



Billings Indian Health Service Area H1N1 After Action Report

2009 - 2010

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ACKNOWLEDGMENTS

The Montana Wyoming Tribal Leaders Council, in collaboration with Montana and Wyoming Tribes, Tribal Health Departments, the Billings Area Indian Health Service (IHS), all Montana and Wyoming Service Units and Urban Indian Clinics, the Montana State Health Department, Wyoming State Health Department and IHS Immunization Program would like to present the “Billings Area Indian Health Service H1N1 After Action Report, 2009 – 2010”.

This report summarizes the efforts and commitment of the Billings Area Indian Health Service H1N1 Response Team (above) during the 2009 – 2010 H1N1 pandemic.

The Billings Area Indian Health Service H1N1 Response Team worked hard to prevent and treat H1N1 in Montana and Wyoming Indian communities during the 2009 – 2010 H1N1 pandemic.

Well Done!

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BACKGROUND

The flu season starts in winter and usually ends by the beginning of summer. The peak of the flu season has progressively shifted from late December in the 1990s to late March in the 2000s, with an average peak season in February.

In 1995, for the first time since the 1988-89 season, influenza A (H1N1) viruses predominated in the United States overall and was a component of the vaccine (Vaccine components: A/Johannesburg/33/94 (H3N2), A/Texas/36/91 (H1N1), and B/Harbin/07/94).

David M. Bell, et al reported in the “Pandemic Influenza as 21st Century Urban Public Health Crisis Report” the initial appearance of the influenza A pandemic (H1N1) 2009 virus during the spring of 2009 in Mexico City, Mexico, and New York (NYC), New York, USA (metropolitan area populations 20 million and 19 million, respectively) (1).

In April 2009, the Centers for Disease Control and Prevention (CDC) reported the Swine-origin influenza A (H1N1) virus infections in a school in New York City. During spring 2009, CDC systems captured real-time monitoring of the pandemic in NYC, including documenting large increases in children with influenza like illnesses (ILI) seeking care at emergency departments, and tracking its spread throughout the city from one school where it apparently was first introduced and amplified (2).

Carrie Reed et al discussed the estimated Prevalence of Pandemic (H1N1) 2009 in the United States from April–July 2009. Through July 23, 2009, a total of 43,677 laboratory-confirmed infections with pandemic (H1N1) 2009 had been reported in the United States by the 50 states and the District of Columbia, including 5,009 hospitalizations and 302 deaths. This report was regarded as likely to be substantially underestimated. Correcting for under-ascertainment using a multiplier model, an estimate of 1.8 million– 5.7 million cases occurred, including 9,000–21,000 hospitalizations (3).

On October 24, 2009 President Obama signed the emergency declaration for H1N1 Flu (4).

Details of the document can be found at the website below:

<http://www.flu.gov/professional/federal/h1n1emergency10242009.html>

H1N1 and the First Nations/Indigenous Populations and American Indians

La Roche G et al reported Indigenous populations from Australia, Canada, and New Zealand have been found to have a three to eight times higher rate of hospitalization and death associated with infection with the 2009 pandemic influenza A (H1N1) virus (5).

Ryanz Zarychanski et al, from the Canadian Medical Association reported a correlation of severe disease in patients with 2009 pandemic influenza (H1N1) virus infection in January 2010. These researchers reported the fact that “First Nations” ethnicity was associated with severe diseases, relative to other ethnic groups, essentially suggesting “First Nations” as high risk ethnic groups for H1N1 (6).



The “CDC Morbidity and Mortality Weekly Report–MMWR” (December 11, 2009) reported deaths related to the 2009 Pandemic Influenza A (H1N1) among American Indian/ Alaska Natives in 12 States in 2009. In October, two U.S. states (Arizona and New Mexico) observed a disproportionate number of deaths related to H1N1 among American Indian/Alaska Natives (AI/ANs). The report demonstrated American Indian/Alaska Natives (AI/ANs) in the participating 12 states (including the state of Wyoming) had an H1N1 mortality rate that was four times higher than the rate for all other racial/ethnic groups combined. In all age groups, the AI/AN death rate was higher than the rate for all other racial/ethnic populations combined. Among the AI/AN deaths related to H1N1, 81.0% of decedents had high-risk health conditions, compared with 77.6% of persons in all other racial/ethnic populations combined. A greater percentages of AI/AN decedents had co-morbidities including asthma (31.0%) and diabetes (45.2%) than decedents in all other racial/ethnic populations combined (14.1% asthma and 24.0% diabetes) (7).

On Jan. 12, 2010 the U.S. Department of Health and Human Services unveiled two new public service announcement (PSA) campaigns targeting American Indians and Alaska Natives, urging them to get vaccinated for the H1N1 flu. At a press conference announcing the campaigns, HHS Secretary Kathleen Sebelius said the virus has hit Indian Country especially hard, citing a CDC report (above) that showed that Native Americans are four times more likely to die from H1N1 than the general population.

Sebelius said American Indians/Alaska Natives are at a greater risk because they have higher rates of conditions such as asthma, diabetes and heart disease. It is also due to the higher numbers that live in poverty and that lack access to medical care.

American Indian Population has since been defined as “High Risk” for H1N1 in the US.

The States of Montana and Wyoming

The first probable case of H1N1 in Montana was reported in a press release on May 8, 2009. The case involved a Yellowstone County adult male. The first case of confirmed H1N1 in Montana was May 11, 2009 and the first death from H1N1 was an American Indian adult reported on August 6, 2009.

In Wyoming, of the 3,109 confirmed cases, 239 (7.7%) occurred in Fremont County which has the highest American Indian population in one county (20% -25% American Indian population).



Vaccine Distribution

On October 8, 2009, the Department of Public Health and Human Service's Health Alert Network (HAN) System released the following statement on vaccine distribution:

-All 2009 H1N1 vaccine has been purchased by the Federal Government and is being allocated to States based on population estimates and distributed through a centralized distribution process.

-Each week the Centers for Disease Control and Prevention (CDC) notifies the Montana Department of Public Health and Human Services (DPHHS) Immunization Program, regarding the quantity and type of vaccine that is expected to be shipped to Montana. Based on this information, DPHHS then allocates a percentage of the state's total supply of the 2009 H1N1 vaccine to each county and tribe based on population estimates.

-All 2009 H1N1 vaccine will be shipped directly to Local County and tribal health departments. All providers must follow the ACIP recommendations to prioritize vaccine administration to those most at risk of complications associated with infection from H1N1.

On October 21, 2009, the CDC released the "Resource Guide for American Indian/Alaska Native Tribal Governments 2009 H1N1 Influenza Planning and Response" as a resource for tribal governments and tribal emergency preparedness planners, IHS, Tribal and Urban (I/T/U) Indian health care facilities, and state and local partners.

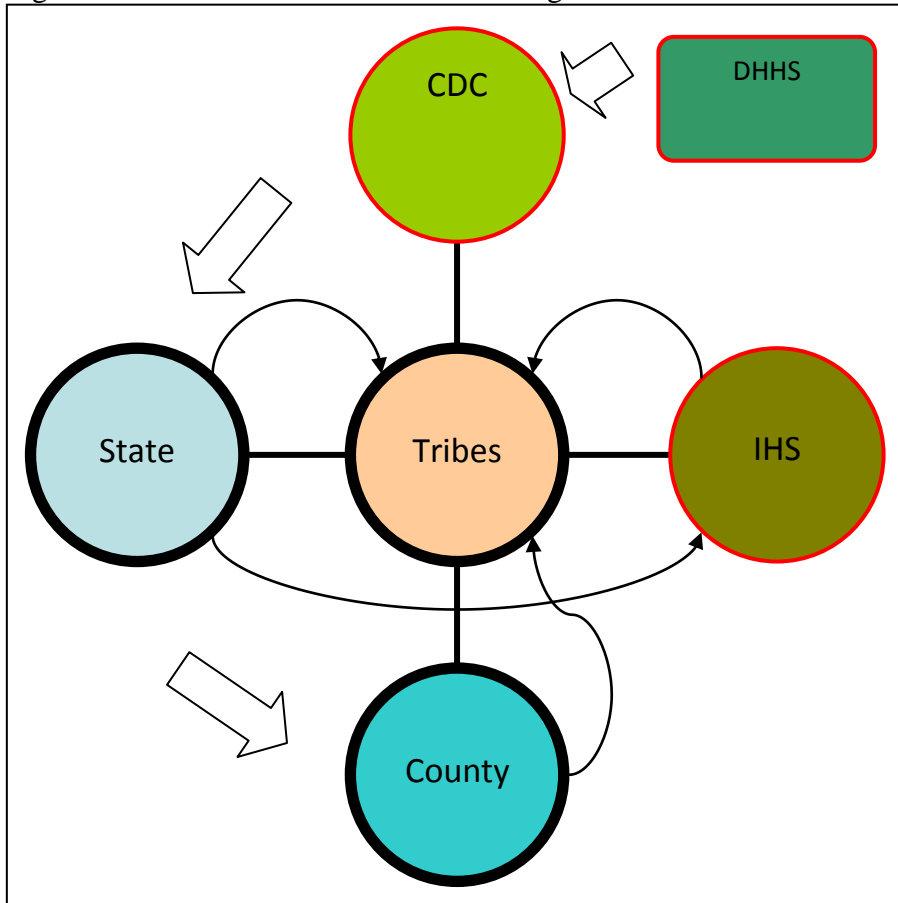
In light of the 2009 H1N1 influenza pandemic, Congress appropriated funding for the "Public Health and Social Services Emergency Fund" to prepare for and respond to the influenza pandemic. HHS received \$350 million in supplemental pandemic 2009 H1N1 funds, \$260 million of which went to CDC to support and enhance state and local public health infrastructure critical to public health preparedness and response. Ninety million dollars was awarded by HHS through the Hospital Preparedness Program (HPP). Because of the need for a quick turn around, CDC used existing funding mechanisms and has awarded the \$260 million through a Public Health Emergency Response (PHER) grant to the current 62 Public Health Emergency Preparedness (PHEP) grantees.

The legislation did not include tribes as eligible grantees for the Public Health Emergency Response (PHER) grant. Current PHEP grantees include all 50 states, the District of Columbia, 8 territories, and 3 urban health agencies. Because only current PHEP grantees were eligible for the PHER funds, tribes were not eligible to apply. Tribes, however, receive funds from state PHER awards.

CDC included specific language in the 2009 H1N1 PHER application mandating that states "work closely with local and tribal entities and governments to assure preparedness at all levels of government and access to the funding necessary to achieve this goal . . . CDC expects the states to engage American Indian/Alaska Native tribal governments, tribal organizations representing those governments, tribal epidemiologic centers, and/or Alaska Native Villages and Corporations located within their boundaries."



Figure 1. Tribal Allocation of Funds during the 2009 – 2010 H1N1 Pandemic



In 2010, funding allocations stabilized, and with some degree of difficulty Tribes were able to receive funds to purchase refrigerators and employ more public health nurses to administer vaccines during the H1N1 Pandemic, building their infrastructure in response to the public health emergency.

BILLINGS AREA INDIAN HEALTH SERVICE H1N1 RESPONSE TEAM

In the 2009 flu season (winter 2008 to beginning of summer 2009), the H1N1 pandemic began. The Billings Area Indian Health Service (BAO-IHS) developed an action plan with an H1N1 Response Team who met regularly during the 2009 flu season.

Billings Area H1N1 Response Team Goals and Objectives:

- 1) Support Service units, Tribes and Urban Centers (SU/T/U) in logistics and planning for Novel H1N1
 - Assessment of current plans and logistics at SU/T/U
 - Transmit consistent and concise information from Headquarters and State to SU/T/U
 - Strengthen current plans with SU/T/U
- 2) Monitor progress in addressing gaps
 - Collect Data reports (PCC, RPMS)
 - Surveillance
 - Service Unit Situational reports
- 3) Provide clear, concise, consistent communication with service units, Tribes and Urban Centers, as well as staff
 - Weekly Communication
 - BAO-IHS Meetings
 - SU/T/U Conference Calls
 - Calendar with all calls identified
 - Regular updates on Billings Widget
 - SharePoint
 - Maintain ICS structure at BAO-IHS
- 4) Collaboration and Partnerships
 - Provide and share access to information with the Rocky Mountain Tribal Epidemiology Center
 - Integrate the Rocky Mountain Tribal Epidemiology Center in the Incidence Command System
 - Heighten partnerships between SU/T/U
- 5) Provide guidance on implementation of H1N1 vaccination and prevention of H1N1 illness
 - Recommend criteria for administration of vaccine and anti-virals
 - Staff Safety

In the 2010 flu season (winter 2009 to beginning of summer 2010), the specific vaccine for H1N1 pandemic was being developed. The Billings Area H1N1 Response Team started meeting in early August to develop strategies for accommodating the new H1N1 vaccine acquisition, distribution and administration.

The Billings Area H1N1 Response Team also participated in H1N1 briefing meetings with the Indian Health Service Headquarters/Tribes; CDC conference calls; Association of State and



Territorial Health Officers (ASTHO); National Association of County and City Health Officials (NACCHO); and Emergency Nurses Association (ENA) educational calls.

As a result of the various partnerships, the Billings Area H1N1 Response Team was strengthened. Montana and Wyoming IHS Service Units, Urban Centers and Tribal Health representatives were invited to join in weekly updates and sharing meetings with the Billings Area H1N1 Response Team. Representatives were also encouraged to participate in Montana State Health Department and Wyoming Health Department update meetings. Meetings with the Billings Area H1N1 Response Team started in August 2009 and ended in April 2010. There were over fifteen (15) Billings Area H1N1 Response Team meetings and up to twenty five (25) conference calls between the Billings Area H1N1 Response Team and Service Units, Urban Centers and Tribal Health Department representatives. The Billings Area Office also had about fifteen (15) conference calls with IHS headquarters.

Initially, the agenda for the meetings comprised of various topics including:

- 1) Defining the role of the IHS Billings Area
- 2) Identify Team Members
- 3) Define roles of Team Members
- 4) Communication (who does what where when and how)
- 5) Surveillance (who does what where when and how)

Other topics discussed during follow-up meetings include:

- 1) Situational report
- 2) Surveillance update
- 3) Mitigation update
- 4) Vaccine update
- 5) Communication/Education
- 6) Service Unit Update

Note: Service Units H1N1 Preparedness and H1N1 vaccination readiness assessments were performed during these meetings. These have been included below.



BILLINGS AREA INDIAN HEALTH SERVICE H1N1 RESPONSE TEAM TABLES AND FIGURES

Table 1. Service Units H1N1 Preparedness Assessment Questions 2010 Flu Season -Function, Strengths, Accomplishments, Plans, Concerns, Questions, Issues, Gaps

<p>Team Meetings Frequency Work Format Tribal Involvement</p> <p>Guidelines CDC State Other</p> <p>Pandemic Flu Plan Written and Updated Specific to Location Viewed as Helpful Part of Emergency Preparedness Plan</p> <p>Communication Health Alert Network State Calls & Website (TCC) Tribe County</p> <p>Vaccine Adequate Storage and Security Designated Person for Vaccine Receipt Tracking Usage and Reporting</p> <p>Plans for Recall for Second Dose</p> <p>Vaccine Side Effects and Reactions Designated Process for Reporting Standing Orders for Immunization Written and Updated Prioritization in Shortage Situations VIS and Parental Consent Plans to Add H1N1</p> <p>Documentation, Recall, Reporting EHR Template IMM Package Timeliness</p> <p>Antiviral Medication Adequate Storage and Security Designated Person for Antiviral Receipt Tracking Usage and Reporting Current Supply Sources and Demand Education Infectious While on Antiviral</p> <p>Staffing Current Staffing Contingency Plans for Staff Illness OT, CT, SWAT Teams Other Professionals Available Volunteers Education and Credentialing</p>	<p>Supplies Gloves, Masks Hand Washing Tylenol Waste Disposal</p> <p>Media General Information Multiple Venues Special Topics</p> <p>Mass Vaccination Models Locations Clinic, Community, Schools, Home Evenings, Weekends</p> <p>Simulation Extremes Crowds and Waiting Times Angry Patients Poor Turnout</p> <p>Non-Beneficiary Billing Seasonal Influenza Vaccine Vaccine Received Immunizations Currently Offered Plans for Community Clinics</p> <p>Local Issues Other</p>
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Table 2. H1N1 Vaccination Readiness Assessment Questions 2010 Flu Season –Preliminary Assessment –H1N1 Vaccination Readiness

<p>Team Membership</p> <ul style="list-style-type: none"> Public Health Nurse Ambulatory Care Nurse Pharmacist Physician Infection Control Emergency Preparedness Media Representative Tribal Representative Other <p>Does a team exist? Are meetings held weekly? Do all the members come to meetings or communicate with team? Is there a working plan format guiding the meeting business? Has the tribe been involved in all the meetings? Are there written pandemic flu plans?</p> <p>Guidelines</p> <ul style="list-style-type: none"> CDC Clinical and Public Health Guidelines – http://www.cdc.gov/h1n1flu/guidance/ CDC Educational Materials http://cdc.gov/h1n1flu/flyers.htm State Resources – www.montanapublichealthtcc.org Immunization Action Coalition www.immunize.org State Conference Calls <p>Communications</p> <ul style="list-style-type: none"> Tribes (To whom within the Tribe?) HAN (Do all critical team members receive HAN directly?) State County Schools Hospitals Emergency Preparedness Contact Information for All Critical Personnel and Partners <p>Written Plans</p> <ul style="list-style-type: none"> H1N1 (especially mass immunization campaigns) Older Pandemic Plans (Are they current and available? Is it helpful?) <p>Standing Orders and Collaborative Agreements</p> <ul style="list-style-type: none"> Are there current standing orders for H1N1 and seasonal immunizations? Do standing orders define how vaccine supply will be prioritized if supply is limited? Do standing orders define how to handle lower priority patients who demand vaccine? <p>VIS and Parental Consent</p> <p>Mass Clinics and Ongoing Immunizations</p> <ul style="list-style-type: none"> Clinic, Community, and Home Locations Evenings and Weekends OT & CT SWAT Teams (Are there unemployed or retired nurses in community?) Pharmacists Credentialed to Administer Vaccine Other Volunteers Joint Efforts with County or Private Sector Contingency Plans for Major Staff Illness Education and Credentialing for H1N1 <p>Coordinated Efforts with County or Private Sector</p> <ul style="list-style-type: none"> Non-Beneficiary Issues and Liability Staff Credentialing Issues Billing (Medicaid, Medicare, Private Insurance can be billed for vaccine administration.)
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Vaccine

Who will receive vaccine shipments?
Is storage space adequate for large amounts of vaccine?
Are existing refrigerators adequate?
What alternative refrigerators might be used?
Are there plans for purchasing additional refrigerators?
McKesson?
How will vaccine be transported to outlying clinics?
How secure are vaccine storage locations?
How will vaccine usage be tracked to ensure it is given to appropriate high risk persons?

Recall for Second Vaccine Dose

When and how will recalls for second dose be done?
What media efforts will be used for reminding persons of need for second dose?
What special efforts will be used for recalling high risk patients?
(IMM Package is currently being patched to include H1N1 and recall at 28 days.)

Antiviral

How much antiviral is presently available?
What is the expiration date?
Were some antiviral provided by other source? Who?
Where are antivirals stored?
What priority guidelines are used to determine who receives antivirals?
How will additional antivirals be obtained?
Are there concerns with monitoring appropriate use of State supply?
Are patients placed on antivirals educated that they are still infectious?

Supplies

Gloves, Masks, Syringes, Waste Boxes
Hand washing
Other

Documentation

How will immunization be entered into RPMS, EHR, and IMM packages?
How rapidly can documentation into EHR and IMM package occur?
Will entry be done at time of visit (especially in community or school)?
How will patient information be protected in the community setting?
What additional staff is available to help with data entry?
Are EHR templates helpful? Is it working to combine IMM into EHR?
VIS, Lot Number, Risk Benefit, Adverse Reaction
Will documentation be adequate to allow billing?

Extremes

Crowds, Waiting Times, Angry Patients
Poor Turnout
Security Concerns

Side Effects and Adverse Reactions

What is the policy for monitoring and reporting side effects and adverse reactions?

Media

Who is in charge of media?
What media plans exist?
Are there plans for important or special topics?

- Hand washing, avoid touching face and mouth
- Short supply
- Limiting caregivers to infants less than 6 months
- Persons taking antivirals still infectious
- Return for second dose

Simulations

Best Communication Model for Area and Service Units

Email
Intranet
Conference Calls
Other

Other Issues



Figure 2. Indian Health Service Billings Area H1N1 Incident Command Team 2009 Flu Season

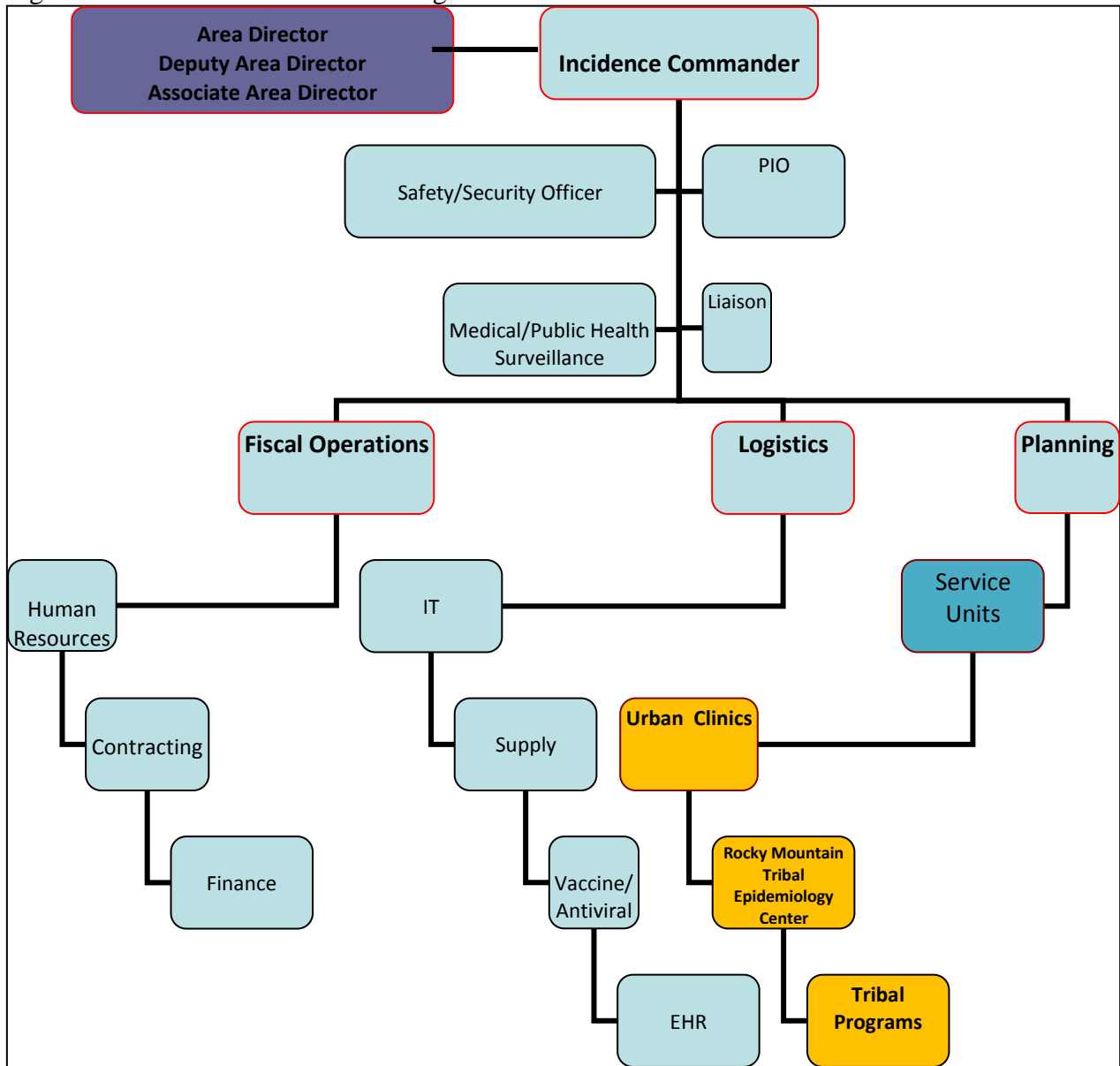


Table 3. Resource Contact List for H1N1 2010 Flu Season

***Resource Contact List for H1N1 *** 6/17/10						
Location	Vaccine (based on Public Health or Clinic Nursing)	Antiviral (based on Pharmacy)	Emergency Preparedness and Surveillance	Incident Command	Tribal Representative	IHS Contact for Individual State to Tribe Conference Calls
Blackfeet	<p>Geri England Geradetta.England@ihs.gov 406-338-6194</p> <p>Juanita Kittson Juanita.Kittson@ihs.gov 406-338-6240</p> <p>Susan Head Susan.Head@ihs.gov 406-338-6269</p>	<p>Gary Baker Gary.Baker@ihs.gov 406-338-6101</p>			<p>Nora Kennedy nlk@3rivers.net 406-338-6332 (work) 406-338-2481 (cell) 406-338-5326 (home)</p>	<p>Geri England Geradetta.England@ihs.gov 406-338-6194</p>
Crow	<p>Luana Auker Luana.Auker@ihs.gov 406-638-3479</p> <p>Nancy Fields-Estell Nancy.Fieldsestelle@ihs.gov 406-639-2317</p> <p>Ella Richards Ella.Richards@ihs.gov 406-638-3500</p>	<p>Amy Minnick Amy.Minnick@ihs.gov 406-638-3359</p>	<p>Luana Auker Luana.Auker@ihs.gov 406-638-3479</p> <p>Dr. Arnold Devous Arnold.Devous@ihs.gov 406-638-3467</p> <p>William Brown Wolf William.Brownwolf@ihs.gov 406-638-3461</p>		<p>William Driftwood williamd@crownations.net 406-638-3832 (work) 406-620-2220 (cell)</p> <p>Susette Nantospang</p>	<p>Luana Auker Luana.Auker@ihs.gov 406-638-3479</p>
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***Resource Contact List for H1N1 ***
6/17/10

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Rocky Boy	<p>Janet Runnion jrunnion@rbclinic.org 406-395-4486</p> <p>Sandra Friede sfriede@rbclinic.org 406-395-4486</p> <p>Jennifer Small jsmall@rbclinic.org 406-395-4486</p>	<p>Darin Miller 406-395-4486</p>	<p>Janet Runnion jrunnion@rbclinic.org 406-395-4486</p>		<p>Janet Runnion jrunnion@rbclinic.org 406-395-4486</p>	<p>Janet Runnion jrunnion@rbclinic.org 406-395-4486</p>
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***Resource Contact List for H1N1 ***
6/17/10

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***Resource Contact List for H1N1 ***
6/17/10

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ROCKY MOUNTAIN TRIBAL EPIDEMIOLOGY CENTER (A Division of the Montana Wyoming Tribal Leaders Council)

The Montana Wyoming Tribal Leaders Council's Rocky Mountain Tribal Epidemiology Center's (MTWYTLC/RMTEC) vision is to have healthy Tribal communities that are sustained through lasting collaborative partnerships.

During the 2009 – 2010 H1N1 pandemic, RMTEC was committed to updating the Montana and Wyoming Tribes on H1N1. There were many uncertainties and fears to be allayed. RMTEC set up a Flu section on its website (www.rmtec.org) with connection to CDC widget and to CDC/flu.gov.

All useful information was posted on the website. RMTEC developed culturally appropriate flyers for the season and distributed both its flyers and those of CDC, IHS, the state of Montana and the State of Wyoming Health Departments to all Tribal Health Departments in Montana and Wyoming. RMTEC also kept all Montana and Wyoming Tribes updated on the H1N1 status in their communities through periodic letters and reports to the Tribal Health Directors.

RMTEC is part of the Billings Area IHS Incident Command and the H1N1 Response Team. On November 18, 2009, a report was filed with the Tribal Leaders on H1N1 in collaboration with Billings Area IHS H1N1 team. The Billings Area IHS report is included below.

H1N1 Situation Briefing on Montana and Wyoming Reservations November 18, 2009

Vaccine

- *To date, 6500 doses of H1N1 vaccine were received and administered on Montana and Wyoming Reservations.*
- *H1N1 vaccine is still in short supply with small shipments received once to twice a week at all Montana and Wyoming Reservations.*
 - *H1N1 vaccine supply is projected to increase in coming weeks.*
- *Staffs are initially providing vaccine through clinics to the highest risk patients. These highest risk groups are: pregnant women, persons who live with or provide care for infants aged <6 months, children aged 6 months--4 years, children and adolescents aged 5--18 years with medical conditions that put them at higher risk for influenza-related complications, and health-care and emergency medical services personnel who have direct contact with patients or infectious material.*
- *Sites plan to expand target groups and move into school or community settings as supply increases.*
- *All H1N1 vaccine is distributed through State Health Departments based on census population. Billings Area monitors vaccine need and advocates for additional vaccine and funding for high risk populations on reservations.*
- *Urban clinics receive H1N1 vaccine through their respective counties. Billings Area is working with Montana State to ensure this happens.*
- *Demand for seasonal flu vaccine increased dramatically this year and existing supply is low. Pharmacists are searching for and ordering additional seasonal flu vaccine.*
 - *Pharmacists were trained to expand the number of qualified vaccinators available.*



Disease Burden

- *Hospitalizations and deaths are occurring in Indian patients throughout Montana and Wyoming. There are deaths being investigated to determine if H1N1 was the cause.*
- *Waves of H1N1 disease occurred in all locations. Currently disease is subsiding but additional peaks are expected.*
- *Billings Area is working with State Health Departments to ensure disease and death reporting occurs so this data can be used by IHS National Epidemiology Center and Centers for Disease Control to determine if there is a greater disease burden in Indian populations.*
- *Personal protective equipment especially N-95 masks is ordered to protect health care and emergency services staff.*

Communication

- *Community education and communication is occurring through patient handouts, posters, newspaper articles, local radio and TV stations, clinic marquees, community meetings, and individual patient follow-up.*
- *Staff are participating in State meetings and conference calls and Centers for Disease Control webinars to remain up-to-date on current recommendations.*
- *All locations are participating with their respective States to ensure a rapid response to changing vaccine supplies and increasing disease burden. Multiple conference calls between Indian Health Service, Tribes, Urban Clinics, States, and Counties occur throughout the week to provide news updates and resolve problems.*
 - *Billings Area Office, Montana-Wyoming Tribal Leaders Council, and Rocky Mountain Tribal Epidemiology Center are collaborating efforts to ensure all important information about H1N1 vaccine and prevention efforts are fully distributed and to improve data gathering strategies to ensure the full impact of H1N1 disease in Indian people is understood.*

Questions and Concerns

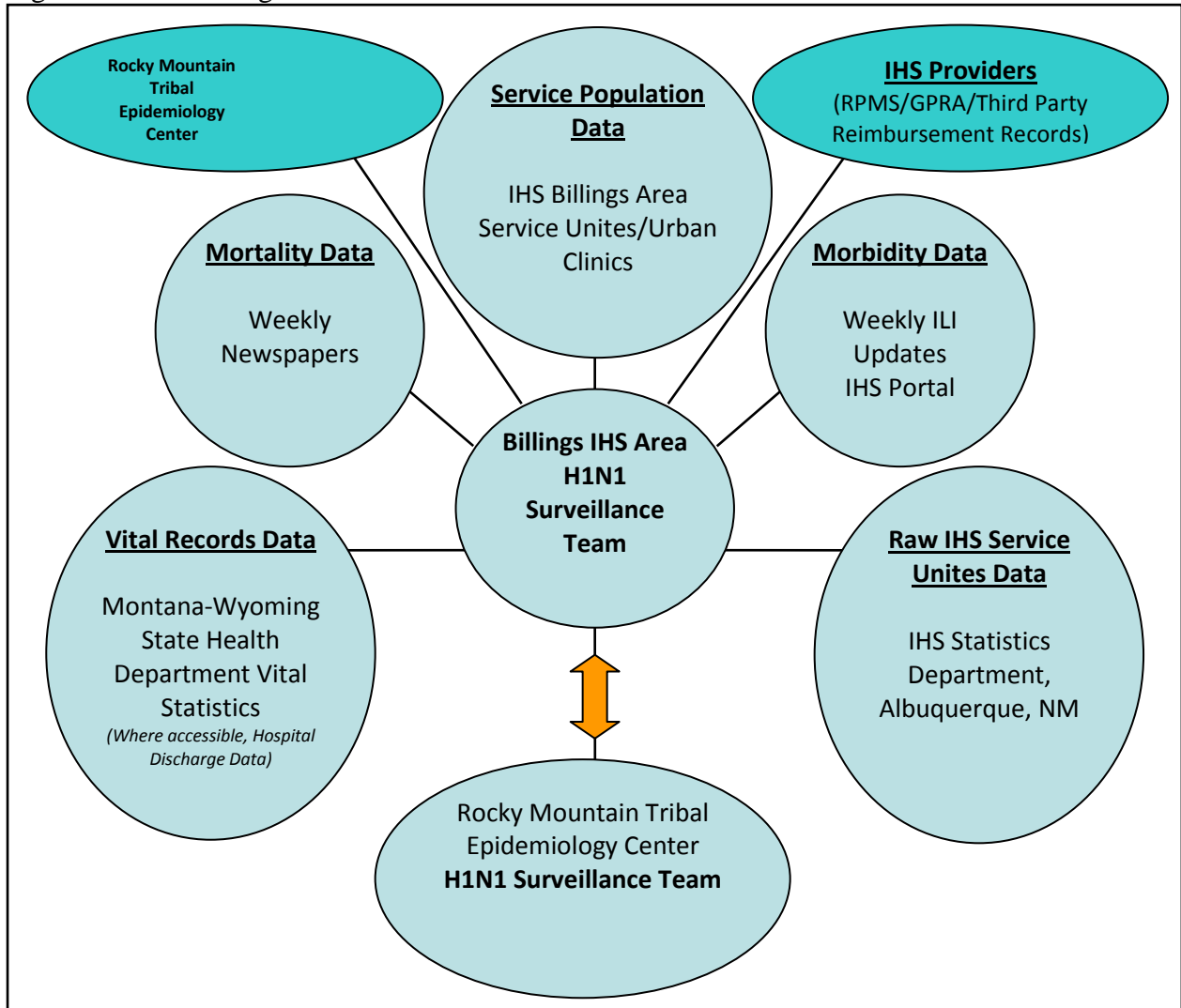
- *The H1N1 Global Pandemic is continuously evolving. The Billings Area Indian Health Service is monitoring the situation very closely.*

RMTEC volunteered to work with the Billings Area IHS on the 'After Action Report' which would include both qualitative and quantitative analysis of the 2009 -2010 H1N1 pandemic season. RMTEC, in collaboration with the Billings Area H1N1 Response Team would use this comprehensive report on lessons learned to plan for other emergency situations in the future, hence this report.

The CDC defines Public Health Surveillance as the ongoing, systematic collection, analysis, interpretation, and dissemination of data regarding a health-related event for use in public health action to reduce morbidity and mortality and to improve health. Data disseminated by a public health surveillance system can be used for immediate public health action, program planning and evaluation, and formulating research hypotheses. The attributes of Public Health Surveillance include: Simplicity; Flexibility; Data quality; Acceptability; Sensitivity; Positive Predictive value; Representativeness; Timeliness; and Stability.

The Table below demonstrates the ideal Billings Area data surveillance for the H1N1 and any other outbreak. Ideally, data should be gathered from various agencies and institutions in order to get a clear picture of the situation at hand. The Billings Area is striving for the ideal by pursuing memorandum of understanding with various agencies and institutions in order to get closer to the ideal surveillance system.

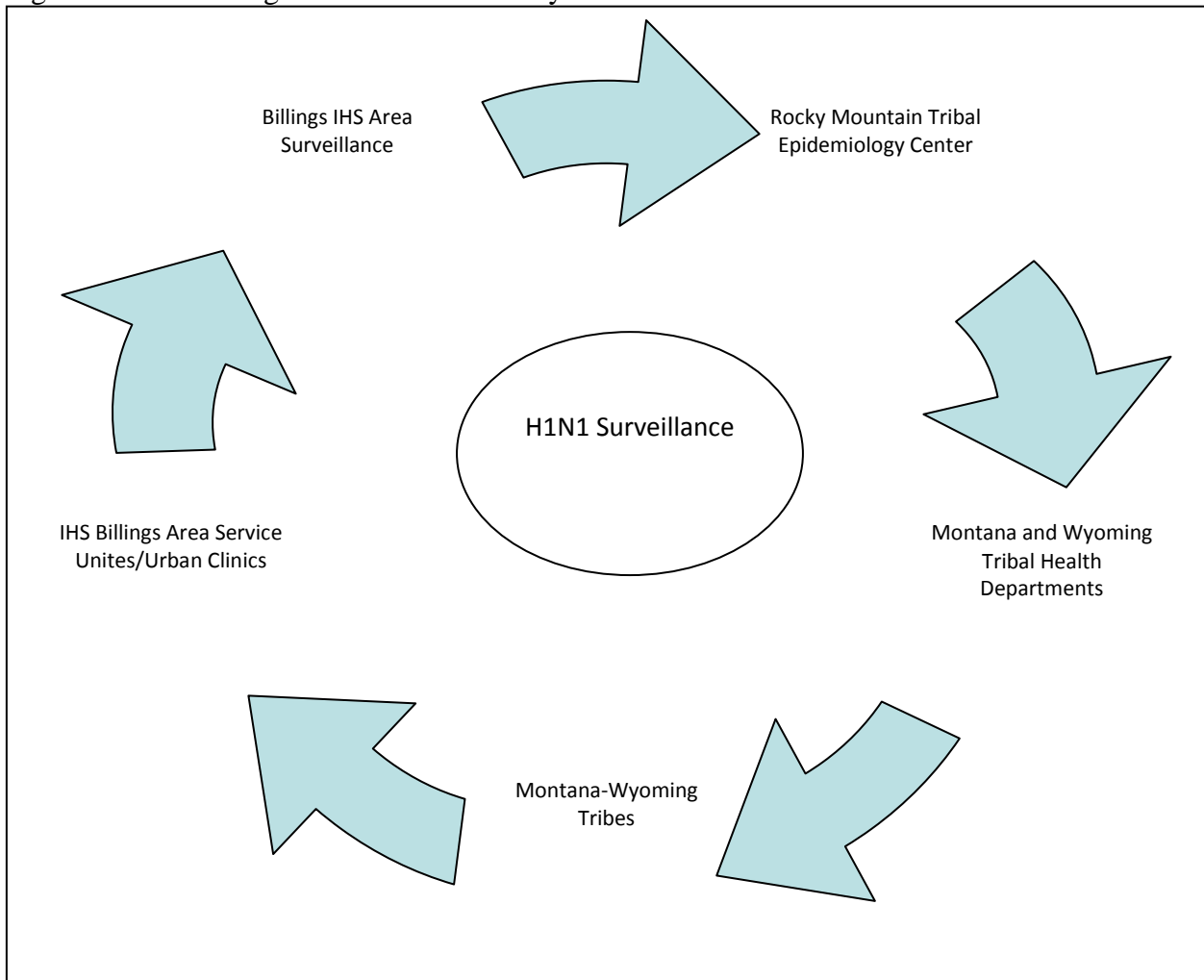
Figure 3. Ideal Billings Area Data Surveillance



The importance of community feedback in surveillance cannot be underestimated. Most agencies and institutions collect data from local communities and write reports for program management purposes only. The interpretations of these reports are often written by researchers who have never visited the communities and the data may be misinterpreted and published without the communities consent. Most communities have become wary of researchers and in small communities data collection has dwindled, causing a vicious cycle of poor data collection. This is often due lack of adequate communication and respect for the communities served, building up to lack of trust of the researchers or health officials.

The Billings Area H1N1 Response Team hopes to overcome this mistrust by disseminating periodic time sensitive representative data to the communities served to show respect and gain their trust and support. Below is a model the Billings Area H1N1 Response Team tried to implement during the 2009 -2010 H1N1 pandemic.

Figure 4. Ideal Billings Area Surveillance Cycle Model



LESSONS LEARNED BY THE BILLINGS AREA H1N1 RESPONSE TEAM DURING THE 2009 – 2010 H1N1 PANDEMIC

An assessment was sent to all members of the Billings Area H1N1 Response Team, including the Montana and Wyoming IHS Service Units, Urban Centers and Tribal Health representatives. The assessment questions included: What worked well? What did not work well? What are your Recommendations? Four Service Units; three Urban Indian Clinics and one State representative responded to the assessment tool. Below are the results of the assessment without modification or as submitted:

“What Worked Well?” - Results Include:

- Communication between all parties at all levels
- Working with County, State, and Tribes
- County, State, Tribe, IHS efforts – very effective Planning stages and meetings with County, hospitals, local doctors, community health center, Indian Health Service
- Regional coordination of different health entities
- Conference calls with State and with Billings Area Office - very informative
- Communication with Billings Area Office staff to provide needed assistance – would like to continue this
- Opening lines of communication between State Immunization Program and local entities – Tribal, IHS, County
- Reservation and County personnel – working as team
- State and local communication – give-receive information, voice concerns, ask questions
- State and Billings Area coordination
- Billings Area dissemination of information
- Billings Area focal point for information - bounce ideas off
- Distribution of vaccine and supplies through County Public Health
- Extensive help from Tribal Health Department in record keeping and charting
- Coordination with county efforts for vaccine – ability to refer patients to County Health Departments
- Assistance getting seasonal vaccine purchased

“What Did Not Work Well?” - Result Include:

- Lack of vaccine
- Lack of vaccine when population was interested in getting it
- Initial slow allocation of vaccine
- Large number patients who could not take nasal form and that was what was distributed initially
- Lack of storage/transport system for vaccine
- Disappointing to see some vaccine going to waste due to freezing
- IHS purchased employee vaccine not useful – already had vaccine from County and Tribes
- Free “portable” refrigerators not useful



- Having to go through County Health - not a pleasant experience
- Lack of respect by having to use a pass through organization to get vaccine
- Mass clinics (like fair grounds) did not reach Native American elders or young children not attending school)
- IHS and State efforts often repetitive
- Difficult to report adult doses to state without utilizing state registry for that age group
- Lots of reporting
- Initial confusion –“who does what”, -“who gets PHER money”, etc.
- Hype and rumors floating around community in reference to vaccine and side effects

Note: One of the respondents responded, “Everything worked fine”.

What are your Recommendations? – Results include:

- More encouragement for Service Units to work with local jurisdictions (County, Tribes, etc.)
- Continuation of communication between County, Tribal, and IHS on day to day issues and planning
- Continuation of State and Billings Area efforts on joint topics – allows busy staff to stay in loop - both calls help
- More coordination with County efforts on vaccine clinics
- Order more seasonal flu vaccines
- Development of bi-directional input into state registry for tracking and updating
- Addition of adults into IHS and State registries and data exchange
- More education for communities
- Clarification - whether numbers from the reservation are included in towns off the reservation but in the same county

Note: There were two respondents with further comments:

One felt -“*When it comes to the public’s health there are no lines drawn – we are all susceptible*”. The other respondent reported -“*I would say more if I felt that our organization had any impact on your decision making*”.

The Billings Area H1N1 Response Team would like to iterate its effort to listen to its stakeholders and fully implement its surveillance cycle model, disseminating periodic time sensitive representative data to the communities served. This is a learning process for all H1N1 stakeholders.



Table 4. Number of H1N1 One Dose Coverage for All Ages by Site

Site Name	Number of H1N1 One Dose Coverage for All Ages	Population	Percentage (%)
ABERDEEN	18719	83043	22.5%
ALASKA	18042	89712	20.1%
ALBUQUERQUE	15884	50496	31.5%
BEMIDJI	9036	31732	28.5%
BILLINGS	12832	44494	28.8%
CALIFORNIA	8961	46589	19.2%
NASHVILLE	5428	31911	17.0%
NAVAJO	57356	169402	33.9%
OKLAHOMA	21971	179476	12.2%
PHOENIX	31023	109059	28.4%
PORTLAND	17866	63215	28.3%
TUCSON	4843	13004	37.2%
NATIONAL TOTALS (IHS/ TRIBAL)	221961	912133	
RATES			24.0%

Data Source: IHS H1N1 Coverage Estimates from the CRS 10.0 Report (visits between July 1, 2009 and June 30, 2010)

Figure 5. Billings Area Percent H1N1 One Dose Coverage by Age Group

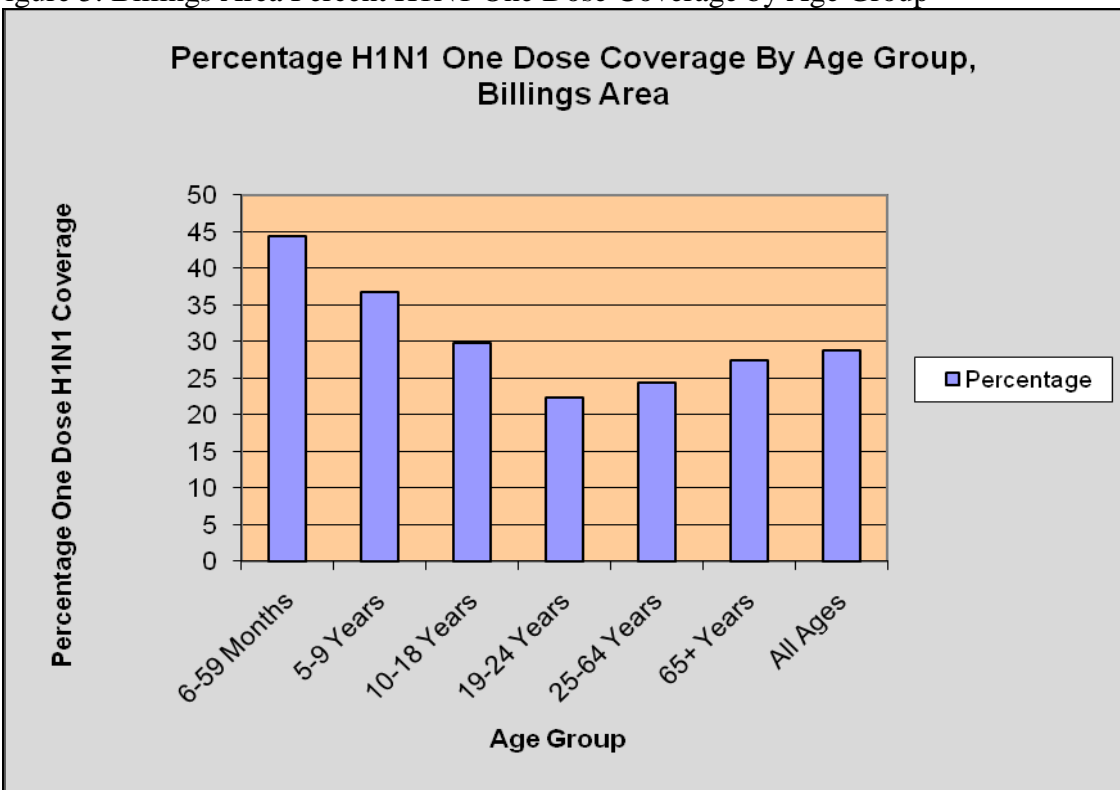


Table 5. Number of Current High Risk (25-65 years) with One Dose H1N1 by Site

Site Name	Number of Current High Risk (25-65 years) with One Dose H1N1	Population	Percentage (%)
ABERDEEN	3568	13031	27.4%
ALASKA	1695	6729	25.2%
ALBUQUERQUE	3155	7924	39.8%
BEMIDJI	1716	4907	35.0%
BILLINGS	2031	5997	33.9%
CALIFORNIA	1748	6449	27.1%
NASHVILLE	1302	6023	21.6%
NAVAJO	8978	20478	43.8%
OKLAHOMA	5120	28086	18.2%
PHOENIX	6403	19777	32.4%
PORTLAND	3399	9132	37.2%
TUCSON	1409	2883	48.9%
NATIONAL TOTALS (IHS/ TRIBAL)	40524	131416	
RATES			30.8%

Data Source: IHS H1N1 Coverage Estimates from the CRS 10.0 Report (visits between July 1, 2009 and June 30, 2010)

Table 6. Number of Current Pregnant Females with One Dose H1N1 by Site

Site Name	Number of Current Pregnant Females with One Dose H1N1	Population	Percentage (%)
ALASKA	927	3048	30%
ALBUQUERQUE	708	1255	56%
BEMIDJI	312	763	41%
BILLINGS	592	1306	45%
CALIFORNIA	193	739	26%
NASHVILLE	203	821	25%
NAVAJO	2007	4240	47%
OKLAHOMA	560	3175	18%
PHOENIX	1390	3187	44%
PORTLAND	477	1278	37%
TUCSON	261	372	70%
NATIONAL TOTALS (IHS/ TRIBAL)	8597	23078	
RATES			37%

Data Source: IHS H1N1 Coverage Estimates from the CRS 10.0 Report (visits between July 1, 2009 and June 30, 2010)

Billings IHS Area: After Action Meeting, 2010

Billings, Montana



BILLINGS IHS AREA: AFTER ACTION MEETING 2010

“H1N1 real experiences and collaboration building”

Date: August 17, 2010

Venue: Montana State University Billings Downtown Campus – 2804 Third Avenue North
Conference Room Broadway IIIA

Time: 7:45am to 5:00pm

OPENING REMARKS

Welcome from Billings Area Indian Health Service and the Montana-Wyoming Tribal Leaders Council/Rocky Mountain Tribal Epidemiology Center was performed by Dr. Douglas Moore and Dr. Folorunso Akintan.

PRESENTATIONS

Presentation Topic: How Did We Do?

Presentation #1: The H1N1 perspective of the IHS National Epidemiology Center, Immunization Program was presented by *Amy Groom, IHS Immunization Program Manager/CDC Field Assignee*

Presentation Title: H1N1: National IHS Perspective (*based on preliminary data*)

Amy Groom gave a comprehensive background on the H1N1 pandemic which was first noticed in Mexico in 2009 and was announced in the US in March/April, 2009. There were several public health responses to the pandemic in the US, including the CDC and IHS surveillance, vaccination, mitigation, communication/education collaborations.

The Billings IHS Area influenza season vaccination coverage was well above the total IHS coverage for children (under 18 years of age) and slightly lower for adults with the lowest coverage among ages 50 years and above. The same pattern was seen in the Billings Area IHS for the H1N1 pandemic vaccination coverage. The area's coverage for children (under 18 years of age) was well above the total IHS coverage for children and slightly lower for adults with the lowest coverage among ages 18 years and above. The Health Care Personnel coverage in 2010 was higher than 2009 for the Billings Area IHS.

The following were stated as the pandemic successes, challenges and new recommendations:

2009 H1N1 Pandemic Successes and Challenges

- Development of ILI surveillance system
- Strengthening of the IHS National Supply Service Center (NSSC) distribution infrastructure
- State-based vaccine distribution
- “Flexibility” of recommendations



2010-2011 Flu Season Recommendations

- NEW Universal Influenza Recommendations!
 - Everyone 6 months and older should be vaccinated!!!
 - In times of shortage or delay, AI/AN identified as a priority group
- New all ages influenza reports in RPMS
- Continuation of IHS ILI and vaccine adverse event surveillance

Presentation #2: The H1N1 perspective of Montana State (Health Department) was presented by *Jim Murphy, Department of Health and Human Services, Montana Department of Public Health and Human Services.*

Presentation Title: H1N1 Experience

Jim Murphy presented on the basic epidemiology of H1N1, the Montana State response to the pandemic and on results and lessons learned. According to Jim, the first case of confirmed H1N1 in Montana was on May 11, 2009, and the first death from H1N1 was an American Indian adult reported on August 6, 2009.

Lab confirmations in Montana peaked between weeks 40 to 42 of the 2009 - 2010 H1N1 pandemic season. Influenza/flu like illness and state wide confirmed and suspected cases peaked in October 2009. A total of 18 deaths relating to H1N1 were reported from August 2009 to May 2010 with 70% of the deaths occurring in adults with pre-existing underlying medical conditions. Deaths rates were higher in American Indians (7.6 deaths per 100,000 American Indians) than Whites (1.5 Deaths per 100,000 Whites).

Montana State Health Department's response to H1N1 includes:

- Seeking and dispersing funds to provide vaccines and antiviral to the Montana population
- Vaccine Distribution Protocols
- Vaccine Administration Protocols
- Addressing the needs of vulnerable populations, racial and ethnic minorities
- Tracking Vaccination rates by county and Reservations (on website)

Jim also discussed lessons learned by the Montana State Health Department including vaccination allocation and distribution; infrastructure and methods for reaching "target populations"

Presentation #3: The H1N1 perspective of Wyoming State (Health Department) was presented by *Robert Grenwelge, CDC Public Health Advisor, Wyoming Department of Health.*

The Wyoming Department of Health has plans for a pandemic situation and this was implemented during the 2009 and 2010 pandemic flu season. Each county has a Public Health Response Coordinator (PHRC) that functioned to develop a broad spectrum of county stakeholders to plan the county level response. Each county was given the option to have their allocation sent to all H1N1 providers in their jurisdiction or to have the entire county allocation sent to Public Health for county distribution.



Public Health Emergency Preparedness grants were provided to all counties and would support hiring temporary staff for vaccine intake, administration and/or data entry as determined by local authority. The Immunization Section followed CDC guidelines to register additional provider sites to be H1N1 vaccine administrators.

Wyoming Public Health Laboratory tested 842 specimens from sentinel providers with 397 specimens confirmed Type A H1N1. Influenza/Flu like illness reporting by sentinel providers peaked between weeks 41 to 43 during the 2009-2010 flu season. Of the 3,109 confirmed cases, 2,974 (95.6%) occurred during week 40-46 of 2009. Of the 3,109 confirmed cases, 239 (7.7%) occurred in Fremont County which has the highest American Indian population in one county (20% -25% American Indian population).

Information submitted to the CDC Countermeasures and Response Administration (CRA) application via flat file downloads from the Wyoming Immunization Registry (WyIR) was helpful in the data driven decisions made during the 2009 and 2010 flu seasons in Wyoming.

Presentation #4: The H1N1 perspective of IHS Billings Area Overall Response and Working Relationships was presented by Dr. Douglas Moore, Chief Medical Officer, Billings IHS Area and Charlene Johnson, AAD – Office of Health Care Programs, Billings IHS Area.

Douglas Moore talked about the “Good”, the “Bad”, the “Ugly”, “Nasty” and “Humility” of H1N1 in the Billings IHS Area.

The Good:

- Team Work
- Partnerships
- Tribal Consultations organized by the States
- Less than tragic morbidity and mortality reports

The Bad:

- H1N1
- Lack of clarity on H1N1 acceptable funds sources

The Ugly:

- H1N1 itself

Nasty:

- Pandemic
- Inter-agency data sharing issues
- Trying leaderships

Humility:

- Ability to not become complacent (ever prepared)

Charlene Johnson talked about the Billings Area H1N1 Response Team's goals and objectives, with a primary focus on providing general guidance to service providers; incident command information, Tribal Educational Materials (development and distribution) and the IHS Chief Executive Officer Media Guidelines, sighting examples from the local media agencies including:

- “Montana records first swine flu death - An adult in Roosevelt County has died from the H1N1 influenza virus, also known as the swine flu.” - Billings Gazette, August 6, 2010
- “Fort Belknap battles swine flu” - Great Falls Tribune, August 14, 2009
- “Swine Flu-related Death Confirmed in Wyoming – The young adult female resident of Fremont County had an underlying health condition....” Press Release, Wyoming Department of Health, August 19, 2009
- “A break down of Swine Flu cases in Montana Indian Reservations - Some American Indian leaders suspect swine flu is spreading more rapidly in Indian Country than elsewhere. If Missoula County had the same proportion of cases as Rosebud County (home to the Northern Cheyenne Reservation), then 100 Missoulians would be affected. Instead, 15 have been confirmed with the virus.” - Billings Gazette, August 22, 2009

Presentation #5: The H1N1 perspective of IHS Billings Area Vaccine Protection Rates *was presented by Rita Harding.*

Rita Harding presented on the Billings Area IHS vaccine rates and the causes of variation in rates reported. The seasonal influenza vaccine coverage was reported to be higher than the H1N1 vaccine coverage among high risk populations in Billings IHS Area. The causes of variation in numbers based on IHS data and State/CDC data discussed include:

- Population Base Numbers (Denominator)
 - Reservation Census Population
 - User Population
 - Active Clinical Patients
- Historical Data Entry (Numerator)
 - Patients Got Vaccine Everywhere
 - Sometimes Records Shared – Other Times Not
- Timing of Data Entry
 - Delays with Community Locations
- Timing of Report
 - H1N1 Vaccine Season Never Really Ended
 - Vaccine Given into May

Presentation #6: The H1N1 perspective of Service Unit/Tribal Health/County Partnership on Local Perspectives and Innovative Ideas *was presented by*

- *Sue Snitker and Ken Hull, Fort Peck Tribal Health*
- *Barb Plouffe, Flathead*
- *Kathleen Adams, Fort Belknap*

Fort Peck Reservation

General Fort Peck measures:

- Fort Peck has an Epidemiology Team with a functioning incident command/joint strategic stock pile plan
- Developed a team protocol for the flu season
- A flu plan
- Memorandum of Understanding with surrounding counties
- Mutual Aid Agreements with the Montana State Health Department

What worked in Fort Peck?

- Weekly Joint News Release
- Of Assistance to IHS
- Tribal Health hired more Public Health Staff
- Performed targeted Vaccinations
- Offered raffle drawings for vaccinations and food at vaccination clinics
- Offered rides for vaccinations
- Uses funds allocated to purchase fridges and laptops

Limitations at Fort Peck:

- High Risk Population –Prenatal population mostly non-IHS registered hence hard to reach
- There were some staff with chronic illnesses hindering the use of the nasal spray vaccine

Flathead Reservation (Compacted/638 Tribe)

General Flathead measures:

- Annual Pandemic Flu Drill
- Informing Tribal Leaders
- Weekly Meetings

What worked in Flathead?

- Delivering vaccines directly to Tribes
- Collaboration with: Schools; Law Enforcement; Fire Department; Two Local Hospitals Women Infants and Children (WIC) and Medical Directors for both County and Tribe

Limitations at Flathead:

- Data Challenge: Various service providers; Medicaid; CHIP and RPMS
- Rural population with significant population with chronic illnesses needing home care
- Awareness and fear was seen as a hindrance and several methods were used to combat these including Newspapers, radios and flyers

Forth Belknap Indian Community

Kathleen Adams gave a brief overview of the H1N1 experience at Fort Belknap emphasizing the good working relations with IHS.

Presentation #7: The H1N1 perspective of Urban Clinic on Local Perspectives and Innovative Ideas was presented by Pam Garza, Indian Health Board of Billings

Indian Health Board (IHB), Billings (Urban Indian Clinic)

General IHB Billings' measures:

- Weekly Staff Meetings
- Vaccines received directly from the County Health Department
- Used all Staff for the Implementation of the Flu Plan
- Employed More Part Time Nurses for the Vaccinations

What worked in IHB Billings?

- Worked closely with the RiverStone Health (County Health department)
- Good Patient Flow was Key
- Lots of Advice from other Agencies Helped

Limitations at IHB Billings:

- Educating the Public
- Coverage of Eligible Population with Limited Staffs

Presentation #8: The H1N1 Patient Perspectives was presented by Sheri Bruington for Janet Reunion, Rocky Boy

Rocky Boy was Number One in Montana for Vaccine Coverage!

Sheri was able to give her view of the patient's perspective on H1N1 from various questions raised by patients at the immunization clinics in Rocky Boy. Sheri gave this view in form of cartoon characters. Some confusing aspects for patients include:

- The Conspiracy Theory
- High Risk group and Non-High Risk Group
- Vaccine Access (higher to High Risk Group while others may be refused)
- Why Two Shots/two Doses
- Why Do the Shots Make One Ill
- Why give a live vaccine/virus to anyone and why nasal spray?

Presentation #9: The H1N1 Staff Perspectives/Recommendations Update was presented by Rita Harding.

Rita went over some new recommendation for the new flu season beginning September 2010:

- Routine flu vaccination is recommended for all persons ≥ 6 months of age
- All children 6 months to 8 years who receive flu vaccine for first time should receive two doses of vaccine
- Seasonal Flu Vaccine will contain A/California/7/2009 H1N1-like strain
- Fluzone High Dose is a newly approved inactive trivalent vaccine for persons 65 years and above.

SMALL GROUP WORK SESSIONS

Everyone worked hard during the H1N1 season and was generally very pleased with the communication and collaboration that occurred with the process.

Five workgroups were spontaneously formed and each group was asked to determine: What worked well? What needs fixing? What are the recommendations? All comments were recorded on charts and discussed as a whole group after the sessions was completed. Some of the topics discussed and listed on the group charts are listed below:

WHAT WORKED WELL?

Collaborations and Communication

Tribes/IHS/State/Counties/Urban
Planning and partnership with everyone
Open communication - setting differences aside
Local Teams
-Local emergency preparedness committees
-All hazards committees
-Epidemiology Teams
Information to schools and daycare

Vaccine

Vaccine clinics - in variety of settings - smaller clinics worked well
School clinics for everyone
Training for Pharmacists – Pharmacists helping
PHER funding – when it came – much needed equipment

Emergency Preparedness

Knowledge of incident command structure
Training/Exercises - practice makes perfect - including more clinic staff in drills
Preplanning (previous year seasonal flu to do drill – put mentality in place)
H1N1 forced administration/staff to read and implement disaster plan

Infection Control

Fit testing/PPE supplies/training
Supplies from State - Cough kits - Availability of hand sanitizer
Work policy (staying home when you are sick) - social distancing



Good insight re building setup and clinic flow - isolation to keep ILI separate

Data and Documentation

Form D – got permissions
Data tracking (hated it but had to be done)
WY bi-directional immunization flow - MT WIZRD

Outreach and Marketing

Call-em-all computer calling tree
Using CHR's for outreach
H1N1 Hotline - Outreach and transportation
Incentives - gas cards - raffle for all who were vaccinated
Partnerships with businesses (e.g. casinos, bars, restaurants, churches)
School nurses tracking number of kids sent home with illness

WHAT NEEDS FIXING?

Summary: There were some concerns about Indian Health Service roles and functions in the emergency preparedness model and this is something everyone would like address in the future. There also is the need to include the Urban Clinics throughout all processes.

Communication

Too many weekly calls - do all in one - conflicting messages
Lack of buy in - teamwork
Power/knowledge/communication gaps - turf wars
Too many bosses
IHS system issues

Urban Clinics

Had most problems - not set up to do what public health wanted them to do
Coordination lacking especially when county overwhelmed

Vaccine

Patients being turned away - hard to turn patients away at beginning especially elderly
Vaccine arrived too late - guideline restrictions on vaccine
Guidelines – to strictly follow or not
Mass clinics – to have or not
No security for clinics
LAIV limitations - nasal flu – not comfortable with it at first
Time for charting - not able to do data entry and check records in field

Antiviral shortage

This was initially an Issue

Education/Awareness

Clients upset about distribution - papers reporting Yellowstone County mass clinics when IHS short
MDs sending patients back to reservations with wrong information - local MD saying not to take H1N1
U-tube videos shown in schools – bizarre things re H1N1
Staff with wrong information

PHER funds

Needed earlier - lots of hoops for IHS



Emergency Preparedness

Lack of understanding of incident command structure - who has health authority?

Infection Control

- HCW hated to get vaccine before patients
- Administration concerned about staff illness with LAIV
- Fit testing

Data and Documentation

Delayed documentation with field clinics

Form D:

- Needs lower reading level - definitions in lay terms
- Too complex - increased work

Problems getting consent forms back

School closures

Needed more help:

- Contract help – review IHS system for quicker contracts

RECOMMENDATIONS

- Working together is better than working alone
- Everybody needs to give up control
- Dispel “attitude” of IHS being big brother
- Create partnerships with Counties, Tribes, IHS
- Provide more assistance to Urban Clinics
- Coordinate conference calls
- IHS needs to partner sooner with State - combine calls – State, IHS, Tribes
- Improve coordination between States, Area Offices in border state and area locations
- Increase media - more “Wes Studi” type

ROUNDTABLE DISCUSSION #1 - EMERGENCY PREPAREDNESS PERSPECTIVES

Future Responses to Disease Outbreaks – Jim Sabatinos, Facilitator

“WHERE DO WE GO FROM HERE?”

All participants were encouraged to bring existing plans for mass immunization and response to communicable disease outbreaks from their various centers and communities to discuss.

Four workgroups tables were filled based on reservation communities. Various reservations and communities were instructed to sit together - Northern Cheyenne and Crow; Rocky Boy and Fort Belknap; Urban Indian Clinics, Browning and Flathead; Fort Peck and Wind River and each group were asked to determine:

- Are we really ready?
- How do we integrate experiences from H1N1?
- Do we have workable plans?
- Do we read and use plans?
- Are the plans useful?
- Are we doing integrated planning and involving our colleagues and partners?
- How do we adapt to changing scenarios and crisis?



All reservation communities reported having an Emergency Preparedness document except the Urban Indian Clinic represented. Browning developed its Emergency Preparedness plan in 2002 and has used this plan in various emergency situations including the 2009 – 2010 H1N1 pandemic. All participants were eager see the Montana Wyoming Tribal Leaders Council and the Rocky Mountain Tribal Epidemiology Center take a leadership role in educating the reservation communities and the Tribes about Emergency Preparedness. Participants suggested the MT-WY Tribal Leaders Council as a forum for Tribal Leaders to be educated on the importance of Emergency Preparedness and recommended a mini annual conference on Emergency Preparedness be sponsored by the Tribal Leaders Council in collaboration with Billings Area IHS and the Montana and Wyoming State Health Departments.

SUCSESSES

- Involvement with States
 - Montana and Wyoming States directly involved Tribes in their emergency preparedness and incident command plans and activities including funding, regular conference calls and training.
 - Montana requires Tribes to host emergency drills on reservations as part of their emergency preparedness grant.
- Wind River Model
 - Wyoming State, IHS, Tribes, County, and local entities all trained together with the assistance of a CDC assignee to Wyoming, and now have a strong collaborative partnership.
- Fort Peck Model
 - Tribe has legal infrastructure to be viewed by State as Public Health Authority.
 - Community has active Epidemiology Team that includes all providers (County, Tribe, IHS, and Private Sector).

CHALLENGES

- Varying levels of internal preparedness and gaps in knowledge at several locations - concerns about key leadership involvement and support.
- Lack of clear identification of lead emergency preparedness persons and confusion about roles in terms of emergency preparedness.
- Need for coordinated training and information sharing at all levels including Tribal Leaders Council and Health Boards.
- Confusion on how IHS fits into the Emergency Preparedness and Incident Command Structure of Tribes and States. (IHS does not have the same legal authorities that Tribes and States have but plays a key hands-on role in emergency response.)
- Need for ongoing efforts on how to provide emergency preparedness services, coordinate mass interventions (like influenza vaccination), participate in mutual aid agreements, and develop memorandum of understanding documents with Tribes.

RECOMMENDATIONS

- Clarify and develop roles in Emergency Preparedness
- Identification of Lead Persons



- Clarification of Roles (Area Office, Service Unit, Tribes, MT-WY Tribal Leaders Council)
- MOA Approvals
- Legal Authorities
- Training Needs
- Communication Forum

ROUNDTABLE DISCUSSION #2 – FUTURE PLANNING

Future Planning: 2010-11 Flu Campaign, Erik Chosa and Rita Harding, Facilitators

- How do we build on the H1N1 experience to expand to the new flu season?
- What are the current recommendations for 2010-11?
- Are we ready to vaccinate entire population as recommended by ACIP?
- How can we be most effective and efficient?
- How do we prioritize if necessary?

Eric led a question and answer session on how to build on the H1N1 experience and expand coverage in the new flu season.

Immunizations and Public Health Priorities and Partnerships*

Date: August 18, 2010

Venue: Billings Area IHS Office - 2900 Fourth Avenue North Second Floor Conference Room A

Time: 7:45am to 5:00pm



BILLINGS IHS AREA: AFTER ACTION MEETING EVALUATION COMMENTS

1. Was the meeting helpful to you? If not, explain why.

- Yes - exchange of ideas and new thoughts on future pandemics very helpful.
- Yes - it's helpful to share experiences and realize your perceptions were not isolated.
- Very!
- I am not an IHS worker so I didn't know the IHS bit. But the info that was shared was great. Lots of work.
- Sharing lessons learned from others is always helpful.
- Planning.
- Collaboration and lessons learned from other areas.
- The breakout sessions (table work group). Hearing from others how they worked out their issues was valuable. What worked and didn't.
- Identifying issues that were common to all participants.

2. What were the most helpful topics and sessions?

- Real experiences.
- Small group discussions on "real experiences".
- Intercommunication.
- Seeing, learning, talking with how other areas have dealt with problems and outcomes.
- This is new information; listening to what other tribes are doing is greatly informative.
- IHS Service Unit and Tribal feedback.
- Hearing what other facilities did differently and what I can incorporate into the next flu season.
- Meeting others and finding out that what they did and whether plans were used or not. How communications in each area was good.
- What worked – what didn't.
- All topics and breakout sessions and groups.
- Amy and Doug presentations.
- Differences between Wyoming and Montana experiences.
- The second to the last. (*would have been emergency preparedness*)
- Discussion of local emergency plans/experiences.
- Pandemic flu plan – identify need for training/education for tribal leaders.

3. What were the least helpful topics and sessions?

- All were helpful.
- They were all valuable to an extent.
- BAO ICS – IHS is not an 'equal' partner with tribes and counties.
- None.
- None.
- All were ok but too long!!!!



- Time dragging on during the afternoon sessions. We could have ended earlier. Too nice of a day. Rita talks too slow.
- It seemed repetitious and could have been done in half day.
- Incident command session.
- Working lunch.

4. What recommendations do you have for further meetings and communications?

- Continue the opportunity to share.
- Regular conferencing by phone on variety of IHS topics (not just epidemiology areas).
- Ongoing email communications with all who attended. List of participants available will provide opportunities to network with others.
- More Tribal/IHS interaction.
- Meet in 6 months to see where we are at to discuss what is working and what is not. Webex meeting calls. Collaborate with State/IHS/Tribe on one call so everyone knows what is going on and they are on same page – eliminates miscommunications.
- Making a plan with a timeline.
- In the absence of more H1N1 disease, perhaps focus on plan updates and continuity funding for planning.
- More training on emergency preparedness.
- KISS – keep it simple – some things over and over
- Being new – all the acronyms were very difficult to track.
- Having lunch on own so that there would be a break in sessions.

5. What topics would you like addressed in the future?

- Pandemic plans – follow-up on leadership involvement.
- An IHS plan on how they are working with Tribes and local counties in providing services and coordinating a mass influenza vaccination, a mutual aid agreement, and MOU with Tribes.
- Trainings for TLC and Health Boards.
- More training of helping (*could not read but was underlined*) collaboration – Tribes - IHS – State.
- How IHS fits into the Tribes and States ICS structure.
- Continue communicable disease.
- More preventive education topics – what works.
- Add other areas like elder care.

6. Other comments:

- Great Ideas! Let's keep the communication going.
- Meeting very educational and informative. Well organized! Thank you.
- Thanks for including Wyoming Dept of Health.
- Good information shared.

- More vaccines for American Indian/Alaskan Natives based on percentage of Indians affected/mortality. A higher percentage of vaccines should be available. How to conduct a mass vaccination clinic.
- IHS needs to better understand “it’s” role – they are not a health authority – they are subordinate to Tribes and County Health Depts. IHS needs to direct all service units to participate in tribal exercises and planning. More IHS staff need to participate.
- It appears Area office is unsure of what their role is. The SUs are working more and more with their Tribes and it appears the Area Office is a little lost. Maybe their role is now more data tracking of all the data put into RPMS.
- What is BAO doing? What are their plans? Who is in charge of this activity?
- The information & sessions seemed repetitious – lost interest with repeating information.
- If working lunch, cut short to be only 6 to 8 hours.

Table 7. Attendees at the Billings IHS Area: H1N1 After Action and the Immunizations/ Public Health Priorities and Partnerships Meeting, September 17-18, 2010

INDIAN HEALTH SERVICE	
BLACKFEET	Susan Head, Director of Nursing
CROW	Luana Auker, Public Health Nurse Nancy Fields Estelle, Public Health Nurse Marie Yarlott, Public Health Nurse Dale BrownWolf, Emergency Preparedness
FORT BELKNAP	Desiree Bell, Clinical Director
FORT PECK	Sue Snitker, Public Health Nurse Tomina Kinzie, Public Health Nurse
N. CHEYENNE	Phil Minnick, Pharmacist
WIND RIVER	Janice Roman, Public Health Nurse

TRIBAL HEALTH DEPARTMENT	
BLACKFEET	Nora Kennedy, Emergency Preparedness
CROW	William Driftwood, Emergency Preparedness Susette Nanto, Emergency Preparedness
FORT BELKNAP	Kathleen Adams, Public Health Nurse Avis Spencer, Emergency Preparedness
FORT PECK	Ken Hull, Emergency Preparedness Chris Four Star, Communicable Disease
N. CHEYENNE	Colleen Yellowrobe, Public Health Nurse Marina Mitchell, Public Health Nurse Suzie Musser, Public Health Nurse
WIND RIVER	Fernando Roman, Emergency Preparedness Kassy Jarvis, Community Health Representative
ROCKY BOY	Janet Runnion, Public Health Nurse Sheri Bruington, Public Health Nurse Jennifer Small, Clinic Nurse
FLATHEAD	Barb Plouffe, Public Health Nurse



URBAN CLINIC	
BUTTE	Danelle Stein, Clinic Nurse
MISSOULA	Cherith Smith, Pharmacist
BILLINGS	Pam Garza, Clinic Nurse

SPEAKERS
Amy Groom - National I.H.S. Immunization Program
Charlene Johnson - Billings Area I.H.S. Office of Healthcare Programs
Dr. Doug Moore - Billings Area I.H.S Chief Medical Officer
Erik Chosa - Billings Area I.H.S. Pharmacy
Rita Harding - Billings Area I.H.S. Nursing
Jim Sabatinos - Billings Area I.H.S Compliance
Folo Akintan - Montana/Wyoming Tribal Leaders Council
Jim Murphy - Montana State
John Anderson - Wyoming State
Robert Grenwelge - Wyoming State
Jonnie Sheehan - Staff Support



**BILLINGS AREA H1N1 RESPONSE TEAM
SUMMARY RECOMMENDATIONS
ON
H1N1 EXPERIENCE
2009-2010**



H1N1 RESPONSE TEAM FOR BILLINGS AREA FOLLOW UP RECOMMENDATIONS FROM H1N1 EXPERIENCE

WHAT DID WE LEARN?

- Continue ongoing communication forums on public health issues with involved staff including Indian Health Service, Tribal Health Programs, and Urban Clinics.
 - Quarterly Conference Calls and/or Webinars – Suggested Topics:
 - Influenza Campaigns
 - Low Childhood Immunization Rates
 - Emergency Preparedness
 - HIV Programs
 - Employee Health
 - Annual Conference
 - Topics and Timing To Be Determined
- Utilize and expand data tracking and communication systems for immunization and communicable diseases.
 - ILI
 - RPMS Immunization Package
 - CSR GPRA Data
 - State Surveillance Sources
 - Confidential Patient Data Exchange
- Expand immunization efforts to emphasize complete and accurate processes.
 - Second Vaccine Doses for Children
 - Quality Improvement Programs for Immunizations
- Clarify and develop Indian Health Service role in Emergency Preparedness.
 - Identification of Lead Person
 - Area Office Role
 - Service Unit Role
 - MOA Approvals
 - Legal Authorities
 - Training Needs
- Expand local capacities of Urban Clinics in dealing with immunizations and communicable diseases.
- Clarify and expand partnership roles with Montana Wyoming Tribal Leaders Council.
 - Roles
 - Data Sharing
 - Communication Networks
 - Cosponsoring Events
- Develop and use more Indian specific media.



- Establish more formal advocacy with States for unique health and vaccine needs of Indian people.
 - Written Requests with Area Director Support and Signature
 - Coordinated Partner Support (e.g. Montana Wyoming Tribal Leaders Council)
 - Involvement of Other High Level Partners and Advocates

- Utilize more staff members in vaccine administration for overall team approach.
 - Pharmacists
 - Clinic and Specialty Nurses

- Explore options for data entry at mass clinics.
 - Group PCC
 - Bi-directional data flow with State Registries
 - In-field Data Entry Options

Please Note: the recommendations above are a combination of responses from the respondents stated above and other H1N1 stakeholders in the Billings IHS Area/Montana and Wyoming State.



APPENDIX



August 17, 2010 AFTER ACTION MEETING

H1N1 REAL EXPERIENCES AND COLLABORATION BUILDING

**Montana State University Billings Downtown Campus – 2804 Third Avenue North
Conference Room Broadway IIIA
August 17, 2010**

- 7:45 to 8:10 **REGISTRATION and LUNCH ARRANGEMENTS**
- 8:10 to 8:30 **OPENING REMARKS**
- Meeting Logistics and Announcements - Rita Harding
- Welcome from Billings Area Indian Health Service and Montana-Wyoming Tribal Leaders Council
Dr. Douglas Moore and Dr. Folorunso Akintan
- 8:30 to 9:30 **HOW DID WE DO???**
- Invited Guest Perspectives
IHS National Epidemiology Center, Immunization Program – Amy Groom
Montana State - Jim Murphy
Wyoming State – Robert Grenwelge
- 9:30 to 9:45 **BREAK**
- 9:45 to 11:30 **HOW DID WE DO???** (continued)
- Billings Area Perspectives
Overall Response and Working Relationships – Dr. Douglas Moore and Charlene Johnson
Vaccine Protection Rates - Rita Harding
- Local Perspectives and Innovative Ideas
Service Unit/Tribal Health/County Partnership – Sue Snitker and Ken Hull, Fort Peck Tribal Health – Barb Plouffe, Flathead and Kathleen Adams, Fort Belknap Urban Clinic – Pam Garza and Ron Johnson, Indian Health Board of Billings Patient Perspectives – Janet Runnion, Rocky Boy
Staff Perspectives – Rita Harding
- 11:30 to 11:45 **BREAK and LUNCH PICK UP**
- 11:45 to 1:00 **WHAT DID WE LEARN???**
WORKING LUNCH and SMALL GROUP WORK SESSIONS
- Small Group Discussion – Real Experiences with H1N1 – Rita Harding, Facilitator
What insights did we gain?
How successful were our collaborations? How did our communication efforts work?
How do our clients and our colleagues view our efforts?
What worked well and should be preserved? What needs fixing?



1:00 to 1:15 **BREAK**

1:15 to 2:00 **WHAT DID WE LEARN???** (continued)

Summary of Key Discussion Points from Small Group Work

2:00 to 2:15 **BREAK**

H1N1 REAL EXPERIENCES AND COLLABORATION BUILDING
August 17, 2010

2:15 to 3:30 **WHERE DO WE GO FROM HERE???**
SMALL GROUP WORK SESSIONS

Small Group Discussion - Future Responses to Disease Outbreaks – Jim Sabatinos, Facilitator
Bring your existing plans for mass immunization and response to communicable disease outbreaks.

Are we really ready? How do we integrate experiences from H1N1?
Do we have workable plans? Do we read and use plans? Are the plans useful?
Are we doing integrated planning and involving our colleagues and partners?
How do we adapt to changing scenarios and crisis?

3:30 to 3:45 **BREAK**

3:45 to 4:45 **WHERE DO WE GO FROM HERE???**
ROUNDTABLE DISCUSSION

Future Planning - 2010-11 Flu Campaign –Erik Chosa and Rita Harding, Facilitators
How do we build on the H1N1 experience to expand the new flu season?
What are the current recommendations for 2010-11?
Are we ready to vaccinate entire population as recommended by ACIP?
How can we be most effective and efficient?
How do we prioritize if necessary?

4:45 to 5:00 **CLOSING REMARKS**



IMMUNIZATIONS AND PUBLIC HEALTH PRIORITIES AND PARTNERSHIPS

*Billings Area Office – 2900 Fourth Avenue North
Second Floor Conference Room A
August 18, 2010*

8:00 to 8:15 **WELCOME and INTRODUCTIONS**

8:15 to 12:30 **HOW DO WE APPLY LESSONS LEARNED FROM H1N1 TO CHILDHOOD IMMUNIZATIONS?**

Low Childhood Immunization Rates – Rita Harding

- Are children in the Billings Area adequately protected from vaccine preventable disease?
- What are our current immunization rates?
- What factors are impacting childhood immunizations?
- Who do we track and immunize? Who should we track and immunize?

Successful Immunization Practices – Amy Groom

- What can we do to improve and maintain childhood immunization protection?
- Are we using and trusting IMM Tracking System and Forecast Options?
- What is the role of Local Immunization Coordinator?
- What new things have or will be coming out of new versions of IMM Package?
- What immunization training opportunities exist?

Open Session with Amy Groom

Send your specific topics and questions to Rita Harding by August 12 for forwarding d to Amy.

- IHS Immunization Practices
- IMM Package Issues
- General Immunization Issues
- Hands On Technical Assistance

Immunization Data Sharing - Donna Lozier, John Anderson, Amy Groom, Rita Harding

- What is new with State Registries?
- How can we correct errors in transmission?
- What are the future directions is electronic data exchange?
 - Bi-directional in MT
 - Real time in WY

Successful Models in the Billings Area Indian Health Service

- Immunization Coordinator Role – Janice Roman, Wind River
- Missed Opportunities - Performance Improvement Plan – Luana Auker, Crow
- IPC - Clinic/Public Health Collaborations – Peggy White and Colleen Yellow Robe, N.

Cheyenne

Other – Open Discussion

Role of Pharmacist in Providing Immunizations – Erik Chosa

- What is the role of the pharmacist in immunizations?
- Are we really utilizing the pharmacist enough?
- What are the needs of the pharmacist?

Staff Competency Issues – Erik Chosa and Rita Harding

- How do we maintain competency of individual nurses and pharmacists?
- What training opportunities are available?



PREPAREDNESS, PLANNING AND EVALUATION WORKING TOOLS

H1N1 Preparedness Service Unit			
<i>FUNCTION</i>	<i>STRENGTHS, ACCOMPLISHMENTS, PLANS</i>	<i>CONCERNS, QUESTIONS, ISSUES, GAPS</i>	<i>RECOMMENDATIONS</i>
Team Membership			
Team Meetings Frequency Work Format Tribal Involvement			
Guidelines CDC State Other			
Pandemic Flu Plan Written and Updated Specific to Location Viewed as Helpful Part of Emergency Preparedness Plan			
Communication Health Alert Network State Calls & Website (TCC) Tribe County			
Vaccine Adequate Storage and Security Designated Person for Vaccine Receipt			



Tracking Usage and Reporting Plans for Recall for Second Dose			
Vaccine Side Effects and Reactions Designated Process for Reporting			
Standing Orders for Immunization Written and Updated Prioritization in Shortage Situations VIS and Parental Consent Plans to Add H1N1			
Documentation, Recall, Reporting EHR Template IMM Package Timeliness			
Antiviral Medication Adequate Storage and Security Designated Person for Antiviral Receipt Tracking Usage and Reporting Current Supply Sources and Demand Education Infectious While on Antiviral			
Staffing Current Staffing Contingency Plans for Staff Illness OT, CT, SWAT Teams Other Professionals Available Volunteers Education and Credentialing			



Supplies Gloves, Masks Hand Washing Tylenol Waste Disposal			
Media General Information Multiple Venues Special Topics			
Mass Vaccination Models Locations Clinic, Community, Schools, Home Evenings, Weekends			
Simulation Variety of Venues			
Extremes Crowds and Waiting Times Angry Patients Poor Turnout			
Non-Beneficiary Billing			
Seasonal Influenza Vaccine Vaccine Received Immunizations Currently Offered Plans for Community Clinics			
Local Issues			
Other			



**BILLINGS AREA INDIAN HEALTH SERVICE
ACTION PLAN FOR NOVEL H1N1 INFLUENZA
Updated 9-9-09**

ISSUE	DESCRIPTION	PROGRESS
Key Contact Persons	<ul style="list-style-type: none"> • Area • Service Units • Tribal Programs 	
Team Meetings	<ul style="list-style-type: none"> • Weekly Area Planning Meetings • Weekly Service Units Calls • Ad Hoc Issues 	
Expectations	<ul style="list-style-type: none"> • Billings Area Response • Teamwork 	
Communication Resources	<ul style="list-style-type: none"> • State Conference Calls • HQ Conference Calls • ASTHO Calls • CDC Guidance • TCC website • HAN Messages 	
Central Document Location	<ul style="list-style-type: none"> • Widget (Share Point) • Iron Key • Service Unit Pandemic Plans and Action Plans 	
Communication Email Lists and Widget	<ul style="list-style-type: none"> • Email Address List • Duplication 	
Vaccine and Antiviral Priority	<ul style="list-style-type: none"> • Policy for Initial Small Allocations of Vaccine • Policy for Antiviral Use Based on Risk 	
Vaccine Supply	<ul style="list-style-type: none"> • Low State Allocations 	
HCW Definition	<ul style="list-style-type: none"> • Direct Care • Essential Services 	
Mass Clinics and Hard to Reach Populations	<ul style="list-style-type: none"> • Schools – Parental Consent and/or Presence • Community – Security • Special Hard to Reach Populations 	



Prefilled Syringe Issues	<ul style="list-style-type: none"> • Vaccine Effectiveness • Legality 	
Monitoring Vaccine and Antivirals Administered	<ul style="list-style-type: none"> • Service Unit Reporting to State and Area • Area Oversight Monitoring 	
Monitoring Disease	<ul style="list-style-type: none"> • Service Unit Reporting • Area Trending 	
Contingency Staffing	<ul style="list-style-type: none"> • Qualified Vaccinators (Pharmacists, Paramedics) • Nurses from Other Programs (Diabetes, Health Education, Quality Improvement) • Contract Staff • OT, CT • Mutual Aid Agreements • Limitation of Services 	
Staff Training and Competency	<ul style="list-style-type: none"> • H1N1 Schedules Based on ACIP Guidelines for All Providers and Vaccinators • H1N1 Antiviral Use for All Pharmacists and Physicians • Surveillance and Case Reporting for All Direct Care Providers • VIS Use and VAERS • Daily Briefings on New Guidance • Documentation of Training and Competency 	
Readiness Assessment	<ul style="list-style-type: none"> • Initial • Ongoing 	
Public Information	<ul style="list-style-type: none"> • Public Service Announcements and Brochures Tailored to Local Population and Prepared in Advance • Topics Include Vaccine, Prevention of Disease, Emergency Plans • Media on Controversial Topics 	
Urban Clinics	<ul style="list-style-type: none"> • Vaccine Supply from County 	
Security	<ul style="list-style-type: none"> • Vaccine Security and Refrigeration 	



	<ul style="list-style-type: none"> • Staff Safety 	
Worker Safety	<ul style="list-style-type: none"> • N-95 Supply • Need for Fit Testing • Personnel - Leave 	
Data	<ul style="list-style-type: none"> • EHR Template • IMM Package Patch • Data Exchange to State • Time Frames 	
Billing	<ul style="list-style-type: none"> • Decision to Bill in Mass Clinic Setting • Non-Beneficiaries 	
FTCA Coverage for Non-Beneficiaries and Off Reservation Locations	<ul style="list-style-type: none"> • Position Description Update 	
Seasonal Flu	<ul style="list-style-type: none"> • Start Times • Additional Supply 	
Montana Grant Inclusion Request	<ul style="list-style-type: none"> • PPE • Antivirals • Training for vaccinators • Staffing • Media Support 	
Gap Analysis Document	<ul style="list-style-type: none"> • Critical Components • Official Response 	
Blackfeet Special Issues	<ul style="list-style-type: none"> • Integration of All Nursing Staff into H1N1 Vaccination Efforts • Training for Ambulatory Care Nursing on Immunization • Responsibility to Adhere to Infection Control and Vaccine Policy • Pandemic Flu Plan – Draft Format • N-95 fit Testing • Inclusion of Tribal Health Director in Planning Meetings 	
Crow Special Issues	<ul style="list-style-type: none"> • Formal H1N1 Team Meetings with Expanded Membership 	



	<ul style="list-style-type: none"> • Integration of All Nursing Staff into H1N1 Vaccination Efforts • PHN Staffing • Process for Appropriately Identifying Household Contacts of Infants • Security During Limited Vaccine Supply • EHR Templates (Lack of CAC) 	
Fort Belknap Special Issues	<ul style="list-style-type: none"> • Refrigerator • Formal H1N1 Team Meetings with Expanded Membership • Positive Media Releases on IHS Preparations 	
Fort Peck Special Issues	<ul style="list-style-type: none"> • NEMHS Antiviral Prescription Practices 	
N. Cheyenne Special Issues	<ul style="list-style-type: none"> • Formal H1N1 Team Meetings with Expanded Membership • Develop Pandemic Flu Plan • PHN Staffing • Use of Other Staff for Vaccinators 	
Wind River Special Issues	<ul style="list-style-type: none"> • Mutual Aid Agreement Specific to WY 	



<p>Rocky Boy Special Issues</p>	<ul style="list-style-type: none"> • Private Sector Antiviral Prescription Practices • PHN Staffing • N-95 Fit Testing • Contingency Planning During Staff Illness 	
<p>Flathead Special Issues</p>	<ul style="list-style-type: none"> • 	



After Action Feedback H1N1 Vaccine Campaign Billings Area Indian Health Service

The Billings Area Indian Health Service is doing after action follow-up on how the H1N1 Vaccine Campaign worked this last year. We plan to use this information to strengthen our responses in the future. Because you were an active participant in this year's campaign, you can provide very valuable feedback and critical information. Please be candid in your remarks. The format is simple to minimize the time required to complete it. Please feel free to address any topic of concern to you no matter how large or small the issue. You may choose to remain anonymous.

YOUR LOCATION:

- Service Unit
- Tribal Program
- Urban Program
- Area Office
- Tribal Leaders Council
- State
- Other (specify)

WHAT WORKED WELL:

What efforts and assistance did you appreciate? What activities were helpful? What would you like to see continued in future efforts?

WHAT DID NOT WORK WELL:

What challenges did you face? What activities were not helpful? What would you like to see discontinued in future efforts?

RECOMMENDATIONS AND OTHER COMMENTS:

How would you like to see the efforts improved? What else would you like to say?

THANKS for providing your feedback and SUPER THANKS for all your hard work during the campaign.

Return forms by March 31 to:

Rita Harding
Box 36600
Billings, MT 59107
406-247-7141
Rita.Harding@ihs.gov



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