

# THE IHS PRIMARY CARE PROVIDER



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

December 1997

Published by the IHS Clinical Support Center

Volume 22, Number 12

## Anxiety Disorders in American Indians and Alaska Natives: Identification and Intervention

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At present, the vast majority of information available regarding anxiety disorders in this country is based on studies with the majority (Caucasian) culture. Leaving unclear the impact of these problems on American Indians and Alaska Natives. In fact, a recent national conference on anxiety disorders in American Indians and Alaska Natives, sponsored by the National Center for American Indian and Alaska Native Mental Health Research, highlighted the fact that information regarding anxiety in American Indian and Alaska Native peoples is almost nonexistent<sup>1</sup>. This lack of scientific knowledge is unfortunate, given that problem anxiety is associated with increased rates of mortality, substance abuse, poor physical and mental health, as well as an overall decreased quality of life<sup>2</sup>.

In this article, we highlight the breadth and importance of anxiety- and fear-related problems in American Indians and Alaska Natives in order to increase the likelihood that professionals working with them will be better equipped to understand, recognize, and more effectively manage anxiety disorders. In addition, we review the scientific literature regarding the nature, prevalence, assessment, and treatment of clinical anxiety in American Indian and Alaska Native people.

### The Nature of Anxiety

Anxiety is a multidimensional emotional state that can be conceptually understood as a "three channel response system" that includes physiological, cognitive, and overt behaviors<sup>3</sup>. Physiological responses associated with anxiety involve a variety of bodily systems, and lead to such changes as elevated heart rate, sweating, muscle tension, and increased respiration. The cognitive channel refers to thoughts and perceptions. Because it is impossible to directly observe thoughts, and often difficult to assess physiological processes as they occur outside of medical settings, an individual's verbal report of these events is frequently necessary for assessment. Overt anxious behavior most often involves avoidance of situations and/or objects, or may include prematurely leaving an event (i.e., "escaping").

It should be noted that these three channels of response to

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anxiety and fear (i.e., physiologic, cognitive, and overt behavior; or component behaviors within each channel) are often independent of one another. As an example, an American Indian woman who abruptly experiences heart palpitations and feelings of impending doom associated with panic while helping to prepare a feast at a tribal gathering may not verbally report a panic attack for fear of "losing face," being disrespectful to family and friends, or making "doom" real by talking about it. Regardless, she may well leave the immediate situation (i.e., "escape") if possible, and may be more likely to avoid leaving her home in the future if the attacks persist. In this case, anxiety-evoked physiological and cognitive responses are evident, along with possible escape and avoidance, even though verbal reports of anxiety are not present. As such, there is often discordance within or among the response channels. Thus, just because an American Indian or Alaska Native person, or a person in the majority population or any other ethnic minority group, does not say "I feel anxious" does not necessarily mean that he or she is not having problems with anxiety. In a similar way, there is often response desynchrony, whereby two response channels, or behaviors within a single channel, respond to treatment at dissimilar rates. For example, one channel may respond first, with others improving more slowly, perhaps weeks later. Overall, it is critical for mental health practitioners working with anxiety disorders to assess all three channels of response that comprise anxiety in order to understand their relation with one another, and to target those problems that are most troubling to a particular individual.

There are many qualitatively distinct states that are categorized under the general rubric of "anxiety." Although the scope of this paper will not permit a detailed description of such anxiety-related states as fear, panic, worry, and stress, it is clear that these negative emotional experiences overlap considerably. That is, all anxiety states are characterized by the aforementioned three channels of response, yet they differ in regard to the chronicity, duration, and magnitude of response, as well as type of associated environmental cues. For example, a panic attack abruptly arises "out of the blue" and is characterized by high levels of bodily arousal, cognitive distress, and escape behavior. In contrast, worry in response to negative life events is more of a cognitive-affective state that persists for longer periods of time, such as a period of hours, and involves less bodily arousal. There also is a frequent coexistence of anxiety-related states with other conditions such as depression.

Anxiety is a natural and adaptive response to life events that nearly all people experience. Indeed, anxiety prepares people to deal with real (or perceived) dangers or concerns. When anxiety occurs for extensive periods of time and/or at extreme levels, however, the functioning of an individual may be negatively affected and thus anxiety may then be considered "pathological." In these cases, a diagnosis of an anxiety disorder may be warranted.

### Prevalence of Anxiety Disorders

According to the Diagnostic and Statistical Manual of

Mental Disorders, Fourth Edition (DSM-IV), the most widely accepted classification system of mental health problems in the US, anxiety disorders are a class of mental/behavioral health problems that are characterized by the emotional states of anxiety, fear, worry, and panic<sup>4</sup>. There are 11 anxiety disorders listed in the DSM-IV, with additional subcategorizations, but there are many more related conditions, which are also associated with life disruption and an impairment in quality of life.

Although anxiety disorders can arise at any time during a person's life, most typically begin prior to 30 years of age and in periods of life stress. Certain anxiety disorders are more common during specific developmental periods. Anxiety disorders in young adults and elders generally occur more often in women than men. For instance the female:male ratio for Generalized Anxiety Disorder is approximately 1 to 1, whereas it is about 4 to 1 for Panic Disorder with Agoraphobia<sup>4</sup>. In childhood, the gender distribution is less apparent, with both females and males having approximately the same frequency of anxiety disorder diagnoses. It is clear that anxiety disorders are familial, with both environmental (learned or acquired) and genetic factors contributing to an increased risk<sup>5</sup>.

Epidemiologic data indicate that anxiety disorders are the second most common psychological disorder across the life span, second only to alcohol and drug abuse. Research that has assessed the rate of anxiety disorders in the month prior to evaluation, however, has shown that these problems evidence the highest prevalence of any class of psychological dysfunction<sup>6</sup>. Although the specific prevalence rate for any given anxiety disorder may vary depending on the study, existing literature suggests the one year prevalence rate for all anxiety disorders ranges from 4 to 8%<sup>7</sup>. Because anxiety disorders are often associated with alcohol abuse/dependence and depression, it is also necessary to consider the possibility of these other conditions when assessing anxiety-related problems in American Indians and Alaska Natives. Similarly, clinicians should consider that an anxiety disorder may be a comorbid, secondary condition, even when a patient's principal diagnosis is alcohol abuse/dependence or depression.

It is not uncommon for persons with anxiety disorders to drink excessive amounts of alcohol in order to avoid feeling "anxious" or "worried." Such alcohol abuse is often referred to as "self-medication" and may contribute to alcoholism in American Indians and Alaska Natives<sup>8</sup>. Similar to anxiety disorders, alcohol abuse is associated with poor physical and mental health and a decreased quality of life; it may also ultimately prevent an individual from recognizing that he or she has an anxiety problem. As a result, a person with an anxiety disorder who abuses alcohol may be less likely to receive appropriate psychological care.

In a similar way, depression and anxiety-related problems often coexist. Although the exact relation between these psychological problems is not clear, one likely pathway is that anxiety disorders may lead people to lessen their participation in daily activities such as working, shopping, or socializing because of generalized anxiety or perhaps a specific fear. In

time, such avoidance behavior may limit the person's contact with positive experiences and social support, thereby prompting depression.

Not surprisingly, epidemiologic studies of specific anxiety disorders in American Indian and Alaska Native populations are nearly nonexistent. Nonetheless, research suggests that in some tribal groups, greater than 50% of the respondents surveyed experience some form of psychological disturbance at some point in their lives<sup>9</sup>. Furthermore, it is clear that alcohol-related problems, as well as rates of depression, are exceedingly high in some American Indian and Alaska Native tribal groups<sup>8</sup>. Given the aforementioned possibility of the coexistence of anxiety with either alcohol abuse/dependence or depression, or both, it is reasonable to suspect that the prevalence of anxiety disorders may be particularly high in some American Indian and Alaska Native groups. Although methodological limitations, such as the lack of operational definitions of anxiety disorders and culturally sensitive assessment devices, restrict the generalizability of these findings, it is reasonable to conclude that psychological disturbances, including anxiety disorders, are a relatively common problem for many American Indian and Alaska Native groups<sup>10</sup>.

#### Assessment

The assessment of fear and anxiety in American Indians and Alaska Natives is only beginning to garner scientific attention. Although numerous anxiety and fear assessment tools exist, such as self-report instruments and structured interviews, the vast majority of these have been developed and tested using only Caucasian populations. The lack of research on American Indians and Alaska Natives may further contribute to this reliance on Caucasian samples to validate assessment instruments. Nonetheless, the potential biases arising from the content and language of Caucasian-based assessments may result in their poor predictive and construct validity in American Indian and Alaska Native peoples<sup>11</sup>. In fact, there is a growing recognition that cultural influences require special consideration in the development, administration, and interpretation of any assessment tools<sup>12</sup>. There is evidence, for instance, that the clinical presentation of certain psychological dysfunctions in American Indians and Alaska Natives may not "match" the clinical presentation of the same conditions in Caucasian samples. For example, behaviors such as social isolation, or impassive or sad facial expressions may signal problems with depression in Caucasian individuals, whereas the same actions in an certain American Indian or Alaska Native persons might instead be associated with specific social roles<sup>13</sup>.

With over 500 American Indian and Alaska Native groups, gathering accurate information regarding the presentation of psychological problems in American Indian and Alaska Native peoples is a difficult task. For instance, intertribal differences

in the degree of acculturation and cultural involvement contribute to heterogeneity among American Indians and Alaska Natives, and may result in unique manifestations of psychological problems. Patterns of cultural differentiation among ethnic groups are apparent in regard to the pathological manifestations of anxiety. There are reports, for example, that decades of cultural trauma have led to an intergenerational Post Traumatic Stress Disorder in American Indians and Alaska Natives that involves anxiety reactions in response to environmental stimuli that have threatened one's life, safety, or personal integrity<sup>14</sup>. American Indians and Alaska Natives may also experience anxiety about the conflict between integrating into the majority culture and retaining strong tribal ties<sup>15</sup>, or performing in a primarily Caucasian educational system in academic subjects as mathematics<sup>16</sup>.

It is also possible that cultural differences may have the opposite effect and perhaps lead to an underidentification of anxiety disorders. For instance, the stereotypical view of American Indians and Alaska Natives as stoic and fearless may make providers less likely to perform an appropriate and comprehensive assessment for anxiety problems. Furthermore, social stereotypes that may only be relevant to specific persons of particular tribal groups may be applied to all American Indians and Alaska Natives. For example, because many members of the Mohawk Tribe have been renowned steelworkers who worked "fearlessly" to build skyscrapers, this lore about them may lead to the false conclusion that all American Indians and Alaska Natives do not fear heights<sup>17</sup>. Also, social phobia might mistakenly be diagnosed in an American Indian or Alaska Native youngster who does not "speak up" and establish eye contact with teachers or Caucasian peers, even though to do so would be inconsistent with his or her culturally-based communication patterns<sup>18</sup>. Conversely, however, such behavior might actually be a result of anxiety and stress experienced by the youngster trying to function biculturally, in both American Indian or Alaska Native (e.g., reservation) culture and the majority (e.g., off-reservation school) culture social settings<sup>19</sup>. Only a careful assessment of these cultural issues will allow proper identification of the root causes of anxiety problems.

Taken together, it is clear that the assessment of anxiety in American Indians and Alaska Natives should be conducted with the recognition that tribal-specific beliefs and cultural practices may result in unique manifestations of anxiety problems<sup>15</sup>. It is therefore necessary for health and mental health professionals working with American Indian and Alaska Native peoples to learn about the unique, as well as typical, cultural aspects of the tribal group(s) with whom they work in order for their assessments of possible anxiety disorders to be sensitive and accurate. For example, it may be beneficial for mental health practitioners to consult with tribal leaders, elders, and traditional healers to learn about factors that may be

related to the expression of anxiety in a particular tribal group. In a similar way, it would be helpful for practitioners to acquaint themselves with the beliefs and traditions of a particular tribal group by speaking with members of that group, asking for assistance, and reading relevant materials. Through such tribal-specific assessment, there will be an increased chance that appropriate interventions can be designed and more accurate epidemiologic information (e.g., the prevalence of anxiety disorders) can be attained in American Indians and Alaska Natives.

### Treatment

Although it is clear that they are in need of the same effective mental health services as the majority population, American Indian and Alaska Native peoples are seriously underserved<sup>1</sup> and have historically underutilized what mental health care there is available<sup>20</sup>. There are a number of factors that likely contribute to this underutilization, such as a lack of American Indian and Alaska Native mental health providers, inattention to American Indian and Alaska Native treatment issues by service providers, as well as limited financial resources of persons in need of care<sup>21</sup>. Because the American Indian and Alaska Native population is steadily increasing<sup>4</sup>, this treatment gap will likely widen unless appropriate actions are taken to better educate mental health professionals to more effectively work with American Indian and Alaska Native peoples<sup>21</sup>.

There are many effective psychological treatments for anxiety disorders as recognized by the DSM-IV. In fact, there are standardized protocols for these treatments available for practitioners<sup>22</sup>. Additionally, treatment manuals that contain brief assessment measures, strategies for targeting problem behaviors, and effective techniques aimed at reducing anxiety-related problems are currently available to practitioners and consumers alike<sup>23</sup>. There is also evidence that pharmacological agents can be used successfully to alleviate many symptoms of anxiety disorders<sup>24</sup>. Similar to assessment instruments, however, both psychological and pharmacological<sup>25</sup> treatments for anxiety disorders have predominantly been tested on Caucasian populations, leaving unclear their efficacy for American Indians and Alaska Natives. It will be valuable for future researchers to test treatment effectiveness specifically for American Indian and Alaska Native populations. There is good reason to suspect that behavioral and cognitive-behavioral approaches will be successful with American Indian and Alaska Natives<sup>2</sup>, much like in the majority culture, because they involve assessing how the *individual* functions in his or her personal environment, and then focus on strategies to promote positive behavior changes in a *situation-specific* manner. Nonetheless, all interventions for psychological problems in American Indians and Alaska Natives should be delivered in a cultur-

ally-sensitive fashion and tailored to individuals, considering the context(s) in which they live (e.g., their family and tribal group).

There are a number of additional reasons for culturally-sensitive therapeutic efforts for American Indians and Alaska Natives with psychological problems in general, and anxiety-related problems in particular. Research suggests that insensitivity to tribal needs, mistrust, and the imposition of Western ideals on psychological problems may contribute to why American Indians and Alaska Natives so often reject conventional psychological services<sup>26</sup>. Cultural awareness is also critical in the verbal and non-verbal communication that is necessary for efficient progress in therapy, as well as for establishing and maintaining trust with the American Indian and Alaska Native clients<sup>27</sup>. In particular, mental health practitioners need to be aware of cultural issues such as the type of role an American Indian and Alaska Native patient will be apt to take in psychological treatment. For example, some American Indians and Alaska Natives may prefer to take more of a passive role in therapy, whereas many forms of Western-based psychological services attempt to encourage the client to take an active role<sup>2</sup>. Similarly, an understanding of individual, family, and tribal history and lore will help to insure accurate assessment and the most ideal treatment strategies. For instance, with a bilingual client, a clinician may want to discuss whether the client wishes to use his or her own tribal language or English (or both) in utilizing cognitive strategies such as coping self-statements. Additionally, culturally-relevant information may benefit mental health professionals in understanding that some American Indians and Alaska Natives may avoid directly speaking of a problem with anxiety<sup>28</sup>, expecting the clinician to accurately infer the difficulty from subtle cues or indirectly related stories. Overall, by taking culturally-related information into consideration with American Indian or Alaska Native patients, the practitioner will be better able to find a mutually appropriate interpersonal communication strategy and to discuss therapy issues, thereby helping to insure treatment will be the most beneficial.

An understanding of and respect for the American Indian and Alaska Native peoples' history and current concerns may also help in establishing therapeutic rapport, and therefore increase treatment efficacy<sup>4</sup>. Specifically, cultural sensitivity may help practitioners to apply treatment modalities that are in accord with the American Indian or Alaska Native clients' world view, thereby enhancing the possibility that psychological services rendered will be viewed as credible<sup>12</sup>. For example, by being aware of particular American Indian and Alaska Native beliefs about the origins of their anxiety problem, it may be possible to incorporate those beliefs in a manner beneficial to treatment. In a similar vein, familiarity with tribal-traditional practices may facilitate non-Indian practitioners con-

sulting with traditional healers (medicine men and women). In this way, both majority culture care providers and traditional healers can learn how to best deliver treatment for anxiety disorders in a particular tribal group, based upon what therapeutic strategies have been effective for similar problems in the past. Clearly, the application of psychological interventions for anxiety disorders with American Indian and Alaska Native groups must be conducted with consideration for cultural differences in order for therapies to be the most efficacious.

### Summary

Anxiety disorders represent a serious mental health problem for American Indians and Alaska Natives<sup>1</sup>. There is nearly an absence of scientific information available, however, regarding anxiety disorders in American Indians and Alaska Natives in general<sup>2</sup>, and specifically the culturally unique manifestations of anxiety in this population<sup>3</sup>. We have attempted to highlight the nature of anxiety and present an overview of what is currently known about anxiety problems in American Indian and Alaska Native peoples. It is clearly an important and timely matter to better equip health care providers to effectively deal with this class of psychological disorders. The authors hope the information provided in this article will help inform health professionals working with American Indian and Alaska Native people about these mental/behavioral health problems in these people. In this way, it will be more likely that research will be conducted to better understand anxiety disorders in this population. Moreover, it is hoped that this information will assist practitioners in sensitively and effectively identifying and treating anxiety problems in American Indians and Alaska Natives. □

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# Pediatric Morbidity and Mortality Review: A Continuing Education and Quality Assurance Activity

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The Rosebud Indian Hospital, located in south central South Dakota, provides health care to the people of the Rosebud Sioux Tribe. Children comprise more than half of the estimated 16,000 residents on the Rosebud Indian Reservation, and account for a substantial proportion of the 75,000 outpatient visits to the hospital for 1994. In order to monitor and assure quality care for pediatric patients visiting the Rosebud hospital, a mechanism of morbidity and mortality review was sought. Although many possible models exist, a unique approach was devised that provides structure for morbidity and mortality review, while offering an educational component that is creditable for continuing education purposes. The resulting mechanism involves the following elements: (1) selection of cases, (2) identification of the attending physicians, (3) development of an educational outline with objectives, and (4) submission of required documentation to the Indian Health Service (IHS) Clinical Support Center (CSC) for sponsorship and awarding of continuing education credits.

In the Rosebud model, cases are identified by physician, mid-level, and nursing providers. The age of all cases chosen for review is between birth and 15 years. In addition, cases need to meet at least one of the following criteria:

1. There is no apparent definitive diagnosis.
2. Medical issues or concerns about the case have been raised.
3. The diagnosis or illness is unusual.
4. The child expired.
5. The child was transferred.
6. The child has been seen previously for the same complaint.

The medical record numbers of cases meeting these criteria are entered on a case registry, which is posted at all points of care (outpatient clinic, nurses station, and the emergency department) within the facility. This sheet is collected and replaced with a blank version in the final days of each month. The cases are reviewed by the Chief of Pediatrics, and are then scheduled for presentation at the conference.

The diagnosis, or some element of care in the selected case, serves as the topic of each Morbidity and Mortality Conference. The Chief of Pediatrics identifies a subspecialist

(appropriate for the topic) to serve as a consultant from one of the surrounding medical centers, which in this area include: Rapid City Regional Hospital (Rapid City, SD); McKennan Hospital (Sioux Falls, SD), Valley Hospital (Sioux Falls, SD), University of Nebraska Medical Center (Omaha, NE), Children's Hospital (Omaha, NE); St. Joseph's Hospital (Omaha, NE); and Cherry County Hospital (Valentine, NE). An educational outline with learning objectives is developed in cooperation with the specialist. The conference announcement is created, and includes the topic, the name and qualifications of the selected specialty consultant, and learning objectives. The conference announcement, an evaluation form, and sign-in sheet are forwarded to the IHS CSC for review.

The Morbidity and Mortality (M&M) Conferences are scheduled for the lunch hour (12-1 p.m.) on the third Thursday of each month, and care is taken to avoid overlapping with other educational or medical staff activities. The conference announcement is distributed to medical staff members, nursing, and the outpatient department 1 to 2 weeks in advance. Whenever possible, the specialty consultant attends the conference in person, but may participate via satellite or teleconference connection. The format of these M&M conferences is as follows:

- The case is presented by the attending physician (10 minutes).
- Prominent items of concern relating to the diagnosis and management of the case are discussed (10 minutes).
- The specialist consultant elaborates on the diagnosis and management of the disorder, satisfying the posed educational objectives.

Following the conference, attendees are encouraged to complete the evaluation form, along with an additional form developed specifically to elicit additional educational needs of attendees. The attendance sheet is forwarded to the IHS CSC following each conference and a summary of the evaluation process is performed and forwarded to the CSC annually.

This mechanism of providing clinically relevant continuing education in a timely manner has been well received by both attendees and the specialist consultants, and contributes greatly to an ongoing and comprehensive process of pediatric morbidity and mortality review at the Rosebud PHS Indian Hospital. □

# Phoenix Performance Evaluation System Accepted by JCAHO

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On November 12, 1997 the Phoenix Area Indian Health Service Quality Management Office received notification from the Joint Commission on Accreditation of Health Care Organizations (JCAHO) that the Phoenix Performance Evaluation System will be included on the list of systems that may be selected by health care organizations to meet accreditation requirements related to the ORYX initiative. A complete description of the ORYX initiative was printed in the June issue of *The Provider* ("JCAHO's Measurement Mandate," Volume 22, Number 6, pages 93-94).

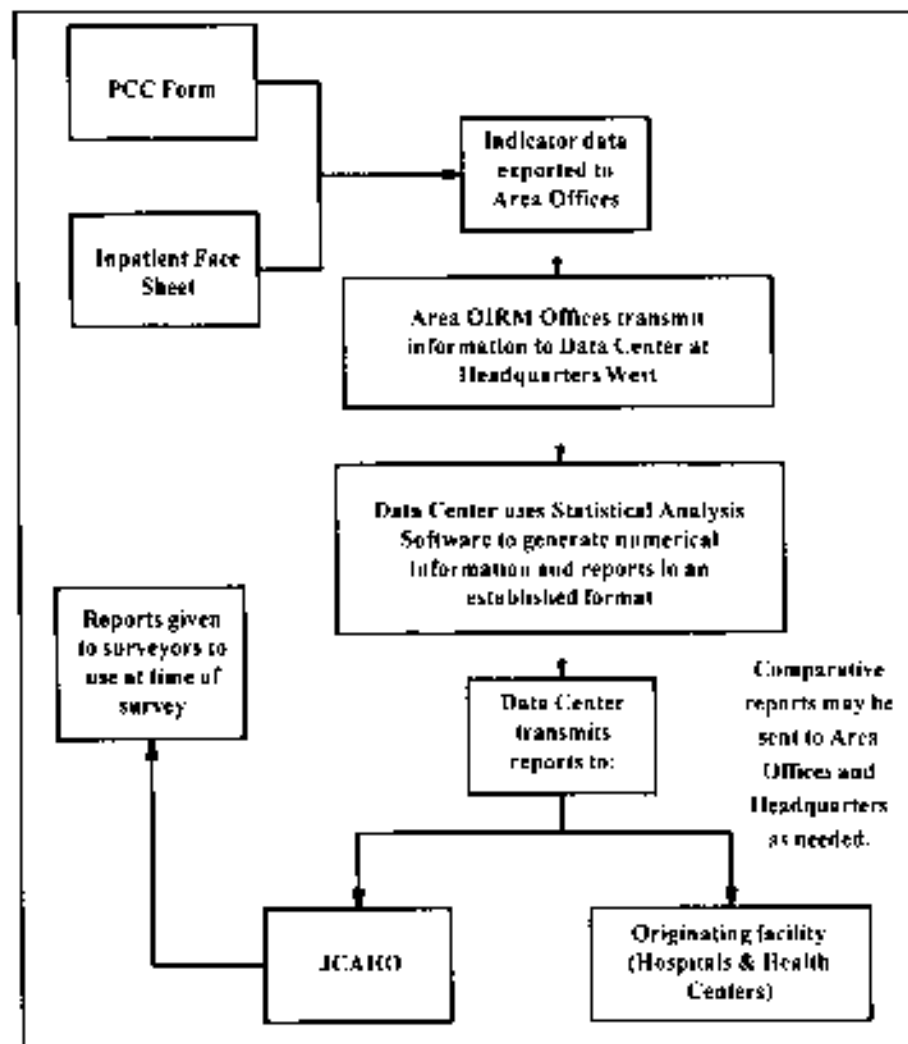
Under this initiative, each JCAHO-accredited hospital must select a performance measurement system by which it wishes to be evaluated by March 2, 1998. This means that each accredited hospital and long term care organization will now be asked to select a sufficient number of measures to address 20 percent of its patient or resident population, or five measures, whichever is less. Data collection must begin in 1998 and the first data must be submitted by the first quarter of 1999.

## How the System Works

Using the "Phoenix" system, performance measurements are generated

directly from data from the Patient Care Component (PCC) of the Resources and Patient Management System (RPMS) and the Inpatient Face Sheet. This system does not require further abstraction or duplicate data entry. This allows for review of 100% of data pertaining to each measure. It also allows for "benchmarking" and comparisons between IHS and tribal hospitals of similar size. Figure 1 describes how the data will flow through the system.

Figure 1. Data flow through the Phoenix Performance Evaluation System.



### Small Hospital Performance Measurement Requirements

The reporting requirements are a function of the size of the facility measured in terms of the inpatient average daily patient load (ADPL) and the number of monthly ambulatory care visits. The special considerations for smaller facilities are described in Table 1.

#### What are the actual indicators?

For ambulatory care, two indicators may be selected from the approved options depicted in Table 2. For inpatient care, two indicators may be selected from the approved options depicted in Table 3. Inpatient facilities may select one indicator from each list if they choose to do so.

Registration requirements, user manuals, and other elements of the Phoenix system are being developed. Presently there is no charge for using the Phoenix Performance Measurement System. Eventually, a cost will be calculated based on actual expenses and the number of facilities using the system. The costs will be held to a minimum and will depend, in part, on the number of Indian health programs that choose to use the Phoenix system.

Should a facility select the Phoenix Performance Measurement System and find that it is not comfortable with the cost or other elements of the system, they have the option to change their selection to any of the other more than 100 JCAHO approved performance evaluation systems any time

until June 30, 1998.

All JCAHO-accredited facilities should have received a packet of information from the Joint Commission listing the performance evaluation systems available to choose from that meet their criteria. To select the Phoenix system, notify the Joint Commission on the form provided by them; it is listed in the blue section on page 31, ID #1899-01 under the title "Phoenix." The system may be selected by any IHS or tribal hospital utilizing the Resource and Personnel Management System (RPMS).

Any facility interested in using this system should send a letter of intent to the Phoenix Area Indian Health Service Quality Management Office, 40 North Central Avenue, Suite 600, Two Renaissance Square, Phoenix Arizona 85044-4424. The letter of intent should state as follows: "It is the intention of the \_\_\_\_\_ Hospital to select the Phoenix Performance Measurement System. Indicators # \_\_\_\_\_ and # \_\_\_\_\_ have been selected. A formal subscription agreement will be submitted at a later date when cost and other elements of the measurement system have been identified." If you have any questions regarding the system or its implementation, please call Alice Warren or Victor Herring at 602-364-5193 or 364-5167.

It is anticipated in the near future all communication regarding the system will be directed to a Program Manager located at the Data Center in Headquarters West and that the word "Phoenix" will be replaced by "Indian Health Service." □

Table 1. Small hospital Performance Measurement Requirements.

ADPL/#Visits	Requirements
Hospital has an average daily patient load (ADPL) of less than or equal to 30	For inpatient measures, the data will be analyzed quarterly (instead of monthly)
Hospital has an ADPL of less than 10, and has more than 150 ambulatory visits per month	Hospital must select an acceptable measurement system but may choose two performance measures that focus on 20% of the ambulatory patient population in place of selecting inpatient measures (monthly data points will be used for analysis)
Hospital has an ADPL of less than 10, and has less than 150 ambulatory visits per month	Hospital is temporarily excused from the new requirements while the Joint Commission identifies alternative



**Table 2. Ambulatory Care Indicators.**

Indicator	Description
*DI-0001	<p>Purpose: Appropriate dental care for children</p> <p>Numerator: Any dental visit within the year</p> <p>Denominator: Any child who is at least six months old, but less than two years old</p>
*WH-0001	<p>Purpose: Adequate assessment of menses and potential pregnancy</p> <p>Numerator: Documentation of the LMP (last menstrual period) on each visit</p> <p>Denominator: Any patient who is female and 12 through 50 years old, presenting to ER GYN, Women's Health Primary Care</p>
HP-0001	<p>Purpose: Assessment of appropriate childhood immunizations</p> <p>Numerator: Age appropriate immunizations</p> <p>Denominator: All children from birth through 18 months old</p>
HP-0002	<p>Purpose: Elder immunization for influenza</p> <p>Numerator: Having received an immunization for influenza within the year</p> <p>Denominator: Any patient who is 65 years of age or older within the year. Exclude anyone having an egg allergy</p>
*HP-0003	<p>Purpose: Identification of obese patients</p> <p>Numerator: A recorded weight of 150% of ideal or greater at any time during the year</p> <p>Denominator: Any patient</p>
HP-0004	<p>Purpose: Nutritional education for obese patients</p> <p>Numerator: A documented episode of nutritional education (intervention)</p> <p>Denominator: All patients with a recorded weight of 150% of ideal or greater</p>
DM-0001	<p>Purpose: Control of diabetes</p> <p>Numerator: Has at least one HbA<sub>1c</sub> of 7.5% or less</p> <p>Denominator: Any patient ever having a diagnosis of diabetes mellitus. Exclude all gestational diabetics</p>
DM-0002	<p>Purpose: Prevention of kidney complications in diabetes patients</p> <p>Numerator: Having a blood pressure less than or equal to 135/80</p> <p>Denominator: Any patient with a diagnoses of diabetes mellitus and hypertension</p>
DM-0003	<p>Purpose: Protection of diabetic patient's kidneys from complications</p> <p>Numerator: Patients receiving an ACE inhibitor (e.g., lisinopril, captopril, enalapril, etc.)</p> <p>Denominator: Any patient with a diagnosis of diabetes mellitus and hypertension</p>
*DM-0004	<p>Purpose: Identification of obese diabetic patients</p> <p>Numerator: A recorded weight of 150% of ideal or greater, at any time during the year</p> <p>Denominator: Any patient who has ever had a diagnosis of diabetes</p>
DM-0005	<p>Purpose: Management of overweight diabetic patients</p> <p>Numerator: A documented episode of nutritional education in the last year</p> <p>Denominator: All patients who have ever had a diagnosis of diabetes mellitus and also had a recorded weight of 150% of ideal or greater</p>
DM-0006	<p>Purpose: Early diagnosis of diabetic retinopathy</p> <p>Numerator: Annual eye examination</p> <p>Denominator: Any patient with a diagnosis of diabetes mellitus</p>
DM-0007	<p>Purpose: Diabetic dental health</p> <p>Numerator: Annual dental examination</p> <p>Denominator: Any patient with a diagnosis of diabetes mellitus</p>
PC-0001	<p>Purpose: Appropriate treatment of chronic otitis media in young children</p> <p>Numerator: ENT consultation</p> <p>Denominator: Any child who is one month through five years of age who has had three episodes of otitis media in the past year</p>

\*Note: These indicators have not been approved by JCAHO

Table 3. Inpatient Care Indicators.

Indicator	Description
*RM-0001/IP	<p>Purpose: Identification of early or inappropriate discharge</p> <p>Numerator: Any readmission within 24 hours of discharge for the same diagnosis</p> <p>Denominator: All admissions</p>
RM-0002/IP	<p>Purpose: Admissions having missed diagnosis or inadequate treatment in emergency patients</p> <p>Numerator: Any admissions within 48 hours of an ER discharge to home</p> <p>Denominator: All ER admissions</p>
RM-0003/IP	<p>Purpose: Risk management</p> <p>Numerator: Cardiac arrest within 48 hours of surgical procedure</p> <p>Denominator: All hospitalized patients having a surgical procedure</p>
RM-0004/IP	<p>Purpose: Risk management</p> <p>Numerator: Unscheduled return to OR within 24 hours</p> <p>Denominator: All inpatients having had a surgical procedure</p>
*RM-0005/IP	<p>Purpose: Risk management</p> <p>Numerator: Any transfer to another facility within 24 hours of admission</p> <p>Denominator: All admissions</p>
*RM-0006/IP	<p>Purpose: Identification of hospital acquired injuries</p> <p>Numerator: Any patient injured after being admitted to the hospital</p> <p>Denominator: All admissions</p>
RM-0007/IP	<p>Purpose: Identification of any inpatient admission following day surgery</p> <p>Numerator: Inpatient admissions following day surgery</p> <p>Denominator: All day surgeries</p>
UR-0001/IP	<p>Purpose: Medical management of cellulitis</p> <p>Numerator: Length of stay equal to or greater than five days</p> <p>Denominator: All admissions with a primary diagnosis of cellulitis</p>
OB-0001/IP	<p>Purpose: Tracking incidence of C-sections</p> <p>Numerator: Deliveries by C-section</p> <p>Denominator: All deliveries</p>
OB-0002	<p>Purpose: Tracking incidence of vaginal deliveries after C-Section</p> <p>Numerator: Vaginal deliveries</p> <p>Denominator: All deliveries with a diagnosis of previous C-section</p>
DM-0001/IP	<p>Purpose: Management of diabetic patients, nutritional education</p> <p>Numerator: Evidence of nutritional education during hospitalization</p> <p>Denominator: All inpatients with a primary diagnosis of diabetes mellitus</p>

\*Note: These indicators have not been approved by JCAHO

# Call For Papers

## 10th Annual IHS Research Conference

The Tenth Annual Indian Health Service (IHS) Research Conference, sponsored by the IHS Research Program and the IHS Clinical Support Center (the accredited sponsor) will be held the week of April 27, 1998 in Albuquerque, New Mexico.

Papers are invited for oral or poster presentation in the following categories: Aging, AIDS, Alcohol and Substance Abuse, Cancer, Cardiovascular Disease, Diabetes, Environmental Health, Epidemiology, Health Care Administration, Health Promotion and Disease Prevention, Health Services Research, Injury Prevention, Mental Health, Nutrition, Oral Health, and Women's Health. Research measuring the effectiveness of innovative health care delivery interventions or research that demonstrates partnerships between researchers and tribes is especially welcome.

Abstracts must be received no later than close of business February 20, 1998 to be considered for review (see "Instructions for Preparing Abstracts" below). Notice of acceptance of abstracts will be mailed no later than March 31, 1998.

For abstract consultation (style, etc.), contact Ms. Linda Arviso-Miller at 505/248-4142; Fax: 505/248-4384, e-mail: larvisom@smrp.ihs.gov

### Instructions for Preparing Abstracts

1. Use the abstract form on the next page to prepare your abstract. All copy must fit within the frame. This form may be copied.
2. Accepted abstracts will be reduced and printed in the conference program. Remember that you are producing camera-ready copy. Submit your abstract in a type size no

smaller than 12 pitch typewriter type or a 10 cpi font on a word processor. Single space all copy. Do not include figures, tables, equations, mathematical signs or symbols, or references in the abstract.

3. The abstract content should be structured as follows: title, author and affiliation (**No Degrees**), purpose/background, methods, results, and conclusions. Place an asterisk next to the name of the presenting author. Conclude your abstract with the sentence: "For further information: [Name and address of author serving as point of contact]." The abstract must fit within the frame on a single abstract form and be no more than 250 words in length.
4. Check the desired form of presentation: oral, poster, or either.
5. Please fill out the biographical sketch below: it must accompany the original abstract. **Do not submit a curriculum vitae or resume.**
6. All abstracts should be sent to: Ms. Linda Arviso-Miller, Conference Coordinator, Indian Health Service Research Program, 5500 Homestead Road, NE, Albuquerque, New Mexico 87110 (telephone: 505/248-4142). **Submit one original signed by the primary author. Please also submit a diskette with the abstract in a PC-compatible WordPerfect or ASCII text file.**
7. Abstracts must be received by close of business, February 20, 1998.
8. We will notify authors of the acceptance or rejection of their papers no later than March 31, 1998.

### Biographical Sketch

(Please Type)

Primary Author/Presenter \_\_\_\_\_

*(As you would like it printed in the Final Conference Program)*

Mailing Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Telephone Numbers: Work ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ Home: ( ) \_\_\_\_\_

E-mail Address \_\_\_\_\_ Position Title \_\_\_\_\_

Secondary Authors: (Name, Title, Place of Employment): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Send the abstract and biographical sketch to: Ms. Linda Arviso-Miller, Conference Coordinator, IHS Research Program, 5500 Homestead Road, NE, Albuquerque, NM 87110. 505/248-4142; Fax: 505/248-4384; e-mail address: larvisom@smrp.ihs.gov

Indian Health Service Research Program  
10th Annual Conference  
Call for Papers  
**ABSTRACT FORM**

[Empty box for abstract content]

Submitted for:

- Oral Presentation       Poster Presentation       Either

If this abstract is not accepted for oral presentation, would you consider a poster?

- Yes       No

Indicate the major content area of your abstract:

- Nursing       Medicine       Environmental Health  
 Community Health       Nutrition       Behavioral/Mental Health  
 Dentistry       Epidemiology       Other \_\_\_\_\_

**Abstracts must be received by February 20, 1998.**

Signature of primary author: \_\_\_\_\_ Date: \_\_\_\_\_

# IHS Pharmacy Intranet Operational

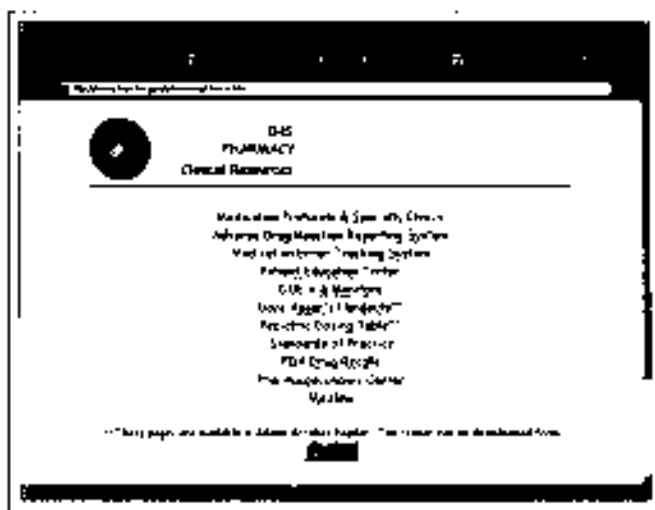
*Samuel M. Hope, RPh, MS, Oklahoma City Area Pharmacy Officer and Acting Director, IHS Pharmacy Services, Oklahoma City, Oklahoma*

The Indian Health Service Pharmacy Communications Committee is pleased to announce the first IHS pharmacy intranet site. The purpose of this intra-agency web site, the address of which is *home http://www.ih.gov/pharmacy*, is to facilitate communication between and among pharmacists in the IHS and those at tribal and urban Indian health facilities connected to the IHS intranet network.

As an *intranet* site, this location is only accessible from behind the IHS network security "firewall." This makes it a private location, and it cannot be accessed by the general public, or from your home PC or any other remote location unless the connection originates within the security firewall (that is, within the *ih.gov* domain). This feature allows for exclusive use of the information by IHS and Indian health program pharmacists with access to the IHS network.

This new site contains news and information, patient education information, Drug Use Evaluations (DUE), announcements, Continuing Pharmacy Education (CE) information, pharmacy vacancy announcements, and much more. The figure below depicts an example of one to the many pages on the web site. Information on the pharmacy intranet is developed and maintained by IHS pharmacists. This web site will be a primary means of communication for all IHS pharmacists.

Pharmacists should visit the site often in order to enhance patient care activities and to network with other pharmacists in the IHS. Contributions are strongly encour-



aged to enhance information sharing and communication among Indian health program pharmacists. For more information, you may contact Carolyn Johnson, RPh, at the Taos-Picuris Indian Health Center; her e-mail address is *cjy@albuquerque.ih.gov*. □

## MEETINGS OF INTEREST □

### **Sharing Solutions in a Changing Indian Health Care Environment: The 1998 Meeting of the National Councils** <sup>401</sup> January 5-8, 1998 Phoenix, Arizona

The National Councils (Clinical Directors, Service Unit Directors, Chief Medical Officers, and Nurse Consultants) of the Indian Health Service will hold their 1998 annual meeting January 5-8, 1998 in Phoenix, Arizona. This year's theme is "Sharing Solutions in a Changing Indian Health Care Environment." An exciting and informative program is planned to address Indian Health Service/Tribal/Urban program issues

and offer solutions to common concerns throughout Indian country. Indian Health Program Chief Executive Officers and Clinic administrators are invited to attend. The meeting site is the Hyatt Regency Phoenix at Civic Plaza, 122 North Second Street, Phoenix, Arizona. The Clinical Support Center (CSC) is the accredited sponsor of this meeting. Please contact Gigi Holmes at (602) 640-2140 for more information or to request a registration packet. Alternatively, you may use the CSC 24-hour Fax Retrieval Service by calling 602-640-2140 choosing "8," and then selecting document number 4001.

### **Native Women and Cancer Conference**

**January 8-10, 1998 Tucson, Arizona**

Cancer is the second leading cause of death in American Indian and Alaska Native Women. Data indicate that the incidence rates of different types of cancer vary from tribe to tribe, and that many types of cancer appear to be increasing in frequency. Five year survival rates for all cancers combined remain poor for American Indians (33.4%) compared to those for the general population (51.4%).

Reasons for the lower cancer survival rates for American Indians are uncertain, but most observers link these poor outcomes to risky lifestyle choices (poor nutrition, etc.), late detection, inadequate access to health care, and various socio-cultural barriers. Most American Indian languages contain no word for cancer, and this translation can add to misinterpretation about the disease. Misunderstandings are also fueled by a generalized fear of cancer. Indeed, cancer is one of the most dreaded diseases in mainstream society, and American Indians and Alaska Natives also share this fear.

Risky lifestyle choices, high mortality rates due to later detection and diagnosis, and the socio-cultural beliefs of Indian communities about cancer will be the focus of the upcoming *Native Women and Cancer Conference* sponsored by the University of Arizona College of Medicine, Native American Research and Training Center, Department of Family and Community Medicine, at the Arizona Health Sciences Center. Physicians, nurses, social workers, hospice personnel, Community Health Representatives (CHRs), public health professionals, and lay persons will benefit from attending. The conference will be held January 8-11, 1998 in Tucson, Arizona, at the Double Tree Guest Suites Hotel, 6555 East Speedway Boulevard; the phone number for the facility is 520-721-7100. Preregistration will take place on January 7, 1998 from 3 pm to 6 pm; a reception will follow. The registration fee is \$150, and payment will be accepted in the form of a personal check, money order, or certified check; purchase orders or payment by credit card will not be accepted. Payment can be made to Native Women and Cancer Conference, NARIC, 1642 East Helen Street, Tucson, Arizona 85719. For further information, please call Douglas Sixkiller-St Clair, PhD, c, CRC, CVE at 520-621-5075.

### **IHS Basic Colposcopy Workshop and Colposcopy Refresher Workshop**

**March 16-19, 1998 (Basic) and March 18-19, 1998 (Refresher) Albuquerque, NM**

The Indian Health Service (IHS) Cancer Prevention and Control Program will offer two colposcopy workshops, a basic

colposcopy workshop directed at entry level colposcopists, and a refresher workshop to provide a review for experienced colposcopists working in IHS or tribal facilities. The curriculum for both programs will include current concepts in lower genital tract disease: a review of cervical lesion identification and grading; colposcopy of the vulva and vagina; management of vulvar, vaginal, and cervical intraepithelial neoplasia; and new technologies for the future. The format will include lectures and small group discussions of case studies with slides.

Providers from self governance and 638 tribes who have taken IHS Cancer Prevention and Control Program (CPCP) shares are encouraged to apply, but will be charged tuition (\$500 for the basic workshop and \$200 for the refresher activity) and will be expected to provide for their own travel and per diem. Attendees from IHS direct program and tribal sites that have left CPCP shares with the Agency will have tuition and travel costs provided by the CPCP.

Interested providers should contact Roberta Paisano, MPH, IHS Cancer Prevention and Control Program, 5300 Homestead Road N.E., Albuquerque, NM 87110 (phone 505-248-4133), e-mail [rpaisano@2.smp@ihs.gov](mailto:rpaisano@2.smp@ihs.gov).

### **Diabetes in the Elderly**

**March 27-29, 1998 Phoenix, Arizona**

A conference entitled *Type 2 Diabetes In the Elderly: Issues and Challenges* will be held March 27-29, 1998 in Tempe (Phoenix), Arizona. The target audience is geriatricians, endocrinologists, internists, family practitioners, and allied health professionals involved in the care of elderly patients with type 2 diabetes. Nationally known experts will discuss the epidemiology, pathophysiology, and treatment of diabetes and its complications in this high risk population group.

The conference is being planned by representatives from the Indian Health Service Clinical Support Center; the National Institute of Diabetes and Digestive and Kidney Diseases, the National Institute on Aging, and the American Diabetes Association, Arizona Affiliate. 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 designates this continuing education activity for up to 11¼ hours of Category 1 credit toward the Physician's Recognition Award of the American Medical Association. Each physician should claim only those hours of credit he or she actually spent in the educational activity.

For more information or a copy of the brochure with the agenda and hotel information, contact the American Diabetes

Association at 602-863-4731, ext. 100, or fax 602-861-0542.

**Advances in Indian Primary Health Care**  
**April 15-17, 1998 Albuquerque, New Mexico**

The first annual continuing medical education course entitled *Advances in Indian Primary Health Care* will be offered for primary care physicians who work in Indian health at Federal, tribal, or urban sites. Medical students and residents who are interested in serving Indian populations are also welcome. The course will be presented by the IHS Senior Clinicians in Family Practice, Internal Medicine, Pediatrics, and Obstetrics and Gynecology, in cooperation with the University of New Mexico Health Sciences Center School of Medicine Area Health Education Center. It is designed for new and experienced primary care physicians to learn about advances in clinical care specifically relevant to Indian populations, with an emphasis on southwestern tribes. An opportunity to learn from clinicians experienced in the care of Native Americans will be featured. Clinical disease control program directors and Senior Clinicians will be available for program development and consultation.

The course will begin in the afternoon on Wednesday, April 15 and end at noon on Friday, April 17. Continuing education credit will be available. A registration fee will be charged. More information will be published in future issues of *The Provider*. For more information and registration forms, contact Chuck North, MD, Senior Clinician for Family Practice, PHS Indian Hospital, 801 Vassar Drive, NE, Albuquerque, New Mexico 87106. The phone number is 505-256-4065, the fax is 505-256-4093, and the e-mail address is north chucki@ihs.gov.

**Diabetes in Native Americans**  
**June 3-5, 1998 Oklahoma City, Oklahoma**

Type 2 diabetes has become a major cause of mortality and morbidity in the Native American population. The purpose of the conference entitled *Diabetes in Native Americans*, to be held June 3-5, 1998 in Oklahoma City, Oklahoma, is to provide a forum for Native American tribal members, health educators, health care providers, and scientists to discuss, exchange, and disseminate current information about tribal perspectives, intervention, and prevention of the disease and its complications.

The conference will cover: (1) tribal perspectives of diabetes including perceptions, beliefs, needs, and expectations; (2) epidemiology of diabetes and its complications in Native Americans; (3) management of diabetes and its complications; (4) prevention of diabetes and its complications; and (5) rec-

ommendations from tribal representatives and other participants for future activities. We invite participants to submit abstracts addressing the above topics for oral or poster presentation at the meeting.

The conference is being planned by representatives from the Indian Health Service; the Colleges of Medicine and Public Health, University of Oklahoma Health Sciences Center; the National Institute of Diabetes and Digestive and Kidney Diseases; the Centers for Disease Control and Prevention Diabetes Translation Division; and several American Indian tribes. The accredited sponsor of the conference for continuing education is the IHS Clinical Support Center.

Abstract submissions should be postmarked no later than February 1, 1998. The abstract should be approximately 175 words, single-spaced on a single, plain white, 8½ by 11 inch sheet of paper. Include the title and the name(s) of the author(s) at the top, exclude the affiliations of the author(s), and underline the presenter's name. In a separate cover letter, provide the address and phone and fax numbers of the contact to whom we should send all correspondence. Please send abstracts to the University of Oklahoma Health Sciences Center, College of Public Health, Office of the Dean, P.O. Box 26901, Oklahoma City, OK 73190.

**IHS Research Conference**  
**April, 1998 Albuquerque, NM**

The Tenth Annual Indian Health Service (IHS) Research Conference, sponsored by the IHS Research Program and the IHS Clinical Support Center (the accredited sponsor) will be held the week of April 27, 1998 in Albuquerque, New Mexico. Papers are invited for oral or poster presentation in the following categories: Aging, AIDS, Alcohol and Substance Abuse, Cancer, Cardiovascular Disease, Diabetes, Environmental Health, Epidemiology, Health Care Administration, Health Promotion and Disease Prevention, Health Services Research, Injury Prevention, Mental Health, Nutrition, Oral Health, and Women's Health. Research measuring the effectiveness of innovative health care delivery interventions or research that demonstrates partnerships between researchers and tribes is especially welcome. Abstracts must be received no later than close of business February 20, 1998 to be considered for review. Notice of acceptance of abstracts will be mailed no later than March 31, 1998. An abstract form and instructions can be found in this issue of *The Provider*.

For abstract consultation or registration information, contact Ms. Linda Arviso-Miller at 505/248-4142; Fax: 505/248-4384, e-mail: larvisom@smtc.ihs.gov. □

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## Change of Address or Request for New Subscription Form

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### THE IHS PRIMARY CARE PROVIDER

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