



THE IHS PRIMARY CARE PROVIDER



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April Is STD Awareness Month, So GYT!

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Many of our STD/HIV prevention partners are working hard to address the education and prevention needs of their respective communities and are helping to further the efforts of GYT. This month's Primary Care Provider provides unique, relevant, and up-to-date information about STD prevention interventions, disease management, and educational tools that can be useful in developing capacity, evaluating services, and enhancing care.

We have included a number of articles highlighting the intersection between technology and adolescent health, and how new media channels are creating innovative opportunities for disseminating sexual health information. STD management is a continually evolving and changing field. Those who provide care must have the most current and up-to-date guidance; included are several pieces discussing new treatment recommendations and how STD/HIV screening and treatment services can create opportunities for improving care. Identifying creative ways to educate, advocate, and evaluate STD prevention efforts is essential to meeting the needs of our patients and the providers who serve them. We've highlighted a number of activities and materials from the field that are working toward educating the community and improving and standardizing care. We hope that the spectrum of information and resources presented will be useful in your program's efforts to address the STD prevention needs of your community.

We encourage you to help spread the word regarding the GYT campaign and to support GYT activities in your local community. To learn more about how you can support STD Awareness Month and the GYT campaign in your community, we invite you to visit CDC's STD Awareness Resource Site (www.cdc.gov/stdawareness) and the GYT campaign (www.itsyoursexlife.com/gyt).

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The IHS National STD Program

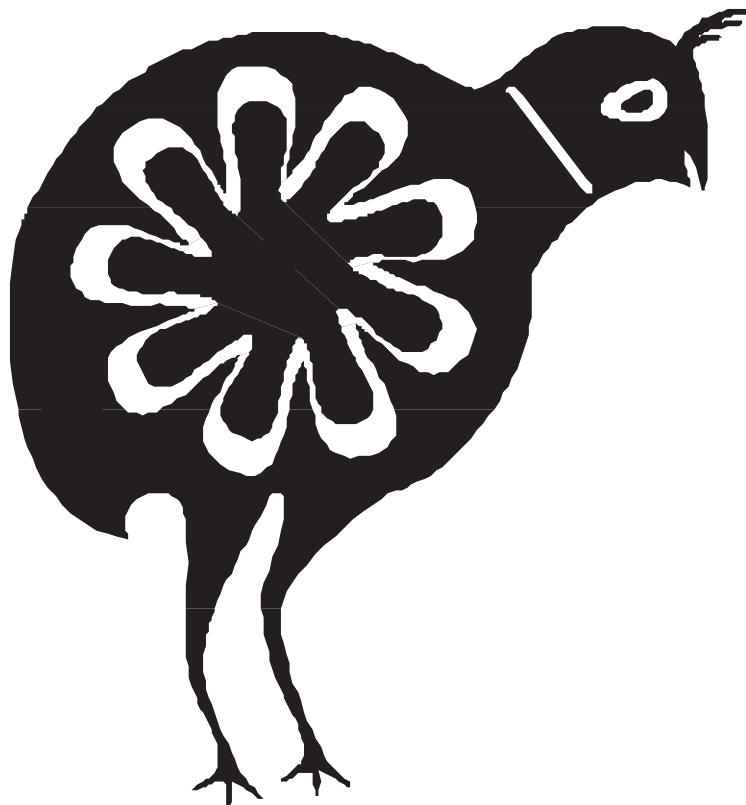
CDC and IHS have collaborated for more than ten years to support the IHS National STD Program. The program is managed and operated by 2.5 FTEs, all of whom are CDC staff assigned to work on AI/AN issues. Scott Tulloch (Program Manager) and Lori de Ravello (Public Health Advisor) are based in Albuquerque, New Mexico; Dr. Melanie Taylor (Medical Epidemiologist) is based in Phoenix, Arizona and supports the program half-time.

The program's goal is to support tribes, IHS facilities, and urban Indian health programs to improve STD

prevention and control efforts. By leveraging partnerships, the program is able to extend itself across Indian Country in support of prevention interventions, surveillance efforts, service delivery improvement, and outbreak response.

This is the second year that the National STD Program has presented a special April issue of The IHS Provider to draw attention to STD Awareness Month; the noteworthy efforts of the program and its partners are reflected throughout the articles.

For more information about the IHS National STD Program, visit <http://www.ihs.gov/epi>.



2010 CDC STD Treatment Guidelines

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In December 2010, the CDC issued updated STD treatment guidelines. This article highlights some of the major changes in these evidence-based guidelines, which were last revised in 2006. A summary table of recommended treatment regimens developed by the CA STD/HIV Prevention Training Center (CA PTC) for Federal Region IX is also included. Please refer to the complete 2010 CDC guidelines as well as tools such as the CDC's wall chart summary table and pocket guide of treatment recommendations at <http://www.cdc.gov/std/treatment/2010/default.htm>. Additional STD resources and information on STD training can be found at California STD/HIV Prevention Training website <http://www.stdhivtraining.org> and the National Network of Prevention Training Center website <http://www.stdpreventiontraining.org>.

Prevention of STDs

The 2010 guidelines encourage health care providers to routinely obtain sexual histories and provide prevention counseling. For sexually active adolescents and adults at high risk for STDs or HIV the United States Preventive Services Task Force (USPSTF) recommends high-intensity behavioral counseling. In addition, the guidelines note that patients seeking an STD evaluation should be informed about the specific tests that will be performed as part of their evaluation.

The use of vaccination as a primary prevention method is emphasized, as there are now three vaccine preventable STDs: hepatitis A virus (HAV), hepatitis B virus (HBV), and human papillomavirus (HPV). There are two HPV vaccines, a quadrivalent vaccine (Gardasil) and a bivalent vaccine (Cervarix). Both HPV vaccines can be used to prevent cervical precancer and cancer for females ages 9 - 26 years. The quadrivalent HPV vaccine can also be used as genital wart prevention for males and females ages 9 - 26 years. Recommendations to provide hepatitis B vaccine to all unvaccinated persons seeking an STD evaluation and hepatitis A vaccine to all men who have sex with men (MSM) and injecting drug users remain unchanged.

Pregnant Women

Recommendations to screen in early pregnancy for HIV, syphilis, hepatitis B, chlamydia (CT), gonorrhea (GC) (for women at risk) and hepatitis C (for women at high risk) remain unchanged. The guidelines now emphasize that women diagnosed with CT or GC during the first trimester should be

retested within 3 - 6 months, preferably in the third trimester. There is no evidence to support routine testing of asymptomatic pregnant women for bacterial vaginosis (BV) or trichomoniasis.

Men Who Have Sex With Men (MSM)

The guidelines recommend annual screening for STDs, including HIV, CT (rectal and urethral), syphilis, and GC (rectal, pharyngeal and urethral), as well as vaccination against hepatitis A and B. Nucleic acid amplification tests (NAATs) are the test of choice for CT and GC. More frequent screening at 3 - 6 month intervals is recommended for MSM who report multiple or anonymous partners, sex in conjunction with illicit drugs, or who have partners engaging in these activities. New additions to the screening recommendations for MSM include 1) type specific HSV-2 serology in MSM with unknown HSV-2 serostatus; 2) hepatitis B surface Antigen (HBsAg) screening for all MSM; and 3) hepatitis C infection (HCV) screening among MSM who are newly diagnosed with HIV infection and to evaluate new and unexplained elevations in alanine aminotransferase levels among HIV-infected MSM.

Chlamydia (CT)

Treatment regimens remain unchanged, with azithromycin 1 g orally in a single dose or doxycycline 100 mg orally twice daily for 7 days as the recommended CT regimens for non-pregnant women, adults, and adolescents. CT screening for sexually active females age ≤ 25 years continues to be recommended with consideration of male screening in clinic settings with high prevalence, such as adolescent clinics, correctional settings, and STD clinics. NAATs remain the most sensitive tests for CT; vaginal swabs (self collected by the patient or obtained by the provider) perform at least as well as other approved NAAT specimens and are readily acceptable by women.

Partner referral for treatment is the optimal management choice, but if partner follow-up is unlikely, patient-delivered partner therapy (PDPT; also Expedited Partner Therapy, EPT) is an option for heterosexual patients. Re-testing for CT 3 months after treatment is now recommended for both women and men. Treatment regimens for pregnant women continue to be azithromycin 1 g orally in a single dose or amoxicillin 500 mg orally three times a day for 7 days. Test-of-cure (TOC) 3 - 4 weeks after treatment for pregnant women is recommended. In addition, there is new guidance to retest for CT 3 - 6 months after treatment among pregnant women.

Gonorrhea (GC)

Cephalosporins are the only class of antibiotics that are recommended and available in the US for GC treatment. Several important changes have been made to the recommended regimens for uncomplicated GC infection of the cervix, urethra, and rectum 1) ceftriaxone at 250mg IM is the preferred antimicrobial agent (an increase from the prior recommended 125 mg dose); 2) although cefixime 400 mg orally in a single dose is included as second recommended regimen, CDC highlights that it should be used only when ceftriaxone is not an option given lower bactericidal levels with cefixime; 3) dual therapy is recommended with addition of azithromycin 1 g orally in a single dose or doxycycline 100 mg orally twice daily for seven days; 4) dual therapy is recommended regardless of whether ceftriaxone or cefixime is used, and regardless of CT test result. The rationale behind these changes include increasing concerns about cephalosporin resistance, reports of ceftriaxone treatment failures, and the improved efficacy of ceftriaxone 250 mg in pharyngeal infections. For pharyngeal GC the only recommended regimen is ceftriaxone 250 mg IM plus azithromycin 1 g orally in a single dose or doxycycline 100 mg orally twice daily for seven days.

Re-testing for GC 3 months after treatment is emphasized. Partner referral for treatment is the optimal management choice but if partner follow-up is unlikely, PDPT is an option for heterosexual patients. Management of patients with suspected GC treatment failure is addressed in more detail in the guidelines and includes consultation with an ID specialist, culture and susceptibility testing, retreat with at least ceftriaxone 250 mg IM or IV, ensure partner treatment, and report to CDC via local health departments.

Pelvic Inflammatory Disease (PID)

Testing for GC and CT prior to treatment of PID is recommended. Cephalosporins are the main class of antibiotics used in both oral and parenteral PID regimens. Recommended regimens are cephalosporin plus doxycycline, plus metronidazole when BV is present or cannot be ruled out. Clindamycin plus gentamicin remains as an additional recommended parenteral regimen. When cephalosporin therapy is not feasible, the use of fluoroquinolones can be considered if the risk of GC is low, a NAAT test for GC is performed, and follow-up of the patient is likely. If GC is documented, a test using bacterial culture should be performed and the patient should be re-treated with the recommended ceftriaxone and doxycycline regimen. The guidelines contain a new recommendation to use a parenteral cephalosporin regimen in the following scenarios: 1) if there is documented fluoroquinolone resistance; or 2) if culture testing is not feasible (e.g., only NAAT testing is available). In these scenarios, if cephalosporin therapy is not possible and a fluoroquinolone regimen is used, azithromycin 2 gm orally as a single dose should be added.

Syphilis

Syphilis and other genital ulcer diseases increase the risk of HIV acquisition and transmission. The guidelines continue to recommend testing for HIV among all patients diagnosed with syphilis (male or female). Long-acting preparations of penicillin remain the treatment of choice for all stages of syphilis, regardless of HIV status. Inappropriate use of procaine-benzathine penicillin (Bicillin-CR®) instead of benzathine penicillin G (Bicillin-LA®) has been reported, and may result in treatment failure and complications such as neurosyphilis. Benzathine-procaine penicillin combinations and oral penicillin are not effective for the treatment of syphilis. Alternative therapies such as doxycycline are less efficacious and should only be used if there is a medical contraindication to benzathine penicillin G; close follow-up is essential in these patients. Azithromycin-resistant *Treponema pallidum* has developed in several areas of the US, thus limiting its use as an alternative agent. Azithromycin should be used with caution and only in the scenario of penicillin allergy and when doxycycline is not feasible. Azithromycin should not be used for pregnant women or MSM. The guidelines now emphasize that HIV-infected persons should be treated according to the same stage-specific recommendations for primary, secondary, and latent syphilis as is used for HIV-negative persons. Available data demonstrate that additional doses of benzathine penicillin G, amoxicillin, or other antibiotics in early syphilis do not result in enhanced efficacy, regardless of HIV status.

Criteria to obtain cerebrospinal fluid (CSF) evaluation with a lumbar puncture have been updated. The new recommendations for CSF evaluation include 1) patients with signs or symptoms of neurologic disease (e.g., meningitis, hearing loss, auditory disease, cranial nerve dysfunction, stroke, altered mental status and loss of vibration sense) or ophthalmic disease (e.g., uveitis, iritis, neuroretinitis, and optic neuritis); 2) patients with evidence of tertiary disease (e.g., aortitis and gumma); or 3) serologic treatment failure. In addition, patients with ophthalmic or otologic signs or symptoms should have slit lamp ophthalmologic evaluation and otologic examination.

The standard method for syphilis screening involves using a non-treponemal test (RPR or VDRL) as the first test and then confirming a reactive result with a specific treponemal test (TP-PA, FTA-ABS or EIA). The guidelines contain an expanded discussion on the use of automated treponemal tests (EIA and chemiluminescence immunoassay) as first line tests for syphilis screening by some clinical laboratories and blood banks. These tests may have a lower positive predictive value if screening a low prevalence population, so false positive results can occur. Guidance on how to manage a positive treponemal screening test is available (CDC. Discordant results from reverse syphilis screening - five laboratories US 2006 - 2010. *MMWR*. 2011;60 (05):133-137).

Genital Herpes

Although screening in the general population is not recommended, serologic testing for HSV-2 using type specific (glycoprotein G) tests may be useful in patients with 1) recurrent or atypical symptoms and negative HSV culture results; 2) clinical diagnosis of herpes without laboratory confirmation; or 3) a partner with a history of symptomatic genital herpes. Serologic screening should also be considered for HIV-infected persons, MSM at increased risk for HIV acquisition, and persons presenting for STD evaluation with high risk (multiple sex partners). The use of IgM testing for HSV is not recommended because these tests are not type-specific and because these tests may be positive during recurrent herpes.

A new regimen of famciclovir 500 mg once, followed by 250 mg twice daily for two days has been added to the episodic therapy for recurrent genital herpes section. Acyclovir, famciclovir, and valacyclovir appear equally effective when used for episodic therapy, however the guidelines contain new information that famciclovir appears somewhat less effective for suppression of viral shedding.

Vaginitis

Bacterial Vaginosis (BV): Tinidazole 2 g orally once daily for two days and tinidazole 1 g orally once daily for five days have been added as alternative regimens. A DNA probe test (Affirm VP III) and a prolineaminopeptidase test card (Pip Activity TestCard) are two tests noted in the guidelines to have acceptable performance characteristics when compared to Gram stain (gold standard test for BV). These point-of-care tests are useful if Gram stain or pH and wet mount microscopy evaluation are not available.

Trichomoniasis: The recommended regimens to treat trichomoniasis have not changed and are metronidazole 2 g orally in a single dose or tinidazole 2 g orally in a single dose. For HIV-infected women the guidelines suggest consideration of metronidazole 500 mg two times a day for seven days based on recent limited data. Screening for trichomoniasis among sexually active women newly diagnosed with HIV is now recommended. The guidelines contain updated diagnostic evaluation for trichomoniasis including 1) trichomoniasis culture should be obtained in women whom trichomoniasis diagnosis is suspected but not confirmed by wet mount microscopy; 2) an adaptation to one NAAT (APTIMA Combo2) allows trichomoniasis testing to be added to vaginal or endocervical swabs and in urine from women and men; to use these *T. vaginalis* specific reagents, laboratories need to perform CLIA verification studies; 3) trichomoniasis culture of urethral swab, urine, or semen in men is an option but NAATs

have superior sensitivity in men.

Vulvovaginal candidiasis (VVC): Two new regimens have been added to the recommended regimens for treatment of VVC. These regimens are Clotrimazole 2% cream 5 g intravaginally for 3 days and miconazole 4% cream 5 g intravaginally for 3 days. Both clotrimazole vaginal tablet regimens have been deleted from the recommended treatments.

Cervicitis

Women with either 1) mucopurulent endocervical exudate or 2) cervical friability (bleeding easily induced by passage of swab through os) should be tested for GC and CT and be evaluated and treated for trichomonas and BV if present. NAAT testing can be by vaginal swab, cervical swab, or urine. Recommendations for presumptive therapy for CT and when to consider GC therapy are unchanged. Presumptive therapy for CT should be provided in high-risk women (age < 25 years, new or multiple partners, unprotected sex); concurrent therapy for GC is indicated if local prevalence is high (>5%) or the patient is at high risk. Empiric treatment of other women should be based on individualized risk assessment and likelihood of follow-up. Retesting is now recommended at 3 - 6 months if CT or GC was diagnosed.

Urethritis

The guidelines contain new information on the association between *Mycoplasma genitalium* (MG) and nongonococcal urethritis (NGU) with MG accounting for 15 - 20% of NGU cases in the US. The importance of partner therapy for males diagnosed with NGU regardless of whether a specific etiology is found is emphasized, including a new recommendation for empiric CT treatment for all sex partners in the past 60 days. Retesting is now recommended at 3 - 6 months if CT or GC was diagnosed.

HPV

As mentioned in the STD prevention section (see above) there are now two HPV vaccines licensed in the US.

The quadrivalent vaccine and the bivalent vaccine both offer protection against HPV types that cause 70% of cervical cancers; the quadrivalent vaccine also protects against HPV types that cause 90% of genital warts. Women who have received the HPV vaccine should continue routine cervical cancer screening because the vaccine does not address 30% of cervical cancers caused by HPV types not included in the vaccine. The guidelines contain a new patient applied treatment regimen for patients with genital warts; sinecatechins 15% ointment applied three times daily for up to 16 weeks.

California STD Treatment Guidelines Table for Adults & Adolescents 2010

These guidelines reflect the 2010 CDC STD Treatment Guidelines and the Region IX Infertility Clinical Guidelines. The focus is primarily on STDs encountered in office practice. These guidelines are intended as a source of clinical guidance; they are not a comprehensive list of all effective regimens and are not intended to substitute for use of the full 2010 STD treatment guidelines document. Call the local health department to report STD infections; to request assistance with confidential notification of sexual partners of patients with syphilis, gonorrhea, chlamydia or HIV infection; or to obtain additional information on the medical management of STD patients. The California STD/HIV Prevention Training Center is a resource for training and consultation about STD clinical management and prevention (510-625-6000) or www.stdhivtraining.org.

DISEASE	RECOMMENDED REGIMENS	DOSE/ROUTE	ALTERNATIVE REGIMENS: To be used if medical contraindication to recommended regimen.
CHLAMYDIA			
Uncomplicated Genital/Rectal/Pharyngeal Infections ¹	<ul style="list-style-type: none"> Azithromycin or Doxycycline ² 	1 g po 100 mg po bid x 7 d	<ul style="list-style-type: none"> Erythromycin base 500 mg po qid x 7 d or Erythromycin ethylsuccinate 800 mg po qid x 7 d or Levofloxacin ² 500 mg po qd x 7 d or Ofloxacin ² 300 mg po bid x 7 d
Pregnant Women ³	<ul style="list-style-type: none"> Azithromycin or Amoxicillin 	1 g po 500 mg po tid x 7 d	<ul style="list-style-type: none"> Erythromycin base 500 mg po qid x 7 d or Erythromycin base 250 mg po qid x 14 d or Erythromycin ethylsuccinate 800 mg po qid x 7 d or Erythromycin ethylsuccinate 400 mg po qid x 14 d
GNORRHEA: Ceftriaxone is the preferred treatment for adult and adolescent patients with uncomplicated gonorrhea infections. Dual therapy with ceftriaxone 250 mg IM (increased from 125 mg) Plus azithromycin 1 g po or doxycycline 100 mg po bid x 7 days is recommended for all patients with gonorrhea regardless of chlamydia test results. ⁴			
Uncomplicated Genital/Rectal Infections ¹	Dual therapy with <ul style="list-style-type: none"> Ceftriaxone or, if not an option Cefixime ⁵ PLUS <ul style="list-style-type: none"> Azithromycin or Doxycycline 	250 mg IM 400 mg po 1 g po 100 mg po bid x 7 d	<ul style="list-style-type: none"> Cefpodoxime 400 mg po or Cefuroxime axetil 1 g po or Azithromycin ⁶ 2 g po in a single dose
Pharyngeal Infections	Dual therapy with <ul style="list-style-type: none"> Ceftriaxone PLUS <ul style="list-style-type: none"> Azithromycin or Doxycycline 	250 mg IM 1 g po 100 mg po bid x 7 d	<ul style="list-style-type: none"> Azithromycin ⁶ 2 g po in a single dose
Pregnant Women ³	Dual therapy with <ul style="list-style-type: none"> Ceftriaxone or, if not an option Cefixime ⁵ PLUS <ul style="list-style-type: none"> Azithromycin 	250 mg IM 400 mg po 1 g po	<ul style="list-style-type: none"> Cefpodoxime 400 mg po or Cefuroxime axetil 1 g po or Azithromycin ⁶ 2 g po in a single dose
PELVIC INFLAMMATORY DISEASE ^{4, 7, 8}	Parenteral ⁹ <ul style="list-style-type: none"> Either Cefotetan or Cefoxitin plus Doxycycline ² or Clindamycin plus Gentamicin IM/Oral <ul style="list-style-type: none"> Either Ceftriaxone or Cefoxitin with Probenecid plus Doxycycline ² plus Metronidazole if BV is present or cannot be ruled out 	2 g IV q 12 hrs 2 g IV q 6 hrs 100 mg po or IV q 12 hrs 900 mg IV q 8 hrs 2 mg/kg IV or IM followed by 1.5 mg/kg IV or IM q 8 hrs 250 mg IM 2 g IM, 1 g po 100 mg po bid x 14 d 500 mg po bid x 14 d	Parenteral ⁹ <ul style="list-style-type: none"> Ampicillin/Sulbactam 3 g IV q 6 hrs plus Doxycycline ² 100 mg po or IV q 12 hrs Oral ¹⁰ <ul style="list-style-type: none"> Levofloxacin ² 500 mg po qd x 14 d or Ofloxacin ² 400 mg po bid x 14 d or Ceftriaxone 250 mg IM in a single dose and Azithromycin 1 g po once a week for 2 weeks plus <ul style="list-style-type: none"> Metronidazole 500 mg po bid x 14 d if BV is present or cannot be ruled out
CERVICITIS ^{4, 7, 11}	<ul style="list-style-type: none"> Azithromycin or Doxycycline ² plus Metronidazole if BV or trichomoniasis is present 	1 g po 100 mg po bid x 7 d 500 mg po bid x 7 d	
NONGONOCOCCAL URETHRITIS ⁷	<ul style="list-style-type: none"> Azithromycin or Doxycycline 	1 g po 100 mg po bid x 7 d	<ul style="list-style-type: none"> Erythromycin base 500 mg po qid x 7 d or Erythromycin ethylsuccinate 800 mg po qid x 7 d or Levofloxacin 500 mg po qd x 7 days or Ofloxacin 300 mg po bid x 7 d
EPIDIDYMITIS ^{4, 7}	Likely due to Gonorrhea or Chlamydia <ul style="list-style-type: none"> Ceftriaxone plus Doxycycline Likely due to enteric organisms <ul style="list-style-type: none"> Levofloxacin ¹² or Ofloxacin ¹² 	250 mg IM 100 mg po bid x 10 d 500 mg po qd x 10 d 300 mg po bid x 10 d	

CHANCROID	<ul style="list-style-type: none"> Azithromycin or Ceftriaxone or Ciprofloxacin ² or Erythromycin base 	1 g po 250 mg IM 500 mg po bid x 3 d 500 mg po tid x 7 d	
LYMPHOGRANULOMA VENEREUM	<ul style="list-style-type: none"> Doxycycline ² 	100 mg po bid x 21 d	<ul style="list-style-type: none"> Erythromycin base 500 mg po qid x 21 d or Azithromycin 1 g po q week x 3 weeks
TRICHOMONIASIS ^{13,14}			
Non-pregnant women	<ul style="list-style-type: none"> Metronidazole or Tinidazole ¹⁵ 	2 g po 2 g po	<ul style="list-style-type: none"> Metronidazole 500 mg po bid x 7 d
Pregnant Women	<ul style="list-style-type: none"> Metronidazole 	2 g po	<ul style="list-style-type: none"> Metronidazole 500 mg po bid x 7 d

- Annual screening for women aged 25 years or younger. Nucleic acid amplification tests (NAATs) are recommended. All patients should be re-tested 3 months after treatment for chlamydia or gonorrhea.
- Contraindicated for pregnant and nursing women.
- Every effort to use a recommended regimen should be made. Test-of-cure follow-up (preferably by NAAT) 3-4 weeks after completion of therapy is recommended in pregnancy.
- If treatment failure is suspected because GC has been documented, the patient has been treated with a recommended regimen for GC, and symptoms have not resolved, then perform a test-of-cure using culture and antibiotic susceptibility testing and report to the local health department. For clinical consult, call the CA STD Control Branch at 510-620-3400. For further guidance, go to www.std.ca.gov ("STD Guidelines").
- Oral cephalosporins give lower and less-sustained bacteriocidal levels than ceftriaxone 250 mg and have limited efficacy for treating pharyngeal GC. Therefore, ceftriaxone is the preferred medication.
- For patients with cephalosporin allergy, or severe penicillin allergy, (e.g., anaphylaxis, Stevens Johnson syndrome, and toxic epidermal necrolysis), azithromycin is an option. However, because of GI intolerance and concerns regarding emerging resistance, it should be used with caution.
- Testing for gonorrhea and chlamydia is recommended because a specific diagnosis may improve compliance and partner management, and because these infections are reportable by California law.
- Evaluate for bacterial vaginosis. If present or cannot be ruled out, also use metronidazole.
- Discontinue 24 hours after patient improves clinically and continue with oral therapy for a total of 14 days.
- Fluoroquinolones can be considered for PID if the risk of GC is low, a NAAT test for GC is performed, and follow-up of the patient can be assured. If GC is documented, the patient should be re-treated with the recommended ceftriaxone and doxycycline regimen. If cephalosporin therapy is not an option, the addition of azithromycin 2 g orally as a single dose to a quinolone-based PID regimen is recommended.
- If local prevalence of gonorrhea is greater than 5%, treat empirically for gonorrhea infection.
- If gonorrhea is documented, change to a medication regimen that does not include a fluoroquinolone.
- For suspected drug-resistant trichomoniasis, rule out re-infection; see 2010 CDC Guidelines, Trichomonas Follow-up, p. 60, for other treatment options, and evaluate for metronidazole-resistant *T. vaginalis*. For laboratory and clinical consultations, contact CDC at 404-718-4141; <http://www.cdc.gov/std>.
- For HIV-positive women with trichomoniasis, metronidazole 500 mg po bid x 7 d is more effective than metronidazole 2 g orally.
- Safety in pregnancy has not been established; pregnancy category C.

BACTERIAL VAGINOSIS			
Adults/Adolescents	<ul style="list-style-type: none"> Metronidazole or Metronidazole gel or Clindamycin cream ¹⁶ 	500 mg po bid x 7 d 0.75%, one full applicator (5g) intravaginally qd x 5 d 2%, one full applicator (5g) intravaginally qhs x 7 d	<ul style="list-style-type: none"> Tinidazole ¹⁵ 2 g po qd x 2 d or Tinidazole ¹⁵ 1 g po qd x 5 d or Clindamycin 300 mg po bid x 7 d or Clindamycin ovules 100 mg intravaginally qhs x 3 d
Pregnant Women	<ul style="list-style-type: none"> Metronidazole or Metronidazole or Clindamycin 	500 mg po bid x 7 d 250 mg po tid x 7 d 300 mg po bid x 7 d	
ANOGENITAL WARTS			
External Genital/Perianal Warts	Patient-Applied <ul style="list-style-type: none"> Imiquimod ^{15,16} 5% cream or Podofilox ¹⁵ 0.5% solution or gel or Sinecatechins ¹⁵ 15% ointment Provider-Administered <ul style="list-style-type: none"> Cryotherapy or Podophyllin ¹⁵ resin 10%-25% in tincture of benzoin or Trichloroacetic acid (TCA) 80%- 90% or Bichloroacetic acid (BCA) 80%- 90% or Surgical removal 	Topically qhs 3 x wk up to 16 wks Topically bid x 3 d followed by 4 d no tx for up to 4 cycles Topically tid, for up to 16 wks Apply once q 1-2 wks Apply once q 1-2 wks Apply once q 1-2 wks Apply once q 1-2 wks	Alternative Regimen <ul style="list-style-type: none"> Intralesional interferon or Laser surgery or Photodynamic therapy or Topical cidofovir
Mucosal Genital Warts ¹⁷	<ul style="list-style-type: none"> Cryotherapy or TCA or BCA 80%-90% or Podophyllin ¹⁵ resin 10%-25% in tincture of benzoin or Surgical removal 	Vaginal, urethral meatus, and anal Vaginal and anal Urethral meatus only Anal warts only	
ANOGENITAL HERPES ¹⁸			
First Clinical Episode of Anogenital Herpes	<ul style="list-style-type: none"> Acyclovir or Acyclovir or Famciclovir or Valacyclovir 	400 mg po tid x 7-10 d 200 mg po 5x/day x 7-10 d 250 mg po tid x 7-10 d 1 g po bid x 7-10 d	

Established Infection Suppressive Therapy ^{19, 20}	<ul style="list-style-type: none"> • Acyclovir or • Famciclovir ¹⁹ or • Valacyclovir or • Valacyclovir 	400 mg po bid 250 mg po bid 500 mg po qd 1 g po qd	
Episodic Therapy for Recurrent Episodes	<ul style="list-style-type: none"> • Acyclovir or • Acyclovir or • Acyclovir or • Famciclovir or • Famciclovir or • Famciclovir or • Valacyclovir or • Valacyclovir 	400 mg po tid x 5 d 800 mg po bid x 5 d 800 mg po tid x 2 d 125 mg po bid x 5 d 1000 mg po bid x 1 d 500 mg once, then 250 mg bid x 2 d 500 mg po bid x 3 d 1 g po qd x 5 d	
HIV Co-Infected ²⁰			
Suppressive Therapy ¹⁹	<ul style="list-style-type: none"> • Acyclovir or • Famciclovir ¹⁹ or • Valacyclovir 	400-800 mg po bid or tid 500 mg po bid 500 mg po bid	
Episodic Therapy for Recurrent Episodes	<ul style="list-style-type: none"> • Acyclovir or • Famciclovir or • Valacyclovir 	400 mg po tid x 5-10 d 500 mg po bid x 5-10 d 1 g po bid x 5-10 d	
SYPHILIS ^{21, 22}			
Primary, Secondary, and Early Latent	• Benzathine penicillin G	2.4 million units IM	<ul style="list-style-type: none"> • Doxycycline ²³ 100 mg po bid x 14 d or • Tetracycline ²³ 500 mg po qid x 14 d or • Ceftriaxone ²³ 1 g IM or IV qd x 10-14 d
Late Latent and Latent of Unknown Duration	• Benzathine penicillin G	7.2 million units, administered as 3 doses of 2.4 million units IM each, at 1-week intervals	<ul style="list-style-type: none"> • Doxycycline ²³ 100 mg po bid x 28 d or • Tetracycline ²³ 500 mg po qid x 28 d
Neurosyphilis ²⁴	• Aqueous crystalline penicillin G	18-24 million units daily, administered as 3-4 million units IV q 4 hrs x 10-14 d	<ul style="list-style-type: none"> • Procaine penicillin G, 2.4 million units IM qd x 10-14 d plus Probenecid 500 mg po qid x 10-14 d or • Ceftriaxone ²³ 2 g IM or IV qd x 10-14 d
Pregnant Women ²⁵			
Primary, Secondary, and Early Latent	• Benzathine penicillin G	2.4 million units IM	• None
Late Latent and Latent of Unknown Duration	• Benzathine penicillin G	7.2 million units, administered as 3 doses of 2.4 million units IM each, at 1-week intervals	• None
Neurosyphilis ²⁴	• Aqueous crystalline penicillin G	18-24 million units daily, administered as 3-4 million units IV q 4 hrs x 10-14 d	<ul style="list-style-type: none"> • Procaine penicillin G, 2.4 million units IM qd x 10-14 d plus Probenecid 500 mg po qid x 10-14 d

16. May weaken latex condoms and contraceptive diaphragms.

17. Cervical and intra-anal warts should be managed in consultation with specialist.

18. Counseling about natural history, asymptomatic shedding, and sexual transmission is an essential component of herpes management.

19. The goal of suppressive therapy is to reduce recurrent symptomatic episodes and/or to reduce sexual transmission. Famciclovir appears somewhat less effective for suppression of viral shedding.

20. If HSV lesions persist or recur during antiviral treatment, drug resistance should be suspected. Obtaining a viral isolate for sensitivity testing and consulting with an infectious disease expert is recommended.

21. Benzathine penicillin G (generic name) is the recommended treatment for syphilis not involving the central nervous system and is available in only one long-acting formulation, Bicillin® L-A (the trade name), which contains only benzathine penicillin G. Other combination products, such as Bicillin® C-R, contain both long- and short-acting penicillins and are not effective for treating syphilis.

22. Persons with HIV infection should be treated according to the same stage-specific recommendations for primary, secondary, and latent syphilis as used for HIV-negative persons. Available data demonstrate that additional doses of benzathine penicillin G, amoxicillin, or other antibiotics in early syphilis do not result in enhanced efficacy, regardless of HIV status.

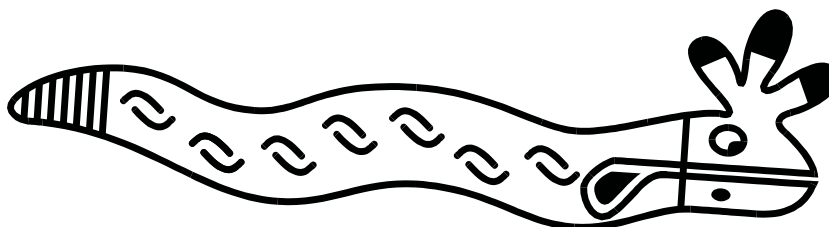
23. Alternates should be used only for penicillin-allergic patients because efficacy of these therapies has not been established. Compliance with some of these regimens is difficult, and close follow-up is essential. If compliance or follow-up cannot be ensured, the patient should be desensitized and treated with benzathine penicillin.

24. Some specialists recommend 2.4 million units of benzathine penicillin G q week for up to 3 weeks after completion of neurosyphilis treatment.

25. Pregnant women allergic to penicillin should be treated with penicillin after desensitization.



Developed by the California STD/HIV Prevention Training Center and
California Department of Public Health STD Control Branch
Updated March 2011

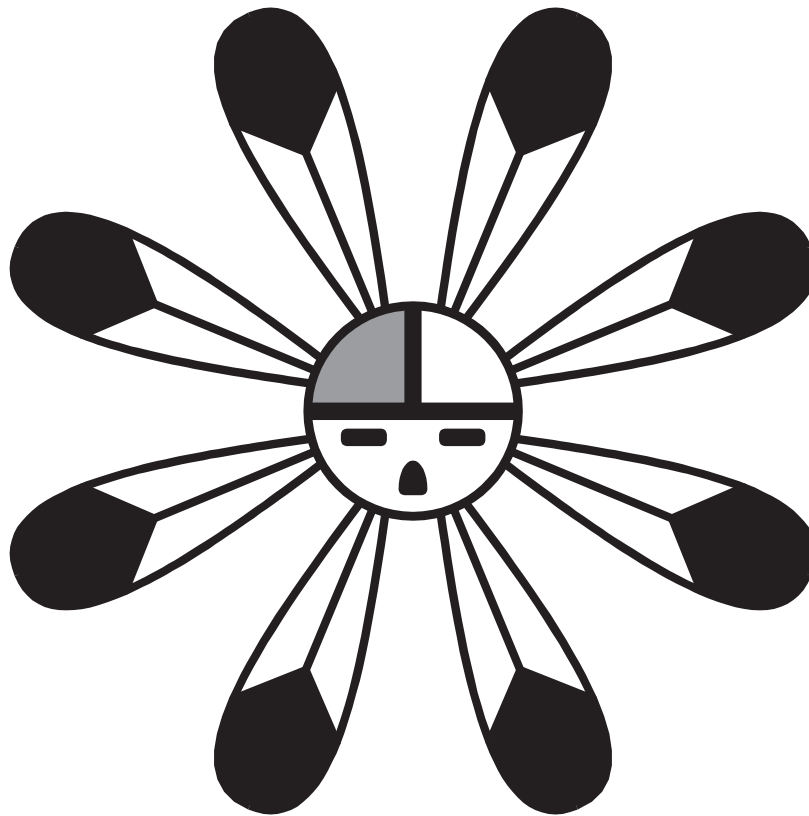


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Community-Based HIV Testing among American Indians in Pine Ridge, South Dakota, 2008–2009

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Abstract

Purpose: A large tribe in South Dakota implemented community-based HIV testing to increase access to testing and determine use of health facilities.

Methods: From October 2008 to October 2009 the program offered rapid HIV tests at community events, and asked participants about health care usage.

Results: A total of 429 persons were tested. All persons received results. Two tests were reactive, but negative in confirmatory testing. Most participants (80%) had accessed care in the past 12 months, either a scheduled visit (44%) and/or an emergency/acute care visit (47%).

Conclusions: These results show that HIV screening in health facilities is critical. In this sample, HIV screening in scheduled and non-scheduled medical visits would reach most participants. The community-based program has grown in acceptance and usage and will continue, and a tribally run program has begun on an even larger scale.

Introduction

Recent CDC guidelines recommend at least one HIV test of 13 - 64 year olds, regardless of risk factors.¹ Many persons at risk for HIV infection do not consider themselves at risk, or do not disclose risks to their provider, and patients with HIV may visit health facilities for years without being tested and diagnosed.²⁻⁵ A universal, non-risk factor-based strategy may identify more infected persons.^{1,6-8} Patients who are seen in health care setting but not tested for HIV represent a missed opportunity, especially in emergency or acute care settings.

Early detection of HIV/AIDS, which facilitates initiation of highly active antiretroviral treatment, is essential to increase survival time post-diagnosis of patients with HIV/AIDS.⁹ American Indians/Alaska Natives (AI/AN) rank third in the rate of new HIV infections (incidence 14.7/100,000 population in 2007) among all US races and ethnicities.¹⁰ In addition, American Indians/Alaska Natives have the shortest survival time from

AIDS diagnosis to death,¹⁰ underscoring the importance of early detection in this vulnerable population.

Pine Ridge Hospital and its two satellite clinics serve about 50,000 tribal members of the Oglala Sioux Indian Tribe. The health care facilities are part of the Indian Health Service (IHS), a federal agency within the Department of Health and Human Services, which is responsible for providing health services to eligible AI/AN. The IHS is the principal health care provider and health advocate for Indian people, and its goal is to raise their health status to the highest possible level. The IHS provides a comprehensive health service delivery system for approximately 1.9 million AI/AN who belong to 562 federally recognized tribes in 35 states.

Starting in 2005, Pine Ridge medical staff began offering HIV testing at key community events and venues. In 2008, Pine Ridge Hospital began discussions to expand HIV screening services as per CDC guidelines. In 2008 - 2009, the community-based program sought to determine recent use of health facilities by participants to see if facility-based screening would reach this cohort.

Methods

From October 2008 to September 2009, community-based HIV tests were offered in public and institutional settings such as tribal sports tournaments, pow-wows, and a tribal jail. Tests were generally offered in an exhibit booth setting. One outreach worker gave pre-test counseling, took patient information, and administered the test. A second worker gave results and post-test counseling in an area separated by a folding screen for privacy. In some settings, persons were eligible for a raffle prize if they tested, although the raffle ticket was only given once the person came for their results.

The community outreach program used oral rapid testing technology (OraQuick Advance Rapid HIV-1/2 Antibody Test, OraSure Technologies, Inc. Bethlehem, PA). Persons who consented to testing were given a unique ID number, which was used to identify them for post-test counseling. Participants provided two phone numbers and an address to allow for follow up in case a person did not return for test results.

In order to best determine the role of community-based screening in reaching persons who would not otherwise access care and routine HIV screening, we asked participants about their access to care in the 12 months prior to the testing date and recorded data concerning the location and number of these visits. Conditional maximum likelihood estimates of the odds ratio and Fisher Exact 95% confidence intervals (95% CI) were

calculated using Open Epi (<http://www.openepi.com/TwoByTwo/TwoByTwo.htm>).

Results

A total of 429 persons were tested, of whom 408 were tested at public venues (pow-wows, sports tournaments, and a health fair), and 21 in a tribal correctional facility. The largest single event tested 250 persons. All persons received the rapid test results on the same day, at the venue where they tested. Two rapid oral tests were initially reactive (preliminary positives); however in both cases, they were found to be negative during confirmatory testing.

Most respondents (344/429, 80.2%) had accessed health care in the past 12 months. Of these, a nearly equal proportion of patients had accessed care via a scheduled visit (154/344 44.8%) as via acute care or an emergency room (163/344, 47.4%). A small proportion (23/344, 6.7%) had accessed both scheduled and non-scheduled medical care. Women were more likely to have accessed health care (Table 1), and among those who had accessed health care, most had been seen at a scheduled visit. Men were more likely to have accessed acute care than scheduled care. Among persons who had accessed any type of medical care in the past 12 months, most (279/344, 81%) had accessed care at a direct-care IHS facility.

Discussion

In this group of AI/AN participants who participated in community-based screening, a high proportion had accessed health care facilities, primarily IHS facilities, in the prior twelve months. The frequent use of health care facilities in this sample underscores the importance of implementing HIV screening in health care settings. Acute care facilities are an important opportunity to offer HIV screening to men. Pine Ridge hospital and its two satellite clinics, with technical assistance and fiscal support of the IHS National HIV/AIDS Program, has begun to offer more systemic HIV screening to all 13 - 64 year olds as of July 2009.

Community-based screening has gained acceptance over time; the number of persons who agreed to be tested at one public venue has grown over 300% in three years (from 80 to 250 persons). Community screening also offered qualitative advantages. Testing in locations that are comfortable to the community has been conducive to more in-depth and candid counseling sessions, helped de-stigmatize HIV testing, and provided a testing environment that is perceived as being more confidential than small rural health clinics. In addition, program staff has noted a shift in participants from early years of the program from a low-risk demographic (older married couples and grandmothers testing for the incentive) to a higher-risk population (younger persons within the age range of most sexually transmitted diseases who are testing primarily to learn their serostatus).

As the result of numerous trainings, many tribal community health workers (CHRs) are qualified in giving

rapid HIV tests, and to provide results and referrals to HIV medical and social services. The tribal program has grown to eclipse the federal program in 2010, providing over 600 community-based tests.

These data have certain limitations. This sample may not be representative of the community as a whole. We did not ask participants if they had been tested for HIV during their visits to health care facilities, so we cannot estimate the number of missed opportunities for HIV testing, nor the proportion of patients who chose community-based testing over facility-based testing for reasons of convenience, comfort, or other reasons.

Conclusions

The utilization of health care services by this sample of the population is high, and facility-based HIV screening is a critical service. The community-based program is growing in size and acceptance, and provides community members with an alternative setting to small, rural, federal clinics for HIV counseling and screening.

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Table 1. Use of health care facilities in the previous 12 months by 429 American Indian participants in community-based rapid HIV testing, by sex, South Dakota, 2008–2009*

Characteristic	Women	Men	Odds Ratio	99% Confidence Interval
Accessed any health care in previous 12 months	216/255 (84.7%)	128/174 (73.6%)	2.0	1.2-3.3
Among those who accessed care, type of care:				
Scheduled visit	108/216 (50.0%)	46/128 (35.9%)	1.8	1.1-2.8
Acute care	68/216 (31.5%)	56/128 (43.8%)	0.6	0.4-1.0
Emergency room	20/216 (9.3%)	14/128 (10.9%)	0.8	0.4-1.9
Both scheduled and non-scheduled care	20/216 (9.3%)	12/128 (9.4%)	1.0	0.4-2.3
IHS facility	176/216 (81.5%)	103/128 (80.5%)		

* Categories not mutually exclusive -



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.ih.gov.

IHS Child Health Notes

Quote of the month

“The greatest happiness love can offer is the first pressure of hands between you and your beloved.”

Stendahl

Articles of Interest

Short- and long-term risk of infections as a function of group child care attendance: an 8-year population-based study. *Arch Pediatr Adolesc Med.* 2010 Dec;164(12):1132-3

Objective. To determine whether the frequency of infections during the first eight years of life varies according to age at initiation and type of group child care (GCC).

Design. Eight-year (1998 - 2006) prospective cohort study.

Setting. Families with a newborn living in Quebec in 1998.

Participants. A representative sample of families (n = 1238) selected through birth registries.

Main Exposure. Home care compared with small or large GCC during the early (i.e., before 2½ years old) or late (3½ - 4½ years old) preschool period.

Main Outcome Measures. Maternal reports of children's respiratory tract, ear, and gastrointestinal tract infections during the early preschool, late preschool, and early elementary school (5 - 8 years old) periods.

Results. Compared with children cared for at home, those who started large GCC in the early preschool period had higher rates of respiratory tract infections (incidence rate ratio [IRR], 1.61; 95% confidence interval [CI], 1.27-2.03) and ear infections (IRR, 1.62; 95% CI, 1.19-2.20) during that period but lower rates of respiratory tract infections (IRR, 0.79; 95% CI, 0.66-0.96) and ear infections (IRR, 0.57; 95% CI, 0.37-0.88) during the elementary school years.

Conclusions. Children contract infections around the time they initiate large structured group activities. Participation in large GCC before 2½ years old, although associated with increased infections at that time, seems to protect against infections during the elementary school years. Physicians may reassure parents that infections during the first child-care years do not lead to a higher overall burden of infections.

Editorial Comment

I find these results both expected and comforting. Parents worry about the adverse effects of placing their children in day care at an early age. This study suggests there is a finite amount

of upper respiratory illnesses that most children are going to acquire. Call it conservation of misery. You can get these episodes out of the way as a toddler and be less ill on entry to kindergarten or if you skip day-care you are more likely to have increased minor infections in elementary school.

Infectious Disease Updates

Rosalyn Singleton, MD, MPH

Excess Respiratory Infections in American Indian/Alaska Native Children: Relationship to Household Environmental Factors

The disproportionate morbidity and mortality from lower respiratory tract infections (LRTIs) among American Indian and Alaska Native (AI/AN) children is one of the major infectious disease health inequities in US children. Significant progress has been made in reducing LRTI hospitalizations since the 1990s. The LRTI-associated hospitalization rate in 2006 - 08 for AI/AN children <5 years and infants <1 year decreased by 32% and 41%, respectively, compared to 1998 - 99. However, the LRTI hospitalization rate in AI/AN infants remained twice as high as US infants. LRTIs accounted for nearly 50% of all AI/AN infant hospitalizations compared with ~25% of hospitalizations in the general US infant population.

Factors affecting the child, their environment, and the pathogens all contribute to LRTI risk. Excess LRTIs in AI/AN children have been associated with host factors such as prematurity and cardiorespiratory disease; with environmental factors such as household cigarette smoke, smoking during pregnancy, feeding practices, overcrowded housing, wood stoves, lack of running water; and with numerous viral and bacterial pathogens, such as respiratory syncytial virus, influenza, human metapneumovirus, parainfluenza virus and *Streptococcus pneumoniae*.

Because LRTI infections are linked to diverse risk factors and multiple pathogens for which no vaccine exists, elimination of this disparity will require a multi-faceted approach. This includes clinical care (adequate pre-natal care, high influenza and pneumococcal conjugate vaccine coverage, optimizing RSV prophylaxis, and education on feeding practices) and collaboration with partners in other disciplines to increase access to in-home running water service and address problems of household air quality and crowding.

Update of American Indian/Alaska Native Literature
Jeff Powell, MD, MPH

Randomized controlled trial of a paraprofessional-delivered in-home intervention for young reservation-based American Indian mothers. *J.Am.Acad.Child Adolesc. Psychiatry*, 48:6, June 2009.

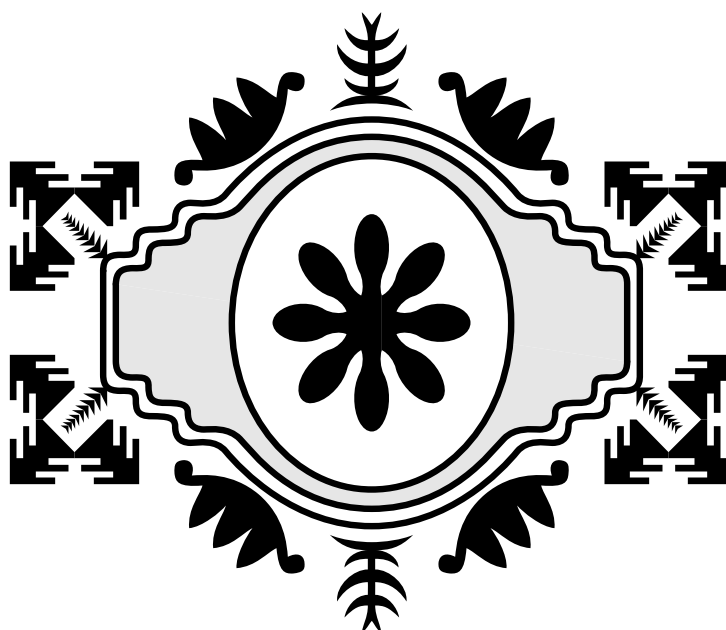
This month's submission investigates the effectiveness of early paraprofessional home visitation for young American Indian (White Mountain Apache and Navajo) mothers. The article is of interest because it fills a gap in the literature on early home visitation and the use of paraprofessionals, and is another important example of community based participatory research addressing disparities in behavioral health outcomes amongst Native Americans. This publication demonstrates that American Indian paraprofessional (i.e., layperson) early home visitation is effective in improving mothers' parenting knowledge and perceptions of healthy infant behavior.

To summarize, the study authors enrolled 175 pregnant mothers at 28 weeks of gestation. The mothers were then randomized into treatment and control arms. Both treatments and controls received one hour long home visitations between birth and one year of age. The treatment group was to receive 25 home visits, and the control group 23. Both treatment and control group home visitors were paraprofessionals highly trained (500 hours of training) in following Healthy Families America's home visitation guidelines. The treatment arm provided a Family Spirit curriculum based upon the American Academy of Pediatrics' *Caring for Your Baby and Child: Birth to Age 5* standards and recommendations. Because of the ethics of human subjects research, the authors commendably provided a meaningful curriculum to the control

group, as well: controls received content specific to breastfeeding and nutrition education. The mothers and infants of each group were then assessed at baseline enrollment (28 weeks gestation), as well as 2, 6, and 12 months after delivery. Assessment data collection included maternal self-reports reflecting a variety of measurement tools focusing on maternal perceptions of knowledge, health, and behavioral status of themselves and their infants. In addition, an observational assessment tool evaluating parent support and stimulation of the child in the home was used (the HOME checklist).

While the study faced difficult challenges (such as roughly 50 percent attrition), it is notable because of the positive outcomes identified. Maternal parenting knowledge was statistically higher in the treatment than the control group. Further, the authors describe that mothers with the largest gains of parenting knowledge rated their infants' behavior the best. Other measures such as the HOME observational tool, and parents' self-reported levels of involvement showed no difference between treatment and control groups. The authors thoughtfully offer several suggestions about why these outcomes did not demonstrate a change with treatment. Several of these relate to the limited experience using these assessment tools among Native American families. These positive findings from a paraprofessional home visitation prevention program are an exciting early step in determining how best to close large gaps in child and adolescent behavioral health.

N.B. Dr. Powell would like to thank Mary Elkins, RN, MPH, for her assistance in helping to obtain and summarize this month's article.



A Road Map to Implementing At-Home Gonorrhea and Chlamydia Testing in Alaska – Logistical Aspects and Adaptation

*Brenna Simons, PhD, Medical Research Associate; and
Connie Jessen, MA, STD Program Manager, both of the Alaska
Native Tribal Health Consortium, Anchorage, Alaska*

Dramatic increases in gonorrhea (*Neisseria gonorrhoea*; GC) infection have been reported in Alaska since 2008.^{1,2} The year 2009 data indicated a 69% increase and the greatest single-year increase in reported GC infection in Alaska since the 1970s.² In addition to the current GC outbreak, Alaska also ranks second highest for chlamydia (*Chlamydia trachomatis*; CT) in the country.³ Women, youth (age 15 - 29), and Alaska Native people are disproportionately affected; in 2009, 67% of the state's reported GC cases and 50% of its reported CT cases occurred in Alaska Native people.⁴ Alaska Native health organizations have jurisdiction over large geographic areas, containing small isolated communities. Community health aides are the primary health care providers in these communities, where high provider turnover, limited resources, competing health care priorities, and perceived lack of confidentiality and privacy are barriers to accessing health care.⁵

To address the overrepresentation of Alaska Native people in STD incidence, and the perceived lack of confidentiality and privacy in rural communities, the IHS National STD Program collaborated with the Alaska Native Tribal Health Consortium (ANTHC) to initiate a web-based, at-home GC and CT testing option in Alaska.

Background of At-Home Testing

Self-collection has been suggested as a viable testing alternative for rural areas and underserved populations, and to alleviate confidentiality and privacy issues surrounding clinical testing.⁶ At-home collected specimens have been shown to be a useful method for increasing screening efforts in general and within high-risk populations that may otherwise not seek testing and care in traditional clinic settings.⁶⁻¹²

Several studies have indicated that sensitivity and specificity of self-collected specimens are maintained in molecular testing such as the GenProbe Aptima Combo 2®.^{9,12-17} The GenProbe Aptima Combo 2® test is a nucleic acid amplification test (NAAT). It detects GC/CT infection by molecular methods that identify pathogens by their individual genetic material, but does not require the pathogen to be viable for valid testing. Thus, the specimen is stable in varying temperatures and conditions that include those experienced

during shipping.^{13-15,18} The Association of Public Health Laboratories recommends vaginal swabs as the preferred sample type for screening.¹⁹ Self-collected vaginal swabs are not intended to replace cervical exams and endocervical specimens, but provide an additional tool for GC and CT testing in clinical and non-clinical settings.^{19,21}

In addition, a National Institutes of Health workshop focusing on the feasibility of self-collected vaginal swabs reported that women prefer vaginal swab self-collection over pelvic examination in most settings, and the vaginal swab is at least as well accepted and often preferred to the collection of first catch urine specimens.⁹ Acceptability of self-collected specimens among men may be lower, but considering the high prevalence of CT and GC, it should still be presented as a viable alternative to traditional clinic-based screening in Alaska. Expanding this service to Alaska will provide testing access to high-risk and less accessible populations, thereby increasing efforts to control and prevent CT and GC.

***I Want the Kit* – Johns Hopkins University**

The web-based STD screening program *I Want the Kit* (IWTK) is housed at Johns Hopkins University (JHU) in Baltimore, Maryland (www.iwantthekit.org). IWTK is currently available in Denver, Colorado; Maryland; Washington, D.C.; West Virginia; Pennsylvania; select counties of Illinois; and Los Angeles County. ANTHC is the first tribal public health entity to collaborate with IWTK to offer these testing services. IWTK utilizes the FDA-approved GenProbe® dual GC/CT test, and CLIA-licensed analysis of vaginal and penile self-collected mailed-in specimens. Current implementation of IWTK within these state and county public health departments is recognized as public health practice and as a reportable clinical diagnostic test to refer patients to STD care and disease investigation services.

This public health initiative is unique and ideal in that the FDA and CLIA-approved GC/CT testing process of IWTK offers confidentiality through at-home testing, a frequently perceived barrier to screening and care in rural Alaskan communities.²²

Adaptation and Implementation of *I Want the Kit* in Alaska

Contracting clinical testing services. ANTHC's arrangement with JHU is only for laboratory testing services,

with no participation in the university's related research activities.^{6,23-25} Alaska participants are not prompted to participate in behavioral surveys or genetic studies of any kind; specimens are destroyed upon completion of the test.

Alaskans with Internet access can request a free GC/CT home collection kit online from the IWTK website. Requestors follow the IWTK procedure to request, receive, and return at-home collected specimens for testing. Information collected includes the person's preferred contact method (i.e., e-mail, phone, cell phone, or letter) for delivery of results. The at-home test kit is mailed to the address provided by the person requesting the test in an unmarked shipping envelope. The requestor is also provided with a toll-free number for accessing test results, general STD information, and medical care referral from the Provider of Record at ANTHC. The CLIA-licensed JHU laboratory provides both positive and negative test results to the Provider of Record for direct patient care or referral to care, and disease investigation services (DIS) for those who test positive. The laboratory at JHU also directly reports the positive results to the State of Alaska Section of Epidemiology (SOE) per Alaska state statute regarding reportable disease.

Provider of Record. Because testing through IWTK is open to all Alaska residents and because Alaska has no county health departments within its public health infrastructure, the coordination between ANTHC and these health organizations is required: Alaska Tribal Health System; State of Alaska Division of Public Health Nursing; State of Alaska SOE; Alaska Federally-Qualified Health Centers (FQHCs) (including 26 FQHCs and 165 FQHC delivery sites); Municipality of Anchorage; and private health care providers.

Much of Alaska's medical needs are served by FQHCs and associated delivery sites, and these are coordinated within both the state and tribal health systems. The FQHCs are interlaced with the Alaska Tribal Health System, such as village clinics, that are staffed by Community Health Aides. Patients who are identified as Alaska Native and/or American Indian beneficiaries are eligible to seek treatment and care within the Alaska Tribal Health System, FQHCs, and the State of Alaska Division of Public Health Nursing. However, for uninsured patients who are not Alaska Native and/or American Indian beneficiaries, the scope of the FQHC provided care is limited to larger delivery sites and the State of Alaska Division of Public Health, including the Division of Public Health Nursing. For insured and Medicaid patients, the referral options remain the same but also include the additional options of direct care by the Provider of Record through prescription at a local pharmacy, an online pharmacy service, or referral to a private provider.

The Provider of Record includes an ANTHC licensed physician, physician assistant, and a registered nurse. The Provider of Record makes an effort to contact persons testing positive and provide linkage to treatment services or direct treatment depending on the patient's preference. (The Provider of Record also makes an effort to contact all negatives.)

All persons who requested and returned an at-home GC/CT test kit through IWTK can call a toll-free number at ANTHC to receive results from a licensed medical provider. Risk surrounding confidentiality and privacy if the patient chooses to seek a provider referral are the same as those of pursuing medical care and treatment for other illnesses.

Disease Investigation Services (DIS): Treatment Follow-up and Partner Services. Per Alaska state statute for reportable diseases, provider reports for positive test information, including patient identifiers and contact information, are forwarded to the State of Alaska SOE by the Provider of Record at ANTHC for DIS, including partner notification and treatment follow-up.

Local Marketing. The final component of Alaska's adaptation of IWTK is marketing. Other public health partners of IWTK have reported a direct correlation between marketing and the number of kit requests.²⁵ ANTHC has begun a campaign that includes television and radio commercials as well as flyers and informational cards distributed at clinics. The ANTHC STD program social marketing website I Know Mine (www.iknowmine.org) focuses on providing health and testing information for Alaska Native youth, which includes a direct link to the IWTK website.

IWTK is a new and innovative tool to provide increased confidentiality and non-clinical availability of STD testing, and to thereby effectively expand STD testing to high risk and less accessible populations. We will continue to monitor our success of the adaptation and implementation of IWTK and share our experiences with other tribes and tribal agencies that are interested in implementing IWTK. For more information about IWTK in Alaska, contact Brenna Simons at ANTHC, telephone (907) 729-1563; e-mail besimons@anthc.org.

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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.

Providing Confidential Reproductive Health Services for Teens

Jessica Leston, MPH, Project Manager, Northwest Portland Area Indian Health Board, Portland, Oregon; Martin Kileen, MD, Medical Director, Acoma-Cañoncito-Laguna Service Unit, San Fidel, New Mexico

Adolescents are the most at-risk population we serve for STDs and unplanned pregnancies. To reach out to them -- and to make them feel comfortable reaching out to us -- can be a challenge. As we meet with partners in IHS, tribal, and urban Indian (I/T/U) facilities across the country, we hear about many success stories -- as well as challenges -- to serving teens. One of the main barriers we encounter is the inability of teens to access confidential reproductive health services at their local I/T/U. For this special STD issue of *The Provider*, we wanted to take the opportunity to review IHS policy on providing confidential services to teens.

The IHS's Indian Health Manual (IHM) specifically addresses these adolescent health care issues in Part 3 -- Professional Services in two chapters: Chapter 3 -- Health Information Management (Section 3-3.14 -- Minors) and in Chapter 13 -- Maternal and Child Health (Section 3-13.10 -- Care of the Adolescent).

The IHS policy states that health services will be provided to adolescents in a manner that will allow them to fully participate in their own health care, which includes assuring that:

- - health services are provided in a manner that is sensitive to teens developmental stage
- - adolescents are provided with education and counseling to make informed, intelligent decisions about health care and make life choices that will affect health positively
- - adolescents right to privacy will be respected

Furthermore, each service unit must have a written plan or protocol that addresses consent regulations, disclosure of information, and education and counseling in accordance with

local resources, state laws, federal regulations, and IHS policy. The Area/Program MCH Chief Consultant is responsible for reviewing plans and ensuring conformity with the policy.

In accordance with applicable state laws, counseling and services regarding pregnancy, STDs, and family planning *may be provided without the parent's or guardian's knowledge and consent*. In general the IHS policy is to encourage adolescents to involve their parents in their health care, but it is the adolescent's responsibility to inform his/her parents. The health care provider should encourage, counsel, and support adolescents in the process of involving their parents or guardians.

As consistent with local and state laws, adolescents may request and receive an exam, screening, or treatment for STDs; contraceptives; a pregnancy test; alcohol and drug addiction treatment; and obstetric care *without the knowledge and consent of parents or guardians*. These services can be provided with *only the adolescent's consent* (unless the teen is unable to consent because of a physical/emotional condition; then customary procedures for treating

patients in those conditions will be used). One important exception: elective sterilization may not be consented to, or performed on, any patient younger than age 21. Consult the Office of General Council if there is a conflict between federal and state laws.

The service unit must protect the privacy of the adolescent by applying the same safeguards to the adolescent's health records and other documents as are applied to those of adults. Parents and guardians may be provided information only with the adolescent's consent.

Each service unit should attempt to assure that health care providers serving adolescents are trained in adolescent development and adolescent health issues as appropriate for the provider's role. IHS should offer education and counseling to adolescents about major health problems of the adolescent age, including accidents, drugs, alcohol, emotional stress, nutrition, STDs, pregnancy, family planning, and maturational

Legal Definition of a Minor Patient

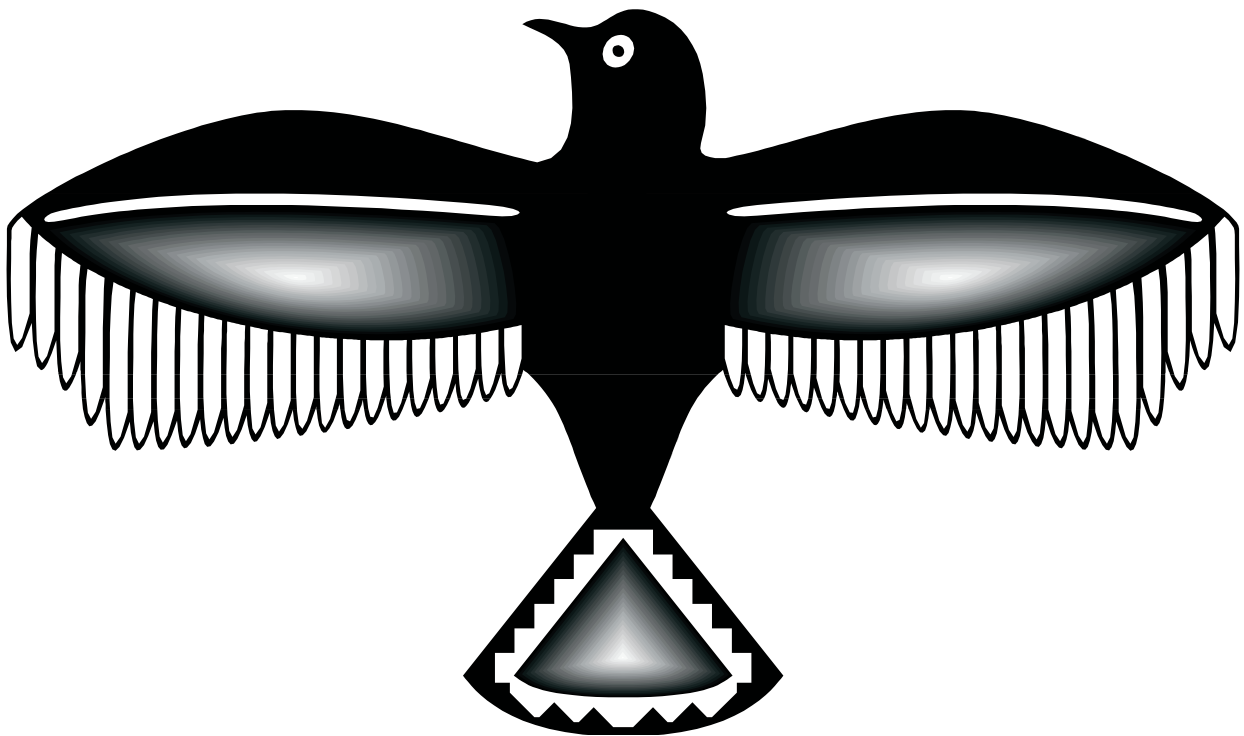
A minor patient is a person who is under the age of legal competence. *This age is established by state law in which the IHS facility is located.* Where no state statute exists, 18 is considered the age of majority. Even in states where 18 years old is considered the age of consent, many states have special exemptions for youth seeking reproductive health services.

The Guttmacher Institute's "State Policies in Brief" series presents up-to-date information on state laws governing minors' access to reproductive health services. See www.guttmacher.org.

disorders such as acne.

Separate adolescent clinics are encouraged. These may simply be at a separate time in the general clinic or provided at an alternative physical location. Adolescents respond best if they can be assured of confidentiality and recognition of their emerging independence; they respond poorly to the classic clinic setting.

From a public health perspective, it is important that adolescents have the option to obtain confidential reproductive health education, counseling, and services. From an adolescent rights perspective, it is important that providers in I/T/U facilities empower adolescents to utilize their reproductive health rights, which includes removing systems and clinical barriers that impede the realization of these rights.



“Friending” Sexual Health: Harnessing Media Technologies to Reach Native Youth

David Stephens, Project Specialist; Jessica Leston, MPH, Project Coordinator; and Stephanie Craig-Rushing, PhD, MPH, Project Director, all with Project Red Talon of the Northwest Portland Area Indian Health Board, Portland, Oregon

The use of media technologies, including the Internet, cell phones, and video games, has become increasingly popular among youth. With the widespread use of social networking and text messaging, health professionals are looking for ways to address sensitive health topics and to meet youth where they are. Media technologies can be particularly useful for reaching tech-savvy youth on sensitive health topics, like sexual health. While sexual health messages can be tailored to the personal interests, age, gender, and maturity-level of the individual through traditional print materials, media technologies offer health professionals a cost-effective alternative method to reach large numbers of youth in geographically dispersed locations.

In 2009, Project Red Talon (PRT – an STD/HIV prevention project housed at the Northwest Portland Area Indian Health Board) surveyed over 400 AI/AN youth (13 - 21 years-old) living in Oregon, Washington, and Idaho to better understand how they interact with media technologies. In general, technology use was common and diverse among survey respondents, mirroring patterns reported by teens in the general population. Youth reported high use of the Internet and cell phones. In addition, almost half of respondents reported having accessed sexual health information on the Internet. Despite the high percentage of survey respondents who used private and anonymous platforms to gain sexual health knowledge, most preferred to receive sexual health information from a trusted adult, health care provider, or parent. Augmenting the knowledge that youth can receive from

traditional means, social media tools have the ability to preserve the entertainment value of messages that youth are used to receiving online, maintain their rights to privacy and anonymity, as well as provide enhanced convenience and accessibility of sexual health information.

The 2009 PRT survey confirmed that no two youths are the same, and no single approach to delivering sexual health information is appropriate for all. To meet everyone's needs, information should be made available in a variety of formats and through a variety of channels. Based on this line of thought, PRT secured funds to develop a multimedia health website and text messaging service for Native teens and young adults that will promote holistic health and positive identity and development. The website and text messaging campaign (funded by the President's National HIV/AIDS Strategy and IHS's National HIV/AIDS and STD Programs) will specifically target AI/AN teens and young adults. The site will address health and social issues important to Native youth and will integrate other social marketing strategies, like MySpace®, Facebook®, Twitter®, and text messaging.

Native youth, elders, and topical experts from throughout the US will be identified to assist in the construction of the website, by becoming authors of blogs, directors of videos, graphic design artists, and more. The text messaging service that is being designed to support the website will send out periodic health tips, provide subscribers with updates on related contests and social service opportunities, and challenge youth to take a more active role in their personal health and wellbeing.

Join us! Text the word “TALON” to 24587 to sign up now!

For more information on PRT's Multimedia campaign, please contact Jessica Leston, jleston@npaihb.org or David Stephens, dstephens@npaihb.org.



Introducing the Native VOICES Project: Developing an Evidence-based STD/HIV and Teen Pregnancy Prevention Intervention for Native Youth

Wendee Gardner, MPH, Project Coordinator, Project Red Talon, Northwest Portland Area Indian Health Board, Portland, Oregon

In response to high rates of STIs and teen pregnancy among AI/AN youth, the Northwest Portland Area Indian Health Board's STD/HIV prevention project, Project Red Talon, is kicking off a new initiative to develop an evidence-based sexual health video for Native teens and young adults. The Native VOICES adaptation project is supported by a three-year grant from the IHS, issued through the Native American Research Centers for Health (NARCH) program.

The project will work closely with tribal and IHS partners to adapt a CDC-recognized intervention, *Video Opportunities for Innovative Condom Education and Safer Sex (VOICES)*, and to evaluate its effectiveness as an STD/HIV prevention resource for AI/AN teens and young adults 15 - 24 years old.

In its current form, the *VOICES* intervention is a single-session, video-based STD/HIV prevention intervention designed for African American and Latino adults.

There are four culturally specific videos available. Skills in condom use and negotiation are modeled in the videos then role-played and practiced by participants in small groups. At the end of the 45-minute facilitator-led session, participants are given condoms based on their individual preference. Evaluation studies found that *VOICES* participants demonstrated 1) an increased knowledge about the transmission of STD/HIV; 2) a more realistic assessment of their personal risk; 3) a greater likelihood of getting condoms and intending to use them regularly; and 4) fewer repeat STD infections.¹

To adapt the *VOICES* intervention for Native youth and young adults, the project will host a series of talking circles, individual interviews, and community feedback sessions over the next three years with tribal and urban-based partners in the Pacific Northwest. Project staff will also seek input from clinicians, health educators, and staff at AI/AN youth-serving organizations on the feasibility of the intervention and ways to successfully integrate the *Native VOICES* intervention into the flow of clinical and social services.

Through taking a community-based, youth-centered approach, the *Native VOICES* project will not only further our understanding of the sexual activity among Native teens and young adults, it will also produce an evidence-based video intervention designed to reduce risk for STD/HIV and

unwanted pregnancy for this population, while offering communities an intervention choice that is cost-effective and viable.

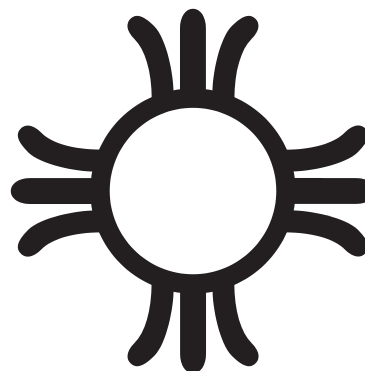
As always, Project Red Talon is committed to supporting healthy decision-making among Native teens and young adults. If found to be effective, the *Native VOICES* intervention will be a one-of-a-kind, culturally-appropriate resource for tribes and tribal organizations throughout the US.

For additional information about the *Native VOICES* adaptation project please contact Wendee Gardner, Project Coordinator, at wgardner@npaihb.org or (503) 416-3275.

To access the original *VOICES* intervention and other effective sexual health interventions visit CDC's compendium of evidence-based interventions at <http://www.effectiveinterventions.org/en/home.aspx>.

Reference

1. - Centers for Disease Control and Prevention (CDC). *VOICES Administrators Preview Guide*. Accessed from the Diffusion of Effective Behavioral Interventions site on January 21, 2011. http://effectiveinterventions.org/Files/09-1029_Admin_Preview_Guide-VOICES.pdf.



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 organizations
- - 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?

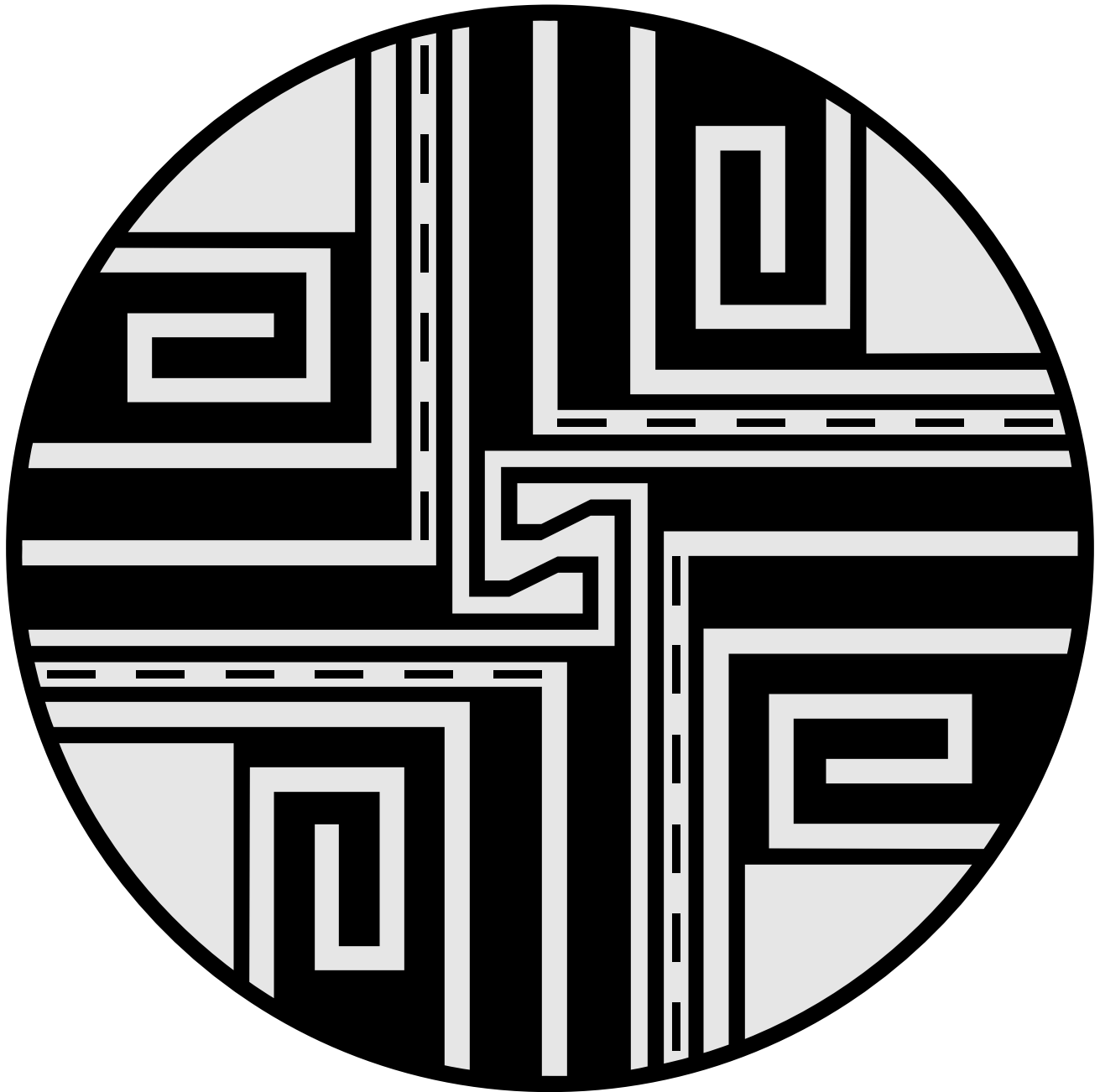
Awarding CTGs will allow communities to focus on advancing state, local, tribal, and territorial policies and systems to reduce the leading causes of death, associated risk factors, and health disparities.

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.



Identifying HIV/STI Screening Opportunities to Improve Nationally Reported Screening Rates using EHR

Robert Onders, MD, Clinical Director, Kodiak Area Native Association, Kodiak, Alaska; James D. Spillane, Clinical Applications Coordinator/Improvement Programs Analyst, Kodiak Area Native Association, Kodiak; Brigg Reilley, MPH, HIV Surveillance Coordinator, Division of Epidemiology and Disease Prevention, IHS, Albuquerque, New Mexico; Jessica Leston, MPH, Project Coordinator, Northwest Portland Area Indian Health Board, Portland, Oregon

Introduction

Providers are called upon to conduct many types of patient screenings. There are currently well over 30 adult preventive health care screening services recommended.¹ Studies show Americans receive about one half of these recommended medical processes despite accessing the health care system.² This underutilization of recommended services has an adverse impact on the health of the population. This is especially true for HIV/STI screening. It can be a challenge to identify which patients are overdue for which screenings, especially when the purpose of visit is unrelated -- for example, identifying that a young woman visiting the clinic for headache is also due for her annual *Chlamydia trachomatis* (CT) screening. However, this is the very nature of screening versus testing; we test patients with symptoms, but we screen apparently well people to find those at increased risk for a disease or disorder. One screening program that has shown success is routine HIV screening for blood donors and prenatal patients. As a result, transfusion-related and mother-to-child transmissions of HIV/AIDS have been reduced significantly. One key element to the success of these screening programs is that all pregnant women and blood donors are screened regardless of apparent risk factors. This screening approach is particularly worthwhile when a disease can be diagnosed with a test that is low cost, highly reliable, and non-invasive, even if the disease has a low prevalence.

The national recommendations for HIV and STI screening are of great importance because early detection can not only lead to medical interventions that result in a cure for the individual (or effective treatment in the case of HIV/AIDS) but can also contribute to the health of the community. Four nationally reported Clinical Reporting Systems (CRS) measures reinforce the national HIV/STI screening

recommendations (Table 1): 1) prenatal HIV screening, 2) annual chlamydia screening for women under the age of 25, 3) comprehensive STI follow up (e.g., if positive for one STI, patients should be screened comprehensively for these others as well: CT/GC/syphilis/HIV), and 4) HIV screening for people between the ages of 13 and 64 (once in a lifetime, depending on risk).

Chart audits at several IHS service units have identified common visit types during which patients who are due for screening can be identified. During medical visits, electronic health records (EHR) reminders can help providers identify patients who are due (or overdue) for HIV/STI screenings. For example, chart reviews at tribal and IHS clinics have shown that over 90% of STI diagnoses are CT, and over 90% of missed opportunities result from patients who have CT and are not being screened for HIV (and syphilis, in regions where this is appropriate). Linking a CT diagnosis with an HIV (and syphilis) screening reminder would greatly increase comprehensive STI screening rates. Chart reviews at service units have also shown that many missed opportunities for annual CT screenings for women under the age of 25 could be avoided if pregnancy tests and other urine tests would prompt a CT screen at time of visit.

EHR, particularly the clinical reminders function, can be instrumental to improved patient outcomes for effective and appropriate HIV/STI health care. As previously mentioned, the majority of health care visits are related to specific problems rather than for preventive or screening services. In order for patients to get the recommended preventive services during a problem-focused visit, the services due for the individual patient must be easily retrievable and must prompt the provider to order them.³ The clinical reminders tool has the potential to offer providers a more effective prevention and outreach mechanism to aid in the deterrence of chronic conditions, including HIV/STI, that diminish the health and quality of life for AI/AN people and the community as a whole.

Kodiak Area Native Association Case Study: Increasing Screening Using Electronic Clinical Reminders

The Kodiak Area Native Association (KANA) was formed in 1966 as a 501(c)(3) non-profit corporation providing health and social services for Alaska Natives of the Koniag region. The KANA service area includes the city of Kodiak and its

Table 1. CRS Measures and Corresponding EHR Reminders

	Measure	EHR Reminders to Increase Screening
<p>Chlamydia National guidelines recommend annual CT screening for sexually active women < 25.</p>	<p>The national measure records the % of women ages 15 - 24 who received a CT screen in the last 12 months.</p>	<ul style="list-style-type: none"> • CT reminder for women ages 15 - 24 with no CT test in last 12 months. • CT reminder for persons diagnosed with CT to be retested after 3 months to evaluate re-infection. • CT screen reminder for women ages 15 - 24 (age range can be modified depending on local data) with pregnancy tests, even if last CT test was within 12 months
<p>Comprehensive STI Screening National guidelines state that STI patients are at high risk and should be screened for other STIs.</p>	<p>The national measure records what % of patients diagnosed with an STI received follow up screening for other STIs within 60 days of initial diagnosis.</p>	<ul style="list-style-type: none"> • HIV (and syphilis in Areas where indicated) reminder for persons diagnosed with CT/GC. • HIV (and syphilis in Areas where indicated) reminder for persons picking up meds for CT/GC.
<p>HIV Screening National guidelines recommend one routine HIV test for 13 - 64 year olds, with repeat testing based on clinical judgment</p>	<p>The national measure records what % of eligible patients were screened for HIV in the past 12 months.</p>	<ul style="list-style-type: none"> • HIV reminder for persons with no HIV test (and who are not HIV+). *

*Although the recommendation is one routine HIV screening, some SUs have elected to use a reminder with a 5-year reminder interval.

If you are interested in any of these reminders for your service unit, please contact your local CAC, or contact Brigg.Reilley@ihs.gov.

connecting road system, and six remote villages: Akhiok, Karluk, Larsen Bay, Old Harbor, Ouzinkie, and Port Lions. KANA encompasses the ten federally recognized Tribes of Kodiak Island and has a patient population of 3,400, averaging 23,000 patient visits a year.

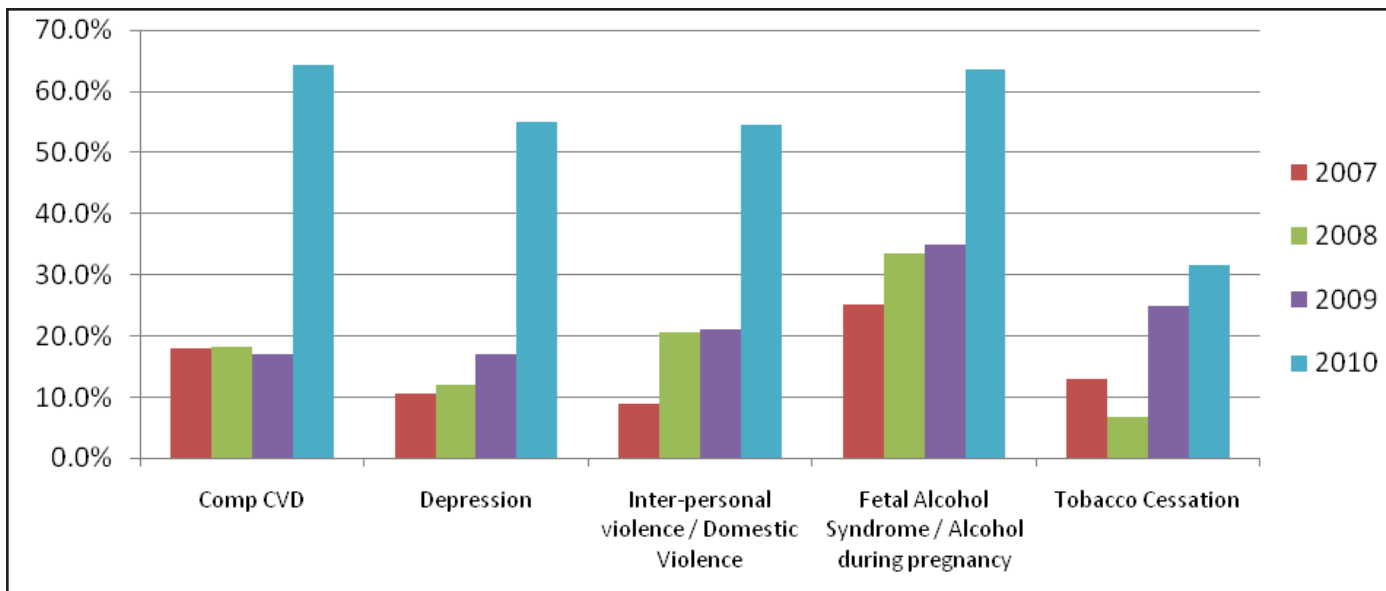
EHR Tracking and Prompting Through Clinical Reminders

KANA began utilizing the clinical reminders function of the EHR in 2009. By tracking health screenings done with clinical reminders in the clinic, KANA determined a series of steps were necessary to obtain greater than 90% completion rate. The first step was the deployment of the reminder to the providers with local modifications until the reminder was functioning well. The second step was to track individual provider utilization rates and give these results to providers with peer comparisons. The final step was to provide case management to individual providers to both notify the clinical team what preventive services were due among patients who had scheduled visits that day, and/or to bring patients in specifically for preventive services due. Since the start of

this process, KANA beneficiaries have seen a significant increase in referrals for the following screenings: comprehensive cardiovascular disease components, depression, inter-personal violence/domestic violence, alcohol dependency, and tobacco use and tobacco cessation (Figure 1). Through this process, KANA has been recognized as the first tribal health organization in Alaska and one of four organizations nationally to meet or exceed all 21 treatment and prevention goals established by the IHS and reported through the Government Performance and Results Act (GPRA) in 2010.

The Resource and Patient Management System (RPMS) EHR clinical reminders program allows providers at KANA to see all services that a patient is due for with a single mouse click, and the program is highly customizable to local screening practices or desires. KANA has found clinical reminders to be the best electronic resource to capture services due during an individual patient visit.

Figure 1. KANA Clinical reminders function for improving GPRA measures, patients screened by condition, 2007 - 2010



Extension of Reminders to HIV/STI Screening

In October 2010, KANA created three locally based reminders to attempt to capture CDC guidelines for HIV/STI

screenings. Figures 2 - 4 demonstrate the pop-up reminder logic that prompts providers at KANA to screen for HIV/STI.

Figure 2. KANA HIV Reminder

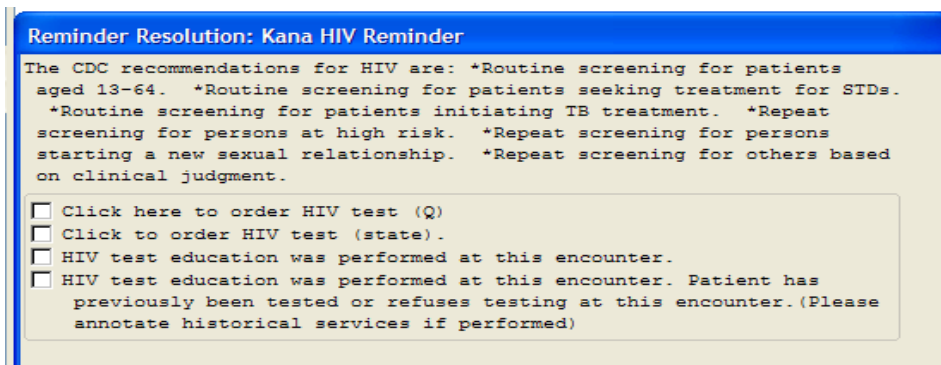


Figure 3. KANA Chlamydia Screening Reminder

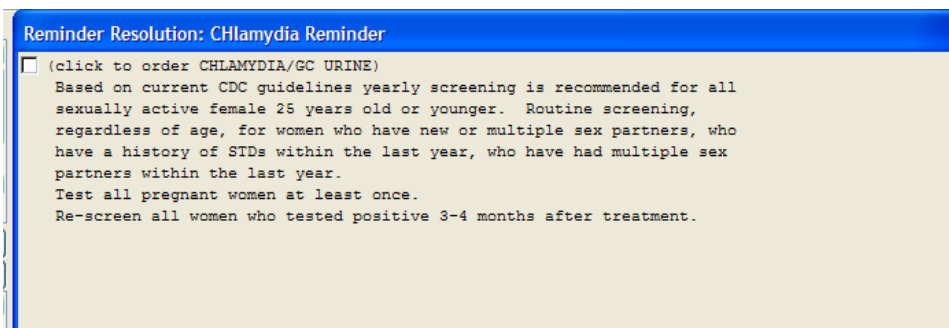
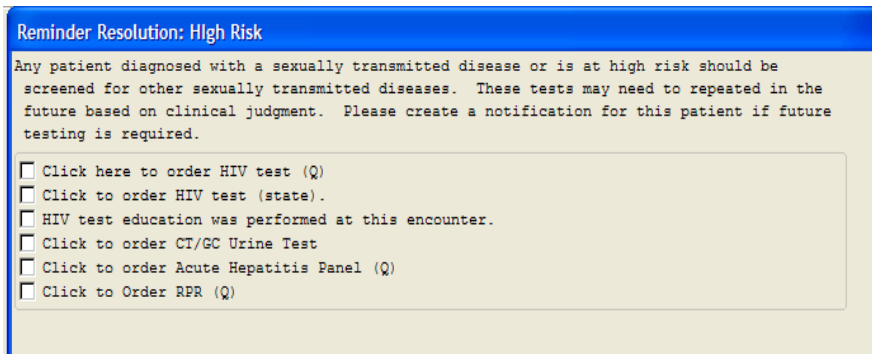


Figure 4. Comprehensive STI Screening (This clinical reminder is “turned on” by a patient being diagnosed with a STI in the last year and turned off by ordering at least an HIV test)



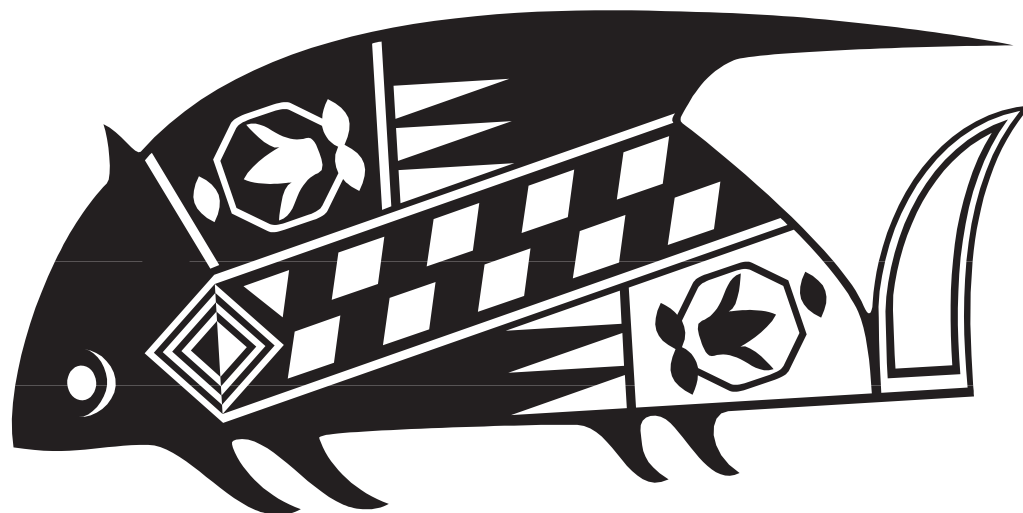
Lessons learned from HIV/STI Clinical Reminders at KANA

In order for an improvement effort to be successful, there are three requirements: will, ideas, and execution. In order for a clinical reminder to be successful these three requirements must be addressed. A clinical member who is knowledgeable about the clinical guidelines and the applicable local data can increase motivation for change and build the will for improvement. Ideas for deployment can be generated by discussing the reminders with multiple providers and other local resources with expertise on the topic. Finally, for successful execution, the reminders must work technically at your site and must be deployed gradually with a strategy of PDSA (Plan, Do, Study, Act) cycles. Start with a single provider and do not expand until it has proved successful for that provider.

For more information about KANA's experience, contact Robert Onders at robert.onders@kanaweb.org or James Spillane at james.spillane@kanaweb.org.

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Partnership to Prevent Teen Pregnancy and HIV/STIs among AI/AN Youth: *It's Your Game . . . Keep It Real*

Ross Shegog, PhD, Associate Director of Communication; and Christine Markham, PhD, Deputy Director; both from the University of Texas Prevention Research Center, University of Texas School of Public Health, Houston, Texas and the *It's Your Game — AI/AN Collaborative Team*

The Centers for Disease Control and Prevention (CDC) recently awarded a grant to the University of Texas Prevention Research Center (UTPRC) for a four-year Special Interest Project (SIP) study to develop, implement, and evaluate an HIV, STI, and pregnancy prevention curriculum for AI/AN middle school youth. UTPRC is collaborating with several tribal partners from across Indian Country to adapt an effective HIV, STI, and pregnancy prevention curriculum called *It's Your Game . . . Keep It Real (IYG)* for online use by AI/AN middle school youth (12 - 14 years of age) and to test its effectiveness in delaying the initiation of sexual behavior among this population.

As has been written elsewhere in this issue of *The Primary Care Provider*, AI/AN youth are disproportionately affected by teen pregnancy, STIs, and HIV compared to their non-Native peers. After a 15-year decline, the national teen birth rate rose between 2005 and 2007. Within this increase, AI/AN teens comprised the greatest growth at 12% compared to other racial/ethnic groups, with one in five AI/AN teen girls becoming pregnant and giving birth before the age of 20 years.¹ AI/AN youth also experience significant and persistent HIV/STI disparities compared to other US teens. In 2008, AI/AN youth 15 - 19 years of age were over three times more likely than non-Hispanic whites and 1.5 times more likely than Hispanics to be diagnosed with chlamydia and gonorrhea,² also increasing their risk of contracting HIV. Studies also suggest that sexual initiation often occurs earlier among AI/AN youth compared to other US teens, and often without pregnancy or STI/HIV protection.¹

National survey data show that many AI/AN youth use media technology at even higher rates than other teens to create social networks and share their culture within and beyond their local community.^{3,4} The *IYG* collaboration will test the use of health communication technology as a channel to provide effective HIV, STI, and pregnancy prevention interventions for AI/AN middle school youth. The effectiveness of an evidence-based curriculum delivered via

the Internet offers a promising innovation for this population.

The *IYG* study is aimed at promoting health equity and reducing disparities by 1) providing those working in Indian Country with a culturally-tailored prevention program for AI/AN youth, and 2) generating a cost-effective, highly reliable web-based sexual health curriculum for widespread access.

About the IYG Curriculum

Developed at the UTPRC, the *IYG* curriculum was designed to prevent HIV, STIs, and unplanned pregnancy among middle school students. As originally developed, the *IYG* curriculum consists of 24 lessons provided in a traditional classroom format and through the computer. The curriculum includes the following content:

- - Biology to explain puberty and reproduction
- - Social support, including healthy friendships and dating relationships
- - Choosing personal limits, identifying challenges, and protecting those limits
- - Emotional, physical, and social consequences of sexual activity
- - Reducing the risks associated with sexual activity

Since 2004, *IYG* has been evaluated in two randomized trials in Texas middle schools with diverse populations, including Hispanic and black youth. Results have demonstrated *IYG*'s effectiveness in delaying the initiation of sexual activity and reducing other risky sexual behaviors among 7th and 8th graders (12 - 14 years of age) for up to 24 months. *IYG* also positively impacts other important factors including intentions, beliefs, perceived norms, and knowledge about sex; self-control and confidence; refusal skills; rationale for not engaging in sexual behavior; and exposure to situations that put them at risk.⁵ The US Department of Health and Human Service, Office of Adolescent Health lists the curriculum as an effective, evidence-based intervention, and the American Public Health Association (APHA) awarded *IYG* its 2010 digital media award. An entirely Internet-based version of *IYG*, comprised of 13 multimedia lessons featuring interactive activities, animations, video serials, peer role model video, quizzes, and games is being released in March 2011 through National Institutes of Health (NIH)/National Institutes of Mental Health (NIMH) funding. This version of *IYG* has the

potential of providing optimal fidelity and reach beyond traditional school-based curriculums, into rural and underserved communities.

Adaptation for AI/AN Youth

The multi-site study for the adaptation of *IYG* for AI/AN youth commenced in fall 2010, and will be conducted in two phases. During Phase 1, the Internet-based *IYG* program will be tested by youth and reviewed by adult stakeholders in participating tribal communities to determine its cultural relevance, acceptability, and appeal for use with AI/AN youth. Carol Kaufman, PhD (Colorado School of Public Health) and William Lambert, PhD (Oregon Health and Science University) will be providing expert consultancy in this process. This process will inform the development of a newly adapted program (*IYG-AI/AN*) that will go through another round of reviews by the youth and community stakeholders prior to field testing. During Phase 2, *IYG-AI/AN* will be tested in a randomized study with 1200 12 - 14 year old AI/AN youth in regional tribal middle schools and Boys and Girls Clubs. The study will assess if youth who receive *IYG-AI/AN* are more likely to delay sexual initiation compared to those who receive a comparison program by a 16 month follow-up. If effective, *IYG-AI/AN* will be made available to AI/AN communities and schools nationwide. Throughout the phases of the project, IRB and tribal approvals will be attained by the appropriate entity.

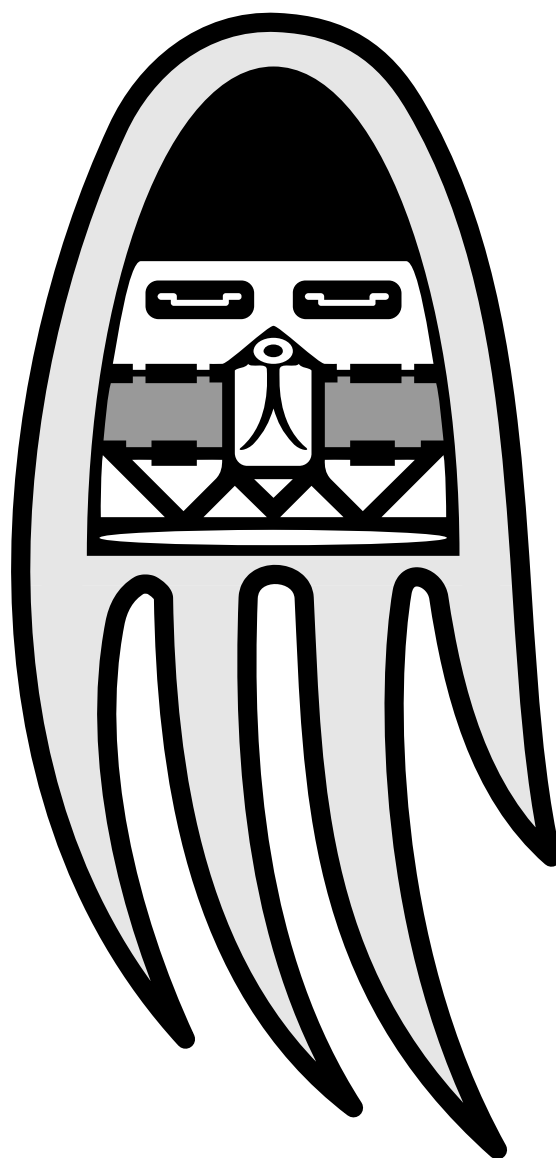
For more information about the existing *IYG* program, visit www.itsyourgame.org (code N78). For more information about the *IYG* cultural adaptation for AI/AN youth, please contact rocio-maria.b.garza@uth.tmc.edu. The principal investigators on this project may be contacted via e-mail at ross.shegog@uth.tmc.edu and christine.markham@uth.tmc.edu.

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Acknowledgement

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Traveling for Work? Information to Help You on the Road

Diane Cooper MSLS, AHIP, NIH Library Services for IHS

IHS staff use information daily to help reach their goals. Here are some information sources that may be useful for your business travel. Mostly, these are apps that you use on a Blackberry, Android, iPhone/iPod, or iPad. Apps may help make traveling a little easier for you. Here are just a few.

Tripit (Free) for Android, iPhone, BlackBerry, Laptop

This handy all-in-one app collates all your travel plans and trip details in one easily accessible place. Just forward your flight, hotel, car confirmation e-mails to Tripit and it will build your trip itinerary for you. Add maps to help you when you arrive at your destination. You have access anytime on your mobile device. If you prefer, you can also use this program on your laptop; you don't have to have a mobile device. You can share your itinerary with family and friends so they know where you are. It might be the trip management program you use over and over. <http://www.tripit.com/>

FlightTrack (\$4.99) for iPad, iPhone/iPod

Tracks flights with zoomable maps; offers real-time departure information, delays, and gate numbers at a glance. It even updates the traveler on any cancellations. Users can also sync timings with their calendar. <http://itunes.apple.com/us/app/id296240199?mt=8>

GateGuru (Free) for iPhone only right now; but will expand to other mobile platforms in the near future

Find your way around airports. You can find services,

retailers, and the places to eat while waiting for your flight or when you have layovers. <http://gateguruapp.com/>

Yelp (Free) for Blackberry, iPhone/iPod, Android, Blackberry, Palm Pre, Windows Phone7, Web browser

This app is great for finding a place to eat in the city you are visiting. It suggests restaurants and you can also use it to search for other services, such as gas stations, banks, and coffeehouses, to name a few. The restaurants and services displayed are often paid commercials. <http://www.yelp.com/>

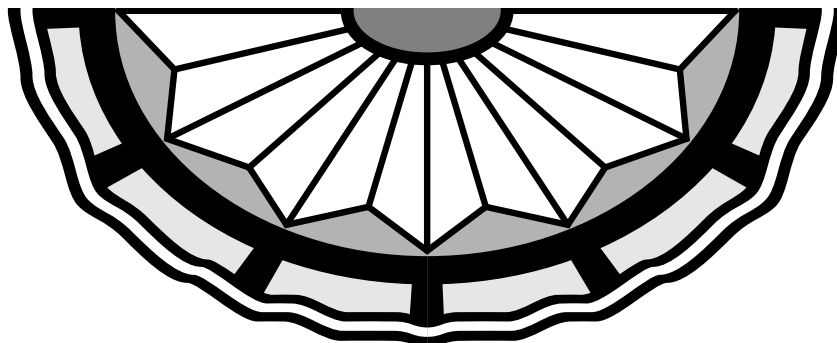
Boingo (\$7.95/month) for Blackberry, iPhone/iPod/iPad, Android, Windows Mobile

A service-provider app that helps you find free and Boingo hotspots worldwide and gets you connected automatically. It enables unlimited Wi-Fi at selected airports, hotels, restaurants, coffee shops, and other venues in more than 200,000 hotspots worldwide. Boingo is useful for frequent business travelers, who can stay connected without having to deal with roaming fees. Users can select from various plans depending on required usage needs. <http://mobile.boingo.com/>

SodaSnap (Free) iPhone/iPod

Take pictures of your travels. You can send them as e-cards back to your supervisor (or, of course, if you wish, to your family and friends). <http://www.sodasnap.com/>

Diane Cooper, Biomedical Librarian and Informationist at the NIH Library, can be reached at cooperd@mail.nih.gov



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.

**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)

Family Practice Physician Social Worker

Consolidated Tribal Health Project; Redwood Valley, California

The Consolidated Tribal Health Project in Redwood Valley, California is recruiting for a family practice physician and a social worker. These positions are full-time with benefits; salary DOE. All applicants will be considered; Native American preference applies. Visit www.cthp.org for an application and job description. Send application and resume to HR Department by fax at (707) 485-7837. ADA/EEO. (3/11)

Family Medicine, Internal Medicine, Emergency Medicine Physicians

Family/Pediatric Nurse Practitioner for School Health Program

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

The Sells Service Unit (SSU) in southern Arizona is recruiting for board certified/board eligible emergency room physician to join our experienced medical staff. The Sells Service Unit is the primary source of health care for approximately 24,000 people of the Tohono O odham Nation. The service unit consists of a Joint Commission accredited 34-bed hospital in Sells, Arizona and three health centers: San

Xavier Health Center, located in Tucson, Arizona, the Santa Rosa Health Center, located in Santa Rosa, Arizona, and the San Simon Health Center located in San Simon, Arizona, with a combined caseload of approximately 100,000 outpatient visits annually. Clinical services include family medicine, pediatrics, internal medicine, prenatal and women's health care, dental, optometry, ophthalmology, podiatry, physical therapy, nutrition and dietetics, social work services, and diabetes self-management education.

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

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

Mid-Level Practitioner Pediatrician

St. Regis Mohawk Health Service; Akwesasne, New York

The St. Regis Mohawk Tribal Health Service is looking for a mid-level practitioner and a pediatrician to work in our general practice clinic. We are located in Akwesasne, New York, and we are uniquely situated in northeastern upstate New York. Split right down the middle by the Canadian border, we are in the northern foothills of the Adirondack Mountains and along the beautiful and historic St. Lawrence River.

We are 90 miles from both Montreal, Quebec, and Ottawa, Ontario (about 5½ hours north of New York City).

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

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

**Family Practice Physician
Family Nurse Practitioner
Physician Assistant
Psychiatrist
Bay Mills Health Center/Bay Mills Indian Community;
Brimley Michigan**

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

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

We are in need of a certified mid-level practitioner, a FNP or a PA, with a background in Family Practice.

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

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

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

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

**Medical Director
Emergency Room Physicians
Emergency Medicine PA-Cs/Nurse Practitioners
Family Practice PA-Cs/Family Nurse Practitioners
OB/GYN Physician
Nurse Mid-Wives
Family Practice Physicians
Rosebud Comprehensive Health Care Facility;
Rosebud, South Dakota**

The Rosebud Comprehensive Health Care Facility in Rosebud, South Dakota is seeking board eligible/board certified physicians and mid-levels with at least 2 - 3 years post-residency experience. We are also in need of ER PA-Cs, family practice PA-Cs, and family nurse practitioners.

Rosebud is located in rural south central South Dakota, west of the Missouri River on the Rosebud Indian Reservation and is approximately 30 miles from the Nebraska border.

We are a 35-bed facility that has a 24-hour emergency department, and a busy clinic that offers the following services: family practice, internal medicine, ob/gyn, pediatrics, general surgery, optometry, dentistry, physical therapy, dietary counseling, and behavioral health. Our staff is devoted to providing quality patient care, and we have several medical staff members who have been employed here ten or more years. The beautiful Black Hills, Badlands, Custer State Park, Mount Rushmore, and Crazy Horse Memorial are just 2 - 3 hours away. South Dakota is an outdoorsman's paradise with plenty of sites for skiing, hiking, hunting, fishing, boating, and horseback riding. Steeped in western folklore, Lakota cultural history, and the lands of such famous movies as *Dances with Wolves* and *Into the West*, there is plenty for the history buff to explore. If you are interested in applying for a position, please contact Kevin Stiffarm, Chief Executive Officer, at (605) 747-3111, (605) 517-1283; or e-mail him at kevin.stiffarm@ihs.gov. (11/10)

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

Join seven experienced primary care physicians in beautiful north central Wisconsin 45 miles from Green Bay. We provide comprehensive primary care for Wisconsin's longest residing residents at a large, established clinic on the banks of the Wolf River. Practice in an efficient setting with committed colleagues, your own nurse, and a robust electronic health record. Inpatient and obstetrical care are provided at a 25-bed community hospital nine miles away, where family doctors do C-sections, colonoscopies, and EGDs. Live in a safe town of 8000 with great schools and endless recreational opportunities. Competitive compensation available, along with loan repayment (NHSC and State of Wisconsin). Contact Kevin Culhane, MD at (715) 799-5786, or e-mail at kevinc@mtclinic.net. (10/10)

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

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

The dietitian will assess, plan, implement, and evaluate community nutrition programming focused on diabetes prevention. Additionally, the community dietitian offers

medical nutrition therapy to clients living with diabetes and pre-diabetes on an on-site, outpatient basis as well as using distance delivery via Polycom. These services are provided to individuals, small groups, and communities in Juneau and the northern SEARHC region. SEARHC is a non-profit tribal health consortium of 18 Native communities, which serves the health interests of the Tlingit, Haida, Tsimshian, and other Native people of southeast Alaska. Residents of southeast Alaska towns share a strong sense of community. Residents take full advantage of the excellent opportunities for fishing, boating, skiing, hiking, and other outdoor activities. Applications are available on-line at www.searhc.org, or please contact Human Resources at (907) 463-6693. (10/10)

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

The Western Oregon Service Unit is a comprehensive

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

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

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

The 16th Annual Elders Issue

The May 2011 issue of THE IHS PROVIDER, to be published on the occasion of National Older Americans Month, will be the sixteenth annual issue dedicated to our elders. Indian Health Service, tribal, and Urban Program professionals are encouraged to submit articles for this issue on elders and their health and health care. We are also interested in articles written by Indian elders themselves giving their perspective on health and health care issues. Inquiries or submissions can be addressed to the attention of the editor at the address on the back page of this issue.



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>.

2011 Native Fitness Training and 14th Annual Native Diabetes Prevention Conference

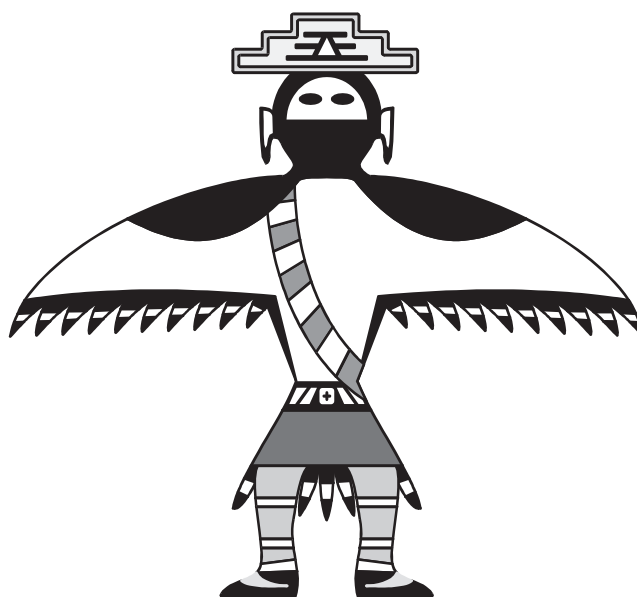
June 12 – 17, 2011; Santa Fe, New Mexico

The American Indian Institute at the University of

Oklahoma is pleased to announce the 2011 Fitness Training and 14th Annual Native Diabetes Prevention Conference to be held at the Eldorado Hotel and Spa in Santa Fe, New Mexico in June. The Native Diabetes Prevention Conference will be held June 13 – 17, 2011, offering a total of 2.0 CEUs (20 hours). The conference brings together individuals representing academia, tribal health systems, public health researchers, practitioners, behavioral health, and tribal members from AI/AN and Canadian First Nation communities. General sessions, workshops, and wellness activities will focus on diabetes prevention, methods of healing for individuals living with diabetes, and self-management practices. Conference sessions include evidence and practice-based programs, AI/AN and First Nations diabetes research, and experiential learning. The deadline to submit a proposal for presentation is Friday, March 18, 2011.

Falling just before the conference, the Native Fitness Training will be held June 12 – 14, 2011, offering 1.6 CEUs (16 hours). Topics covered during the training include anatomy and physiology, biomechanics, nutrition, exercise and weight management, instructional skills, class development, marketing, injury prevention and safety, special populations, choreography, and legal considerations. In addition to building a strong knowledge base, participants will learn how to organize, instruct, and market a Native-specific fitness program in tribal communities. Training is limited to 50 participants.

Please visit our conference webpage for more information or to register online: <http://aii.ou.edu/conferencetrainings/>.



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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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