMTA).

- **Kimberlee Crespin-Richards**, a DNC Contractor, is the OIT Training Coordinator, based in Albuquerque NM.

- **JoAnne Hawkins** is the Sr. Healthcare Policy Analyst (DNC Contractor) on the Meaningful Use National Team, based in Albuquerque NM.

- **Catherine ("Katy") Holck**, MBA, MPH, is a business analyst with Data Networks Corporation, managing the OIT testing for ICD-10. Katy is based in Tucson Arizona.

- **Larry Layne** is a Statistician in the Division of Epidemiology & Disease prevention in Albuquerque NM. He is responsible for working with the Tribal Epidemiology Centers, analyzing and producing reports from the IHS General Data Mart, and manages the Influenza-like Illness Awareness Surveillance system.

- **Carolyn Rhodes** is the IHS VistA Imaging Technical Consultant and works for the IHS VistA Imaging Program Office. She is based with OIT HQ and located in Prescott AZ.

- **Denean Standing-Ojo** is the Assistant Web Services Manager, responsible for policy development, usability, quality control, and assisting in management of web activities for IHS. She is based in Rockville MD.

- **Mary Wachacha** is the Lead Consultant, IHS Health Education Program, responsible for oversight of all education provided within the Indian Health Service. She is based in Rockville MD.

About the OIT Newsletter

The IHS OIT Newsletter is sponsored by Acting **IHS CIO Dr. Howard Hays.** It is published several times throughout the year, with the objective of communicating IHS Office of Information Technology activities to all IHS personnel.

All articles and suggestions for articles are welcome. If you would like to submit an article or have any questions regarding this publication, please contact the editor, Heli L. Roosild, at: Heli.Roosild@ihs.gov. *(All articles are subject to change without notice.)*