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Domestic Violence Pilot Project

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Introduction

Feather River Tribal Health, Inc. (FRTH) is located in northern California and serves a population of more than 7,500 Native Americans living in three counties. The region contains both small urban collections and sparsely populated rural areas. There are three tribes represented in the service area – Tyme Maidu Tribe of the Berry Creek Rancheria, Concow Maidu Tribe of the Mooretown Rancheria, and the Estom Yumeka Tribe of the Enterprise Rancheria, as well has a population of Pomo, Miwok, and other Native American people not indigenous to the area.

FRTH's medical, behavioral health, and dental departments have long recognized that there is a high incidence of domestic violence/intimate partner violence (DV/IPV) among patients. In 2001, FRTH participated as one of three rural clinic sites in California with the Public Health Institute of Berkeley in a statewide research study on Native American women.[1] The results of that study were disquieting: more than one-third of the local Indian women had observed their parents being physically violent with another person, 58% had been sexually molested as children, 80% had experienced domestic violence as adults, 26% had been sexually assaulted as an adult, and 32% had experienced violent victimization during the previous 12 months. These findings were supportive of a study conducted by the State of California Pregnant and Parenting American Indian Study (1995).[2] They found that almost half of the Native American women they surveyed had sought help from law enforcement or had been issued a restraining order for problems with domestic violence.

In 2002, the U.S. Department of Health and Human Services Indian Health Service and the Administration for Children and Families partnered with the Family Violence Prevention Fund on an initiative to improve the DV response of tribal and urban health care facilities. The purpose of this initiative is to increase the role of health care providers in recognizing and responding to this issue.[3] FRTH applied for this initiative funding and was one of six Indian clinics awarded pilot program grants in 2003. The study reported in this paper is a result of the implementation of this initiative at FRTH.

The necessity for implementing such a program is reinforced by several factors. The U.S. Department of Justice has found that Native American women are affected by

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domestic violence at a rate that is greater than all other non-Natives.[4] Domestic violence affects all aspects of a woman's health. It is recognized by IHS as a condition suitable for mass screening in the health care setting. In 1998 an IHS Domestic Violence Survey was mailed to all IHS sites to survey clinic and hospital activities associated with DV.[5] One of the goals of Healthy People 2010 is to reduce the rate of physical assault by current or former intimate partners. Establishing policies and screening for domestic violence/intimate partner violence (IPV) is one of the 2003 Government Performance and Results Act (GPRA) indicators.[6] Finally, the California Penal Code 11160-11163.2 that became law in 1994 requires health care practitioners to make reports to the police under specified circumstances of domestic violence. Practitioners affected by this code include physicians, physician assistants, psychologists, nurses, dentists, and other health care providers. Other states have similar legislation. Failure of a provider to report domestic violence can lead to both civil and criminal penalties.[7]

As the foundation of its pilot program, FRTH had the objectives of establishing a DV screening program in its medical and dental departments, and developing a case management system for handling cases of identified DV. An in-house team was assembled that included two DV counselors, a DV health educator, the medical director, the nursing director, and the behavioral health services director. This team was responsible for developing a planned structure and protocols for implementing a DV screening program. However, prior to developing this structure, the team determined that it was important to first establish a baseline for current responsiveness of the medical department to patient reports of domestic violence.

The purpose of this study was to determine, prior to program implementation, how patient screening and case management were being addressed, thus establishing a baseline for further study of the effectiveness of the program once implemented. The investigators wanted to document whether or not abused women were being identified by FRTH, and whether or not these women were being referred for appropriate treatment and support.

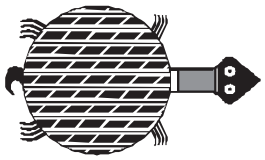
Methodology

A retrospective chart audit was used to explore medical practitioner responses to domestic violence reported in each patient's health history questionnaire. All new patients complete the health history questionnaire at the time of their first medical visit. The charts of all female patients, ages sixteen to eighty, first seen at FRTH in the previous two years, were collected using Registered Patient Management System (RPMS) data. Three hundred and ninety-four charts were identified at FRTH's main clinic and 81 at FRTH's satellite clinic, for a total of 475 charts.

The charts were further screened to identify all female patients who answered yes to experiencing domestic violence on the FRTH new patient health history questionnaire. A total of 94 charts were identified at the main clinic and 13 were identified at the satellite clinic for a total of 107 charts.

An audit tool was developed to enable the collection of demographic information, the patient's chart number, and the practitioner's response to domestic violence history. The audit tool was designed to measure variables representing several negative health indicators frequently indicative of a history domestic violence. These health indicators included how many times the patient had been seen, how many times the patient had come in with a physical injury, if the patient had been prescribed medications for depression or anxiety, and if the patient had complained of chronic pain, all in the last six months. The tool was presented to FRTH's in-house quality improvement committee for review and approval prior to implementation.

The Domestic Violence Health Educator conducted the review during a four-month period at both the main and satellite clinic sites. All data were entered into the Statistical Package for Social Scientists (SPSS) program. Data were analyzed for frequencies, means, and percentages.



Results

A total of 475 charts were reviewed. The criteria for review were that the patients were female and had registered with the clinic within the preceding two years. The charts were screened for reported incidents of domestic violence. The charts of 107 women between the ages 17 and 80 were identified who had reported incidents of domestic violence. The mean age of these women was 40.24 years of age. Of this group, 26.8 percent were Native American and 73.2 percent were non-Native.

Of the 107 women, nine (8%) reported that the abuse was current, sixty-nine (64%) reported that the abuse had not happened within the past two years, and thirty (28%) did not answer the question "When did the abuse occur?" For patients reporting that there was any history of domestic violence, both current and historically, the charts were then reviewed for the medical provider's response to the reported violence. The three responses screened for were: 1) documentation in the chart indicating that the patient was asked about their "yes" reponse to DV questions on the intake form, 2) practitioner referral of the patient to a DV advocate/supportive services, or 3) if the domestic violence was reported as current, did the practitioner make a mandatory report to law enforcement? Table 1 shows the practitioners' responses to reported domestic violence.

Table 1. Practitioners' responses to 107 patient reports of DV

Practitioner Response	Number of Patients
Documentation of inquiry into reported DV	17
Referral to DV advocate/supportive services	17
Report to law enforcement filed	0

Table 1 reports that 16% (N=17) of the charts showed documentation of the reported DV, 16 percent (N=17) of these women were referred to DV advocacy or other supportive services, and none were reported to law enforcement.

For the 107 women who reported current or past domestic violence, four health indicators were screened for in the charts: 1) How many times has the patient been seen in the last six months, 2) How many times has the patient come in with a physical injury in the last six months, 3) Has the patient been prescribed medications for depression or anxiety in the last six months, and 4) Has the patient complained of chronic pain in the last six months?

The number of times a self-reported DV patient had been seen in the last six months ranged from 0 to 10, with a mean of 1.68 times. The number of times a patient had come in with a physical injury in the last six months ranged from 0 to 2, with a mean of .07 times.

Table 2 presents the findings for the final two indicators: prescription medications for depression or anxiety, and complaints of chronic pain during the previous six months.

Table 2. Indicator

Indicator	No. of Pts	% of Pts
Prescribed medications for depression or anxiety	32	30
Patient complained of chronic pain	20	19

Thirty percent of the self-identified DV patients had been prescribed medications during the previous six months for depression or anxiety, and nearly one-fifth (19.0%) had complained of chronic pain during the previous six months.

Discussion

Results of this study show that only 26.8% of the self-reporting victims of domestic violence are Native American, whereas 73.2% are non-Native. This unbalanced ratio was surprising to the investigators since the majority of registered FRTH patients are Native American. These results may be attributed to several variables. First, as with other mental health issues, Native Americans may attach more of a stigma to being a victim of abuse than does the

IHS-ACF Domestic Violence Pilot Project – Phase II

Feather River Tribal Health is one of eight continuing sites in Phase II of the U.S. Department of Health and Human Services Indian Health Service (IHS) and Administration for Children and Families (ACF) Domestic Violence Pilot Project. The IHS-ACF pilot project is a collaborative initiative designed to help Indian Health Service, tribal and urban program(I/T/U) health care facilities and communities improve their response to Domestic Violence. Other project partners include the Family Violence Prevention Fund, Mending the Sacred Hoop Technical Assistance Project, and Sacred Circle. Phase II of the IHS-ACF Domestic Violence Project includes 15 I/T/U health care facilities.

The eight continuing sites from Phase I of the project are: Feather River Tribal Health, Inc., Oroville, California; Ketchikan Indian Corporation Tribal Health Clinic, Ketchikan, Alaska; Houlton Band of Maliseet Indians, Houlton, Maine; Mississippi Band of Choctaw Indians, Choctaw Health Center, Choctaw, Mississippi; Rosebud Indian Health Service Hospital, Rosebud, South Dakota; Zuni Comprehensive Community Health Center, Zuni, New Mexico; Warm Springs Indian Health Center, Warm Springs, Oregon; and Crownpoint Healthcare Facility/Family Harmony Project, Crownpoint, New Mexico.

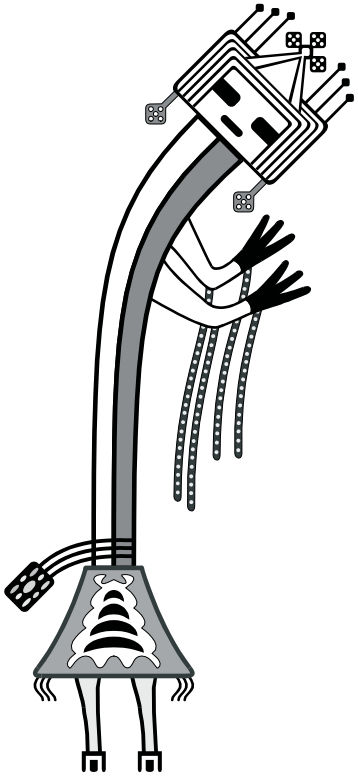
The seven new sites for Phase II are: Utah Navajo Health System, Inc., Montezuma Creek, Utah; Cherokee Indian Hospital, Cherokee, North Carolina; Chinle Comprehensive Healthcare Facility, Chinle, Arizona; Crow/Northern Cheyenne Hospital, Crow, Montana; Kaw Nation of Oklahoma, Kaw City, Oklahoma; Native Project, Spokane, Washington; and United American Indian Involvement, Inc., Los Angeles, California.

For further information about the IHS-ACF Domestic Violence Project, please contact Denise Grenier, Indian Health Service, ITSC, Tucson, Arizona, at (520) 670-4865; e-mail *Denise.Grenier@na.ihs.gov*; or Anna Marjavi, Family Violence Prevention Fund, San Francisco, California at (415) 252-8900; e-mail *anna@endabuse.org*.

general population and may be less likely to report abuse.[6]

A second variable may be the measures used to identify Native American patients. It may take some months or even years for an individual to collect the documentation necessary to be identified as a "verified" Native American. Until that time, the patient is registered with the clinic as non-Native American. The low number of Native American victims can also be attributed to recent organizational changes. Nearly three years ago FRTH greatly expanded its patient base by opening a new, larger facility and offering its medical services to non-Native Americans. Consequently, most of the new registered patients are non-Native Americans.

A total of 475 charts were reviewed, resulting in the identification of 107 women who had reported current or past domestic violence. These numbers are lower than the national average for female victims of domestic violence. The current study did not measure the number of women who left blank the intake question on domestic violence history. It could be argued that women, and Native American women in particular, are hesitant to disclose their histories of domestic violence, and that some women who declined to answer the question had actually experienced domestic violence at some point in their lives.



The data excluded all males and also females under the age of 16. This decision was made because of reporting requirements for child abuse and because females are the most likely victims of domestic violence. For the 107 women who reported current or past histories of domestic violence, data were collected on how many clinic visits there had been during the past six months for each woman. There was a mean frequency 1.68 times; however, this was not a valid health indicator due to usual patient turnover and the study's inability to track the patients' visits to other health care facilities. It could not be ascertained whether or not the women had been screened for domestic violence at another clinic or provider's office.

The study did not utilize a control group; therefore, frequencies for the four health indicators were not compared to frequencies for other patients who were not victims of DV. It could not be ascertained whether or not non-DV patients were being prescribed medications for depression or anxiety, or whether their complaints of chronic pain during the previous six months were at the same rates as those of the DV patients in the study.

There are numerous useful outcomes of the chart audit and study. Medical practitioners at the clinic were surprised at their own low number of documented responses to the women's reports of domestic violence. This realization resulted in several proactive responses. First, several of the practitioners readily participated in developing more substantive domestic violence protocols, and all the medical practitioners and nursing staff participated in extensive protocol training. New family violence protocols were instituted clinic-wide, by all departments, as was a domestic violence response kit used by the medical practitioners. A new patient screening form was developed and is used to screen family violence in all patients age 12 and over. In addition, a family violence-reporting grid was developed and distributed to all clinic staff. This grid is used to guide staff in making decisions on the type of mandatory report required – elder abuse, child abuse, or domestic violence.

Most notable is that physician written referrals of patients to domestic violence intervention programs rose by ninety percent during the five months following the chart audit and protocol training.

Recommendations

The authors of this study will conduct a follow-up chart audit one year from the first audit reported in this study. This will allow the researchers to compare the results of the two audits, and will provide data to analyze for statistical significance. It is hoped that the implementation of new screening tools and domestic violence protocols will notably increase the number of victims identified, as well as the number provided with referral and support services. It is also recommended that the next audit be expanded to include both male and female patients.

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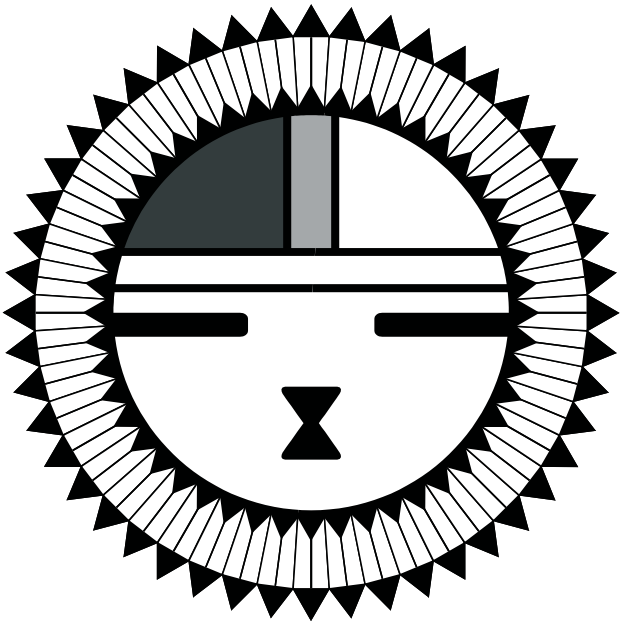

Domestic Violence Awareness Month and Health Cares About Domestic Violence Day

National Domestic Violence Awareness Month is an annual observance sponsored by the National Coalition Against Domestic Violence. Every October across the country, domestic violence survivors and advocates, health care providers, elected officials, law enforcement and public safety personnel, business leaders, faith-based groups, and many others are organizing and participating in domestic violence memorial activities, public education campaigns, and community outreach events.

Health Cares About Domestic Violence Day (HCADV Day) is a nationally recognized awareness-raising day that takes place annually on the second Wednesday of the month, this year October 13. It is sponsored by the Family Violence Prevention Fund and is intended to reach members of the health care community and educate them abut the critical importance of assessing for domestic violence, as well as the long-term health implications of domestic violence and lifetime exposure to violence.

Health care providers are in a unique position to identify and assist victims of domestic violence. If you would like more information about strengthening your hospital or clinic response to domestic violence, as well as how you and you facility can participate in Domestic Violence Awareness Month and HCADV Day activities, contact *www.ncadv.org* and *www.endabuse.org/hcadvd*.

Sample hospital and clinic policies and procedures, tools for screening and intervention, and other resources can be found on the IHS Maternal and Child Health Domestic Violence website at *http://www.ihs.gov/MedicalPrograms/MCH/W/DV00.cfm*.

If you are a victim of domestic violence, call the National Domestic Violence Hotline at 1-800-799-SAFE; TDD: 1-800-787-3224.

Osteoporosis and Fracture Prevention in the Indian Health System: Toward a Public Health Approach

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Introduction

Osteoporosis and fragility fractures have been recognized as major contributors to morbidity and mortality in the United States. In a 50 year old white woman, the lifetime risks of hip fracture and vertebral fracture are 17.5% and 15.6%, respectively.[1] Fragility fractures are primarily a problem of the elderly, with 85% of hip fractures occurring after age 70.[2] Hip fractures can be devastating, leading to mortality and loss of independence. Less than 30 % of elderly individuals with a hip fracture return to their prefracture level of function, and 20 - 25% die within one year of the fracture.[3] Vertebral fractures cause severe pain and often result in hospitalization, and are a major cause of the utilization of health resources. Osteoporotic fractures are a growing public health problem in our aging population.

Osteoporosis rates vary among racial and ethnic groups. The limited data available describing osteoporosis and fracture rates in the American Indian and Alaska Native (AI/AN) population suggest that they are at least as great a problem in AI/AN communities as they are for the general population. The National Osteoporosis Risk Assessment (NORA) study of peripheral osteoporosis screening included 1708 self identified "Native American" women whose risk of fracture over the life of the study was the same as that of "white" women.[4] A small study in the Sac and Fox Nation of Oklahoma showed lower BMD in postmenopausal women as measured by central DEXA than that reported for "white" women.[5] A review of hip fractures at the Alaska Native Medical Center indicated fracture rates higher than reported for white US women during the periods of 1979-1989 and 1996-1999.[6]

The United State Preventive Services Task Force (USPSTF) has determined that the evidence supports screening for osteoporosis in women 65 and older, and for those 60 and older with risk factors.[7]

The purpose of this summary is to explore strategies for applying the recent USPSTF recommendations to the American Indian and Alaska Native population served by the Indian health system (IHS, tribal, and Urban Health Programs) and to suggest an evidence-based public health approach to fracture prevention in a health system with limited access and resources.

Definition of Osteoporosis and the True Clinical "Gold Standard"

Osteoporosis has been defined as low bone mass and an increased fracture risk.[8] A World Health Organization (WHO) working group developed uniform diagnostic criteria including a bone mineral density (BMD) 2.5 standard deviations below the mean bone mineral density of healthy, young, white women (T-score of <-2.5) or fracture in the absence of significant trauma. The WHO further defined osteopenia as a BMD 1 to 2.5 standard deviations below the mean (T-score -1.0 to -2.5), but this definition has unclear clinical value because of the wide range of fracture risk found among women in this category.[9] Fracture risk increases in a continuous fashion as bone mineral density declines.[2] While osteoporosis as a disease state has been defined in terms of bone mineral density, the key public health concern is the reduction of fracture risk.[8] Central dual energy x-ray absorptiometry (DEXA) measurement of BMD has been established as the "gold standard" in terms of bone mineral density measurement, but fracture rates are the true public health "gold standard."

Clinical Risk Factors for Osteoporosis and Fractures

Nicholas and Chen outlined risk factors for osteoporosis and their prevalence in American Indians and Alaska Natives in 2002, including low calcium intake, sedentary lifestyle, issues with body mass index, and smoking.[10] As in many areas regarding AI/AN and osteoporosis, the research base is limited.

Secondary osteoporosis is defined as low bone mineral density "caused or exacerbated by other disorders or medication exposures."[11] According to a 2000 NIH consensus statement, there are a "large number of medical disorders associated with osteoporosis and increased fracture risk".[8] The scope of that discussion is too great for this summary. The most common diseases associated with secondary osteoporosis include: hyperthyroidism, anticonvulsant therapy, hypogonadism, end-stage renal disease, organ transplantation, rheumatoid arthritis, alcoholism, and liver disease.[8,11] Diabetes Mellitus is often cited as a cause of secondary osteoporosis, although the literature supporting this is inconsistent. Fracture risk may be higher in Type 1 diabetes, and increased body mass index may be protective in women with Type 2 diabetes.[11,12] Glucocorticoid therapy is strongly associated with bone loss, and women taking more than 5 mg of prednisone for greater than two months should have regular bone mineral density testing and should be considered for antiresorptive therapy at higher T-scores.[8]

Clinical risk factors can be used to predict those at highest risk for fracture but are not specific enough to provide a basis to initiate therapy. They have been used to identify a higher risk population to screen for BMD.[13,14] The most robust clinical risk factors for hip fracture are age (per 5 year RR=1.5), maternal history of hip fracture (RR=2.0), current cigarette smoking (RR=1.14-2.1), a body weight less than 57.2 kg, use of (or plans to use) oral corticosteroids longer than three months, or serious long-term conditions thought to increase fracture risk, such as hyperthyroidism or malabsorption. Other important hip fracture risk factors are poor vision (RR=1.5), benzodiazepine use (RR=1.6), use of anticonvulsant drugs (RR=2.8) and fall in the previous year (RR=1.6).[14]

Individuals with end stage renal disease (ESRD) are at increased fracture risk, but the bone disease secondary to ESRD is characterized by low bone turnover and is a distinct clinical entity.[1]

Approaches to Screening

The Osteoporosis Risk Assessment Instrument (ORAI), a brief, clinically useful tool, is one of two validated risk factor assessment tools given a "good" quality rating by the USPSTF. [7,13] By assigning points based on age, weight, and use of hormone replacement therapy, it identifies postmenopausal women with a low body weight and all women over the age of 65 as candidates for screening. The ORAI is 95% sensitive and 41% specific for DEXA T-score <-2.5, so it might be most useful to determine which patients aged 60-64 do NOT need further study. The USPSTF has incorporated the ORAI into their recommendations.[7]

Bone mineral density (BMD) remains the single most important predictor of fracture risk and, as noted above, has been incorporated into the diagnostic paradigm for osteoporosis.[9] There are numerous technologies available for assessing fracture risk including central dual energy x-ray absorptiometry (DEXA), peripheral single-energy x-ray absorptiometry (SXA), peripheral DEXA, quantitative computed tomography, and quantitative ultrasound (QUS). A 1996 meta-analysis showed that all technologies had similar abilities to predict fracture, although measurement at the spine is better at predicting vertebral fractures, and measurement at the hip (central DEXA) is better at predicting hip fractures.[2] For all technologies fracture rates increase with decreasing bone mineral density in a continuous fashion.[2,3] Medicare reimburses BMD measurement by all FDA-approved devices when medically necessary according to Medicare guidelines, once every 2 years.[4]

All therapeutic trials to date have used measurement by central DEXA and/or established osteoporosis as entry criteria, and central DEXA has become the standard screening and diagnostic modality in this country and in Britain.[7,5] The USPSTF notes that "DEXA is considered the gold standard because it is the most extensively validated test against fracture outcomes." However, central DEXA is not readily available in many rural Indian health sites.

Quantitative ultrasound (QUS) is portable and does not require a radiology technician to administer. Ultrasound has been demonstrated in large, prospective studies of ultrasound attenuation at the calcaneus to be similar to central DEXA in its ability to predict hip fractures.[6,7] However, heel ultrasound does not appear to identify the same "at risk" women as central DEXA. A heel ultrasound study in a British general practice showed a sensitivity of 71% and a specificity of 83% compared to central DEXA.[8] Thus, therapeutic trials based on central BMD (e.g., DEXA) may not be applicable to patients with low values on calcaneal QUS. The position statement on the use of quantitative ultrasound in the management of osteoporosis by the (British) National Osteoporosis Society states that "Low QUS parameters are stronger predictors of low bone mass than clinical risk factors; individuals found to have low QUS parameters (as defined by machine-specific normative data) may either be referred for confirmation of the diagnosis by axial (preferably hip) BMD measurement or be advised to receive preventative therapy if other strong clinical risk factors are present."[19]

An important public health screening strategy is the identification of women with previous fragility fractures. Hip fractures and vertebral fractures are fragility fractures if minimal trauma is involved. Wrist fractures, especially if the result of a fall from standing, are likely fragility fractures, especially in older women with risk factors. One might consider vertebral X-rays prior to further imaging, especially in older women with kyphosis. Trials have shown fracture reduction in women for whom inclusion in the trial was based on fracture history.[23] Individuals with fragility fractures have osteoporosis, should be treated, and do not need further imaging or risk assessment. Two recent studies in non-Indian populations show women with fractures are substantially under-treated in the United States, with only 22 - 24% of patients filling a prescription for an osteoporosis medication within a year of their fracture.[24,25]

How Is Osteoporosis Being Screened for Currently In the Indian Health Service?

An informal survey of IHS and tribal sites in spring 2004 revealed the following:

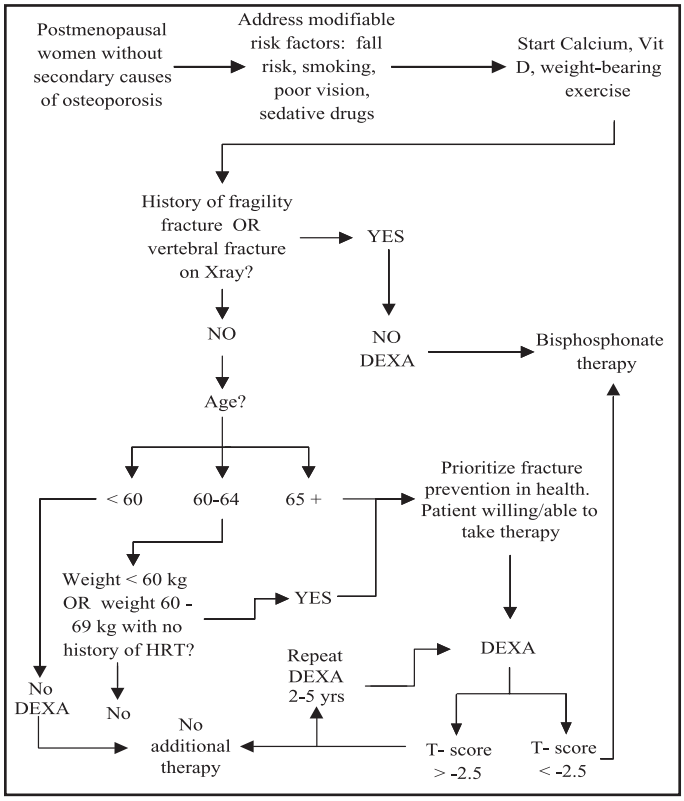
- 2 of 28 responding sites were attempting to screen for osteoporosis with a comprehensive, population-based approach (screening all eligible women).
- 25 of 28 responding sites were screening on a patient-by-patient basis according to clinical judgment.
- 1 of 28 was not screening for osteoporosis at all.

- 16 of 28 have some form of screening technology readily available (onsite or "in town"); some of these use contract health funds, others own the equipment.
- 12 of 18 have to refer patients a distance (and use contract health funds) for screening.

- 3 of 28 have a protocol for osteoporosis screening and management.
- 25 of 28 do not have a protocol.

We have included here a fracture algorithm, currently in use at the Whiteriver Service Unit, that can be used to help guide a screening program and therapy (Figure 1). This algorithm assumes access to DEXA but can be modified for those sites where access to DEXA is limited and presents a barrier to implementation of a screening program. For those sites, calcaneal QUS can serve as an initial screening step (Figure 2).

Figure 1. Whiteriver Service Unit Osteoporotic Fracture Prevention Algorithm

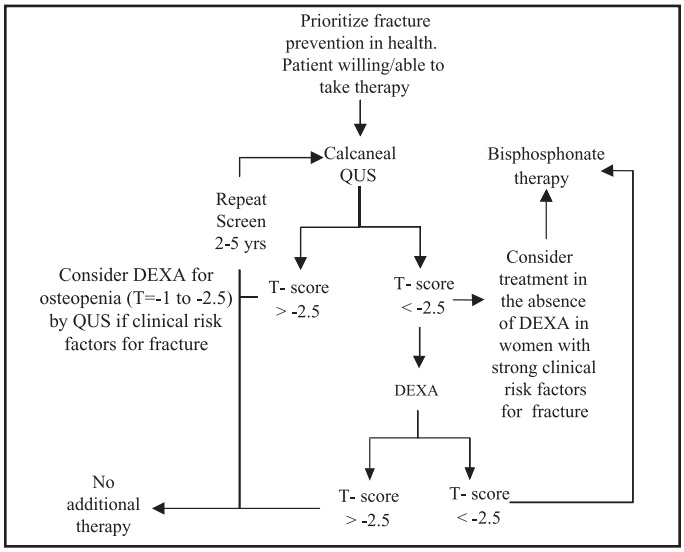


Treatment of Osteoporosis

Medications FDA approved for prevention and/or treatment of osteoporosis include bisphosphonates and selective estrogen receptor modulators. Salmon calcitonin and teriparatide (recombinant human parathyroid hormone) are FDA approved for the treatment of osteoporosis; estrogen is FDA approved for prevention of osteoporosis.[26,27]

The data demonstrating reduction in hip and vertebral fractures in patients with osteoporosis are most robust for bisphosphonates, especially alendronate and risedronate.[26-28] The Fracture Intervention Trial demonstrated that the number needed to treat with alendronate to prevent one hip fracture in five years is 46 for women with previous vertebral fractures

Figure 2. Whiteriver Service Unit Osteoporotic Fracture Prevention Algorithm using QUS



and 66 for women with osteoporosis (T-score <-2.5) documented by DEXA scan.[29] The USPSTF agrees, noting that the number of osteoporotic women needed to treat with alendronate to prevent one hip fracture over a five year period ranges from 41 in women 75-79 to 88 in women 65-69.[7] While studies have used alendronate 10 mg daily, a dose of 70 mg weekly is thought to be equivalent.[30]

The importance of calcium combined with vitamin D in the prevention of osteoporosis and as an adjunct to the treatment of osteoporosis should not be overlooked. The number needed to treat with calcium and vitamin D in some populations, especially older women in nursing homes, to prevent a hip fracture at three years is 25.[28] Vitamin D supplementation in older adults has also been shown to reduce risk of falls.[31] We have included here (Figure 3) an adaptation of the Zuni-Ramah Service Unit osteoporosis prevention protocol.

Figure 3. Osteoporosis Prevention (adapted from Zuni-Ramah Service Unit Protocol)

a. From the start of well-woman care to menopause, all women will be offered calcium supplementation
   i. 500 – 1000mg daily (calcium carbonate 1250 mg once or twice a day)
b. At start of menopause, all women will be offered calcium and vitamin D supplementation:
   i. 500 – 1000 mg calcium daily (calcium carbonate 1250mg once or twice daily)
   ii. 400 miu vitamin D (one multivitamin)
c. Age 65 and older women and men will be offered calcium and vitamin D supplementation
   i. 500 – 1000 mg daily calcium
   ii. 400 – 800 miu vitamin D (calcium/vitamin D once or twice daily plus one multivitamin)
d. Options for supplementation.
   i. Calcium carbonate 1250 mg contains 500 mg elemental calcium
   ii. Chewable tablets contain 200 –400 mg elemental calcium per tab
   iii. Calcium/Vitamin D contains 500 mg elemental calcium and 200 miu Vitamin D
   iv. Multivitamin contains 400 miu Vitamin D

While there are minimal data demonstrating prevention of fractures with therapy in women with osteopenia (T score between –1 and –2.5), some national organizations (National Osteoporosis Foundation and American College of Obstetricians and Gynecologists) recommend treatment with bisphosphonates at T < -2 in women without risk factors and T < -1.5 in women with risk factors.[26,32] This approach is supported by a recently published follow-up to the NORA study.[33] While treating at higher T-scores can be considered, a clinician should be aware that the numbers needed to treat at T-scores >-2.5 are no doubt significantly higher than in women with documented osteoporosis. This approach would markedly increase the cost of a population-based strategy without evidence-based support. The authors recommend that clinicians initially focus on those at highest risk of fracture, that is, those with T-scores of -2.5 or lower.

There is considerable debate regarding the need for serial DEXAs to assess response to therapy.[7,8,26,27] There are no studies demonstrating the benefit of serial DEXAs to measure a response to therapy, and the USPSTF advises against such monitoring. If the cost-effectiveness of a screening strategy is a consideration, serial DEXAs in women on therapy are unlikely to change management and are not necessary.[7,8] Medicare will pay for DEXA no more often than every two years.

Conclusions

Once the decision has been made to screen for osteoporosis as part of a public health effort to reduce morbidity and mortality from fracture, access to screening becomes a critical issue. No single approach will ensure optimal access to osteoporosis screening at every site, but no site should be without an approach to osteoporosis screening. The authors recommend the following:

1. The USPSTF guidelines offer conservative, evidence-based criteria for inclusion into a screening program (all women age 65 and older and those age 60 and older with risk factors).
2. Available data, although limited, suggest that these recommendations are appropriate for American Indian and Alaska Native women. Our obligation is to offer screening and prevention strategies to all eligible individuals, and strategies for implementation must take into account issues of access to screening.
3. Central BMD measurement (central DEXA) is the national standard for screening because there is clear evidence that treatment based on central DEXA T-scores can prevent fracture.
4. Sites that have or can obtain sufficient access to central DEXA measurement should base their screening program on central DEXA. Clinical risk assessment instruments (e.g., ORAI) can help define those postmenopausal women younger than 65 who should be offered DEXA. Sites with capacity for central DEXA (space, staffing, and initial funds for purchase) and which have a sufficient population to support its use (either through 3rd party reimbursement or with funds saved through avoiding contract health expenses for those without alternate resources) might find it cost effective to purchase the equipment. Other sites will find it necessary to contract for these services if the services exist within a reasonable travel distance.
5. Sites that do not currently have capacity for DEXA or ready access for referral to DEXA (either because of cost or travel distance) can develop a screening program based on quantitative heel ultrasound. A DEXA should be sought to confirm low BMD in those in whom calcaneal QUS identifies high fracture risk and to provide a sound basis for treatment. However, if DEXA cannot be obtained, treatment can be offered based on the results of ultrasound screening in the absence of DEXA in women with strong clinical risk factors for fracture.
6. Women and men with established osteoporosis (history of fragility fracture) should be identified and offered treatment. They should not enter a screening protocol.
7. Bone disease secondary to end stage renal disease (ESRD) is a distinct clinical phenomenon, and persons with ESRD should not be included in osteoporosis screening and treatment protocols.
8. A public health approach to fracture reduction must include primary prevention efforts
   a. Ensure adequate calcium and vitamin D intake with supplementation as needed.
      i. Consider offering calcium supplementation to all adult women and calcium vitamin D supplementation to postmenopausal women and men aged 65 and older.
   b. Institute evidence-based fall risk reduction efforts
   c. Encourage weight bearing exercise

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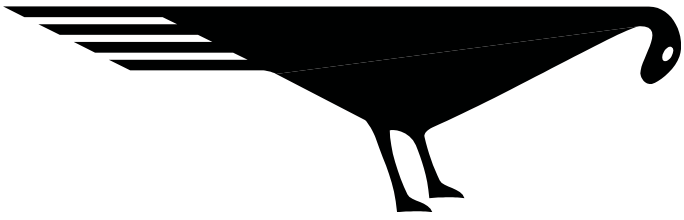

HIPAA Security Compliance Looms

Robert McKinney, Information Systems Security Officer, Acting Director, Division of Information Security, Office of Information Technology, Indian Health Service, Albuquerque, New Mexico

Like many other health care plans and providers, IHS is facing the fast approaching April 20, 2005 deadline for compliance with the HIPAA Security Rule. I am sure we have all seen at some point the laundry list of requirements (see Table 1) that range from assigning information security responsibility to developing a continuity of operations plan. No doubt we have also found ourselves wondering, perhaps out loud, how we are going to meet these requirements. There are not enough hours in the day nor money in the coffers to do all this!

Table 1. HIPAA Requirements

STANDARD	Implementation Specifications		
	Required	Addressable	Total
Security Management Process	4	0	4
Assigned Security Responsibility	+ 0	+ 0	+ 0
Work Force Security	+0	+ 3	+ 3
Information Access management	+ 1	+ 2	+ 3
Security Awareness and Training	+ 0	+ 4	+ 4
Security Incident Procedures	+ 1	+ 0	+ 1
Contingency Plan	+ 3	+ 2	+ 5
Evaluation	+ 0	+ 0	+ 0
Business Associate Contracts and Other Arrangements	+ 1	+ 0	+ 1
SUBTOTALS-ADMINISTRATIVE SAFEGUARDS	=10	=11	=21
Facility Access Controls	0	4	4
Workstation Use	+ 0	+ 0	+ 0
Workstation Security	+ 0	+ 0	+ 0
Device and Media Controls	+ 2	+ 2	+ 4
SUBTOTALS-PHYSICAL SAFEGUARDS	=2	=6	=8
Access Controls	2	2	4
Audit Controls	+ 0	+ 0	+ 0
Integrity	+0	+ 1	+ 1
Person or Entity Authentication	+ 0	+ 0	+ 0
Transmission Security	+ 0	+ 2	+ 2
SUBTOTALS-TECHNICAL SAFEGUARDS	=2	=5	=7
GRAND TOTALS	**14**	**22**	**36**

Source: Summary of Security Safegaurds, DHHS' Health Insurance Portability and Accountability Act (HIPAA) Compliance Guide, 29 October 2003

Well, we are here to help. No, we cannot add hours to the day or print money. What we can do is assist with identifying support for conducting risk assessments; provide guidance and support for risk management decisions; provide required written policies and procedures; suggest solutions for controls; provide a checklist to organize efforts,[1] and provide guidance for coordinating HIPAA compliancy actions with other overarching information security requirements.

During a recent teleconference, I learned that at least one Area is working to become HIPAA compliant in an efficient and farsighted manner that I recommend all Areas consider. That is, while we are stretching days and dollars and working up a sweat to become compliant for HIPAA we should ensure we include all federal information security requirements. Management should strive to incorporate all requirements during the planning phase to meet the more stringent of overlapping requirements now. This will eliminate wasted resources caused by replacing controls implemented for HIPAA with more stringent requirements when addressing, for example, E-Authentication.[2] What we want to avoid is dedicating limited resources to solutions that may not meet more stringent overriding federal information security requirements.

While HIPAA security requirements are a step forward in protecting electronic patient health information for many health care entities, it is in essence a subset of broader more stringent laws, regulations, and directives required of federal government entities protecting federal information. The roots of these requirements stretch back many years to laws such as the Privacy Act of 1974 and the Computer Security Act of 1987, and continue to sprout new branches such as the recently released Homeland Security Presidential Directive (HSPD) 12.[3] These new requirements are evidence that pressure for adequately protecting federal government information is increasing and is coming from a variety of directions impacting business processes, budgets, and operations.

Meeting HIPAA security requirements is a step in the right direction towards achieving the ultimate objective of the forest of federal information security documents; that is, to protect the health and well-being of the public by properly safeguarding their valuable information. April 2005 is just a sprint away. If you are not already stretching and sweating, it is time to break out the gym gear.

Contact us at *robert.mckinney@ihs.hhs.gov*; telephone (505) 248-4137.

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2. E-Authentication Home Page, *http://www.cio.gov/eauthentication/*.
3. Homeland Security Presidential Directive/Hspd-12, *http://www.whitehouse.gov/news/releases/2004/08/20040827-8.html*.

New Library and Information Services Available for Indian Health System

The Indian Health Service, in conjunction with the National Institutes of Health, is pleased to announce the availability of new library and information services for our providers, through the Health Services Research Library. The Indian Health Service graciously acknowledges this generous support from the National Institutes of Health Library.

When?

Starting October 2004.

What Is It?

A program to help you find the clinical and health information and studies you need. It will be useful to research evidence-based medicine for patient care, to obtain consumer health information, and to support your talks and presentation needs.

Who Can Use It?

Indian Health Service physicians, nurses, administrators, and allied health professionals in direct employment of the IHS, or in compacted and contracted American Indian and Alaska Native tribal facilities who are on the WAN (Wide Area Network).

How Does It Work?

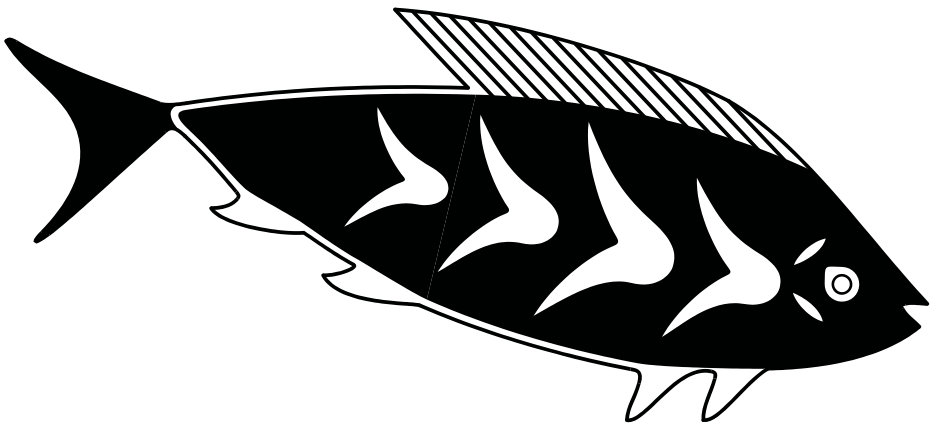
You now have an informationist — a specially trained medical librarian — who can do the following:

- retrieve pertinent clinical literature, filter citations to improve your efficiency, and provide a more focused package of information for patient care;
- help you improve your search skills in different publication databases, e.g., PubMed, Cochrane;
- show you how to access and use electronic resources from the new online Health Services Research Library;
- help you use Reference Manager (RefMan) and Endnote for manuscripts;
- help you with background research for your papers, presentations, and talks.

How Do You Get These Services?

Call or e-mail your medical librarian/informationist at any time:

Diane Cooper, MSLS
Biomedical Librarian/Informationist
Health Services Research Library (a branch of the National Institutes of Health Library)
Bethesda, Maryland
Telephone: (301) 594-2449
E-mail: *cooperd@mail.nih.gov*



Editor's Note: This new column is about healthcare information and tips on how to get it. Diane Cooper is our biomedical librarian/Informationist.

Conquering the Cochrane

Diane Cooper, Biomedical Librarian/Informationist, Health Services Research Library, National Institutes of Health Library, Bethesda, Maryland

One of the richest sources of evidence about clinical treatment is the Cochrane Library. This library is a collection of systematic reviews of medical and surgical therapy and other health care interventions. Mostly, it's about randomized clinical trials.

"Who, or what," you may ask, "was 'Cochrane'?" Archie Cochrane was an English physician/epidemiologist. As a prisoner of war in a German prison camp in World War II, he was allowed to provide medical care to other prisoners with whatever resources were available. "I had considerable freedom of clinical choice of therapy; my trouble was that I did not know which to use and when . . .. I knew that there was no real evidence that anything we had to offer had any effect . . .."[1] After the war, he called attention to the shaky evidence foundation for selecting among treatment choices. His book helped persuade others of the need to have a readily available source of clinical trials on which to base treatment decisions. The Cochrane Collaboration is the international organization that produces and disseminates the Library, and is named after Dr. Cochrane.

Cochrane also appears to have had a sense of humor. Recounting his experiences as a doctor in the POW camps, he described the hardships. At the end, he whimsically said, "[T]hough we were often hungry and got more of our fair share of bombing, we at least escaped a vast amount of paper work."[2]

The Cochrane Database now has over 2000 systematic reviews. In order to have full-text access to its documents, a subscription is needed. The Indian Health Service is negotiating a contract for a full subscription to the Cochrane Library. However, without a subscription, you can still access the abstracts from the Systematic Reviews. If you see something of particular interest, your Library Liaison (me) can direct you in obtaining full-text versions of your selected reviews.

In the last issue of *The IHS Primary Care Provider*, we reported on Bandolier, DARE, and TRIP as sources for evidence-based medicine (EBM).[3] We used "Restless Legs Syndrome" (RLS) and *H. pylori* treatment as test queries. This month, we searched Cochrane for RLS and found no reviews. We searched for *H. pylori* treatment and found that eradication is useful. Then, for fun, we searched for Chronic Fatigue Syndrome and found that both cognitive therapy and exercise are useful. Our experience suggests that it's a good idea to be familiar with more than one EBM source.

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3. Cooper, D: Where to Go for Evidence-Based Medicine, *The I H S Primary Care Provider 2004*; 29: 211.

How to Search the Cochrane Database

1. Go to *www.cochrane.org*.
2. Enter a term in the search box that appears near the top of each screen. Select which compartments you wish to search, usually "Reviews" or "Review Abstracts." Click the *search* icon.
3. A list of records from the Systematic Reviews database will show titles of the documents pertaining to the search term entered.
4. To view the abstracts, simply click on the record title.
5. To return to the record listings, close the abstract window and the list will be forefront again.
6. Continue reviewing the abstracts or enter a new search term to begin the process again.

Diane Cooper is a biomedical librarian/Informationist at the Health Services Research Library, a branch of the National Institutes of Health Library, Bethesda, MD. Her e-mail is cooperd@mail.nih.gov.

Advanced Practice Nurses Annual Business Meeting Report

Judith Whitecrane CNM, IHS National Council of Nurses, Advanced Practice Nursing Representative, Phoenix, Arizona

The Annual Business Meeting for advanced practice nurses (APNs) was held June 7 - 8, 2004, in conjunction with the PA/APN Continuing Education Conference in Scottsdale, Arizona. About 35 APNs from IHS, tribal, and urban programs attended the pre-conference business meetings, and another 35 joined them for the educational sessions. These APNs represented family practice, pediatric, nurse-midwifery, mental health, adult, women's health, and diabetes nurse practitioner disciplines. They came from 24 Indian health sites throughout the United States.

Sandra Haldane, RN, BSN, IHS Principal Nurse Consultant, met with the APNs the entire first day and discussed their practices, evolving roles, accomplishments, and concerns. Appreciation was expressed to Ms. Haldane and Nursing Headquarters for funding three APNs for the Executive Leadership Development Program and for support of this yearly conference. Other topics discussed during this day-and-a-half long meeting included 2004 Indian Health Priorities, review of the previous year's work plan and what was accomplished, and "APN Practice" highlights.

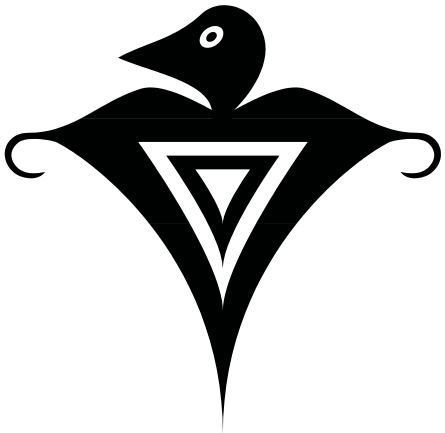
New APN Specialties in Indian Health:

- NP addiction medicine/chronic pain management certification and clinics
- Diabetic NPs, who can independently manage diabetic patients
- Dual certification as a family nurse practitioner and substance abuse counselor
- Mental health NPs are increasing in number and providing mental/behavioral health services, often in rural areas
- School clinic NPs providing acute and well child care in elementary and secondary schools, working with families to improve the health status of AI/AN children. These clinics are often reimbursable.
- APN colposcopists are increasing in number in Indian health, providing colposcopy services

The 2004 Work Plan for Nurse Practitioners in I/T/Us is as Follows

- The proposed National Scope of Practice for APNs will be presented to the National Council of Nurses.
- APNs in a few Areas are still limited to Civil Service GS 11 grade while almost all other Areas are at the GS11/12 grades. Work will continue through the National Council of Nurses to encourage Areas to reclassify these positions to GS 12 grades, consistent with the rest of IHS and in keeping with the level of complexity of care, independent practice, advanced education, national certification, and prescribing privileges APNs must achieve and maintain.
- APN leaders will be looking for ways to market the unique contributions APNs make to the mission of Indian health, including increasing awareness of the excellent outcomes and the high level of patient satisfaction that APN care brings.
- APNs will actively pursue leadership training opportunities and leadership roles in Indian health. There is interest in serving on policy-making committees and councils that impact their practice and delivery of care. There is continuing interest in attending the IHS Executive Leadership Development Program and the Leadership in Context training.

The continuing assistance of the Clinical Support Center and Nursing Headquarters is gratefully acknowledged.



Advocacy Fellowships for Physicians

The Institute on Medicine as a Profession (MAP) of the Open Society Institute is seeking applications from physicians who are interested in advocacy for its January 19, 2005 deadline for the Soros Advocacy Fellowship for Physicians. For more information on the fellowship and on the MAP program, please visit *www.soros.org/medicine*. MAP is especially interested in making minority physicians aware of this funding opportunity.

The Soros Advocacy Fellowship for Physicians is designed to enable physicians to develop or strengthen advocacy skills through collaboration with a U.S.-based advocacy organization during a 12 - 24 month fellowship period.

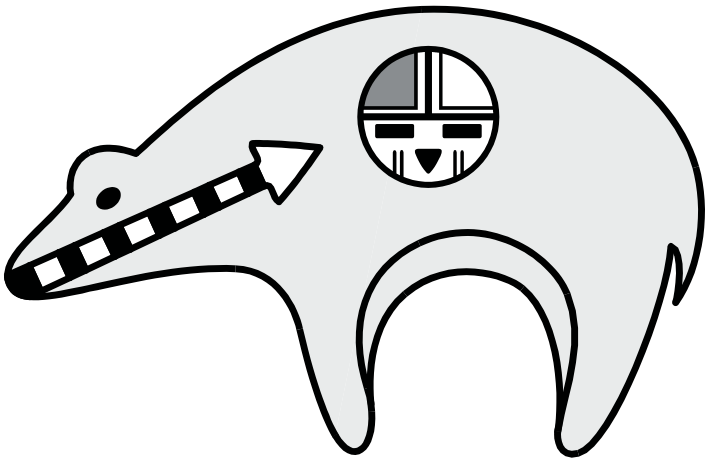
Through this fellowship, participating physicians will design and implement projects that address health care and service delivery or other social issues such as racism, violence, environmental hazards, and education. The program believes that organizations that do policy or system level advocacy benefit by having the presence of a physician collaborating with their staff.

Projects should be focused within the United States and should identify system or policy level changes as the outcome of the fellowship work. One consideration for candidates is that MAP does not fund projects for direct service or research. Although the program welcomes projects that provide opportunities for role modeling, it does not encourage proposals that are solely devoted to training or curriculum development.

Applicants must apply for the fellowship with the commitment of an advocacy organization that is prepared to house, mentor, and support them throughout the fellowship period. A list of advocacy organizations that have expressed interest in participating in the fellowship is available at MAP's website at *www.soros.org/medicine*. Applicants may also apply with organizations other than those listed on the website.

The program encourages applications from physicians at all stages of their careers who have been practicing for at least one year after completing residency. The most competitive applicants are practicing physicians who will have an opportunity to serve as role models, either in an academic or clinical setting, to their colleagues and to future physicians.

Please feel free to share this information with any colleagues or organizations to which the fellowship would be of interest. During the application process, inquiries can be sent to Claudia Calhoon at *ccalhoon@sorosny.org*.



Editor's Note: The following is a digest of the monthly Obstetrics and Gynecology Chief Clinical Consultant's Newsletter (Volume 2, No. 9, September 2004) available on the Internet at http://www.ihs.gov/MedicalPrograms/MCH/M/OBGYN01.cfm. *We wanted to make our readers aware of this resource, and encourage those who are interested to use it on a regular basis. You may also subscribe to a listserv to receive reminders about this service. If you have any questions, please contact Dr. Neil Murphy, Chief Clinical Consultant in Obstetrics and Gynecology, at* nmurphy@anmc.org.

OB/GYN Chief Clinical Consultant's Corner Digest

Abstract of the Month

Overview of the WISEWOMAN Projects: Health Promotion for Disadvantaged Women Features Alaska's Tribal Southcentral Foundation among other recipients.

Background: Although historically Alaska Native women have had a relatively low incidence of cardiovascular disease (CVD), this pattern has changed dramatically in recent years. Alaska Native leaders have identified decreasing cardiovascular risk as an intervention priority.

Methods: From October 2000 to April 2001, Southcentral Foundation, an Alaska Native-owned and managed health corporation in Anchorage, conducted a pilot randomized controlled trial of a heart disease prevention program tailored for Alaska Native women. The aim was to assess feasibility and cultural acceptability, and to develop enrollment procedures. Of 76 women who enrolled, 44 were randomized to the intervention group. Thirty-seven of 44 attended at least two intervention sessions, 23 completed prequestionnaires and postquestionnaires, and 27 returned for 12-month follow-up screening. Thirty of 32 control group participants returned for 12-month follow-up screening. The intervention included 12 weekly sessions on lifestyle change and goal setting. At baseline and 12 months, participants' height, weight, resting blood pressure, fasting lipid levels, and blood glucose were measured. At sessions 1 and 12, participants completed assessments regarding diet, physical activity, tobacco use, and psychosocial status.

Results: At 12 weeks, significant improvements were noted in moderate walking and physical activity self-efficacy. Also observed was substantial movement from the contemplation and preparation stages to the action stage regarding physical activity and heart-healthy eating.

Conclusions: Although the small sample size precludes drawing conclusions about the intervention's effect, participants reported lifestyle and psychosocial changes. The pilot study resulted in protocol changes that improved the design and implementation of a subsequent large-scale study.

Witmer JM, Hensel MR, Holck PS, Ammerman AS, Will JC. Heart disease prevention for Alaska Native women: a review of pilot study findings. *J Womens Health (Larchmt)*. 2004 Jun;13(5):569-78. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15257848*.

OB/GYN CCC Editorial Comment:

This is an example of how tribally-initiated efforts can successfully partner with the research community.

The Supplement contains 15 scientific articles written by more than 50 CDC and collaborating scientists. The articles offer valuable insights into the WISEWOMAN projects, health disparities issues, "lessons learned," and how-to guidance on programmatic issues such as cultural adaptation of materials, cost-effectiveness evaluations, staff morale, and partnering.

The WISEWOMAN demonstration projects have been successful at reaching financially disadvantaged and minority women who are at high risk for chronic diseases. These projects face challenges because they are generally implemented by safety net providers who have limited resources and staff to conduct research and evaluation. On the other hand, the findings from these projects will be especially informative in reducing health disparities because they are conducted in those settings where the most socially and medically vulnerable women receive care.

Will JC, et al. Health promotion interventions for disadvantaged women: overview of the WISEWOMAN projects. *J Womens Health (Larchmt)*. 2004 Jun;13(5):484-502. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15257842*.

From the Biennial Women's Health/MCH meeting, Albuquerque

This meeting was a huge success; go to *http://www.ihs.gov/MedicalPrograms/MCH/M/PROG01.cfm#MeetingLecNotes* to access the following talks.

J. Chris Carey , MD

- *Vaginal Infections and Preterm Labor: An update (PPT 219k)*

Donald Clark, MD, MPH.

- *Domestic Violence Screening and Assessment (PPT 1.5MB)*

Bonnie Duran MD

- *Child Abuse and Neglect and Mental Disorders Among AI/AN women, Part 1 (PPT 933k), Part 2 (PPT 333k), Part 3 (PPT 467k), or entire presentation (PPT 1.4 MB)*
- *Broken Promises: Evaluating the Native American Health Care System U.S. Commission on Civil Rights (PDF 676k)*
- *Child maltreatment prevalence and mental disorder outcomes among AI women in primary care (PDF 100k)*
- *Prevalence and correlates of mental health disorders among Native American women in primary care (PDF 184k)*
- *Socioeconomic disparities in intimate partner violence against Native women: a cross sectional study (PDF 288k)*

Eve Espey, MD

- *Birth Control and Breastfeeding: What is the evidence? Part 1 (PPT 790k), Part 2 (PPT 102k), and Part 3 (PPT 602k)*

Bruce Finke, MD

- *Care of the Older Native Woman (PPT 250k)*
- *Osteoporosis Prevention (adapted from Zuni-Ramah) (DOC 24k)*
- *Osteoporotic Fracture Prevention Algorithm: Whiteriver (XLS 24k)*

Fred Heidrich, MD

- *Osteoporosis from B to H (PPT 2 MB)*

Ursula Knoki-Wilson, CNM.

- *Navajo Cultural Aspects of Obstetric Care (PPT 4.5 MB)*
- *If unable to download this large file (PowerPoint 4.5 MB), then contact Ursula M. Knoki-Wilson CNM.*

Michele Lauria, MD

- *Emergency Delivery Simulations: How to Develop Teamwork (PPT 728k)*
- *VBAC: Is There Such a Thing as Low Risk? (PPT 1MB)*

Larry Leeman, MD, MPH

- *Obstetrical Perinatal Laceration: Anatomy, Prevention, and Repair*
- *Labor Pain: Nature and Management (PDF 352k)*

Rachel Locker MD

- *Domestic Violence: A Health Care Epidemic, Part 1 (PPT 171k)*
- *Domestic Violence: A Health Care Epidemic, Part 2 (PPT 224k)*

Suzan Murphy, RD, MPH, CDE, IBCLC

- *Frequently Asked Questions (WORD 59k)*
- *Breastfeeding: Congratulations Card (WORD 351k)*

Donna Perry, MD, FAAP, FSAM

- *Proving Our Worth: Data Diving in RPMS – Quality or Quagmire (PPT 59k)*
- *Adolescent Health: Consent, Confidentiality, and Conundrums (PPT 3.2 MB)*

Sharon Phelan, MD

- *Nausea and Vomiting in Pregnancy (PPT 635 KB)*
- *Tobacco Cessation in Pregnancy (PPT 139 KB)*

Judy Thierry, DO

- *Births at IHS and Tribal Hospitals : 1992 – 2001 (PPT 159k)*

From George Gilson, Anchorage

There is a new Perinatology Corner continuing education module: Preterm Labor and Preterm Premature Rupture of Membranes. Go to *http://www.ihs.gov/MedicalPrograms/MCH/M/PretermLaborandPreterm.cfm*

From Steve Holve, Tuba City

The September Indian Child Health Notes offer a review of the new recommendations for the influenza vaccine for children ages 6 to 23 months and all of their household contacts. What are effective strategies for delivering this vaccine to so many in so short a time? Also, a review of literature showing the effectiveness of the hepatitis A vaccine in Native Americans. Go to *http://www.ihs.gov/MedicalPrograms/MCH/C/documents/ICHN904.doc*.

From Jane Powers, Ft. Duchesne, Utah

Office for Victims of Crime - Child Abuse Project

The Indian Health Service and the Office for Victims of Crime Child Abuse Project are partnering in a coordinated effort between two government agencies to provide equipment, training, and resources to medical providers (doctors, nurse practitioners, and physician assistants) within the Indian health system for the medical evaluation of child abuse. The program is a two-year commitment and requires support from the supervisor and participant, as well as the employing agency. Year one consist of an intense one-week didactic/classroom training experience, an image capture device/software lab for documentation of medical examinations, cultural awareness training, and a mock trial of various court case scenarios. Every participant attends a one-week hands on preceptorship with one of the expert faculty at that expert's site. Needed equipment for each site is funded by the project (except for computers and internet access). Year two consist of mastering the art of forensic documentation with the image capture device, participation in Grand Rounds, and development of site-specific policies and procedures. All participants complete an advanced preceptorship, and a site visit by the project director is made. A certificate of completion is given to successful participants, and program resources continue to be available to them. Past and current participant sites include: Bethel, Dillingham, Kotzubue, Juneau (Alaska); Whiteriver, Tuba City, San Carlos, Gila River (Arizona); ACL Hospital, Shiprock, Pine Hill, Gallup (New Mexico); Belcourt (North Dakota);

Keewenaw, Sault Ste. Marie (Michigan); Ft. Belknap, Ft. Peck, Crow Agency, Northern Cheyenne (Montana); Clinton (Oklahoma); Ft. Thompson, Wagner, Sisseton (South Dakota); and Ft. Washakie (Wyoming).

For further information please write to CDR P. Jane Powers, APRN, BC, FAANP, Ft. Duchesne Indian Health Center, P.O. Box 160, Ft. Duchesne, Utah 84026; e-mail *Jane.Powers@ihs.gov*; telephone (435) 725-6839; or visit the website at *http://www.ovccap.ihs.gov*.

Obstetrics

Treatment for cervical intraepithelial neoplasia and risk of preterm delivery.

Conclusions: LEEP and laser cone treatments were associated with significantly increased risk of PROM. Careful consideration should be given to treatment of CIN in women of reproductive age, especially when treatment might reasonably be delayed or targeted to high-risk cases.

Sadler L, et al. Treatment for cervical intraepithelial neoplasia and risk of preterm delivery. *JAMA*. 2004 May 5;291(17):2100-6.*http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15126438*

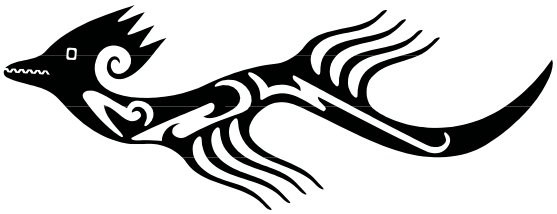
OB/GYN CCC Editorial Comment

For young women who have not yet completed reproduction, LEEP may not be the best therapeutic option for treating CIN, especially of low malignant potential. Women who clearly require surgical intervention may be better served with a procedure such as cryotherapy. Also see Crane et al in Gynecology below.

Outpatient Cervical Ripening: Successful Small RCT

Conclusion: A single 25-microgram outpatient intravaginal dose of misoprostol is effective in decreasing the interval to delivery in women with unfavorable cervices at term.

McKenna DS, Ester JB, Proffitt M, Waddell KR. Misoprostol outpatient cervical ripening without subsequent induction of labor: a randomized trial. *Obstet Gynecol*. 2004 Sep;104(3):579-84. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=retrieve&db=pubmed&list_uids=15339772&dopt=Abstract*



OB/GYN CCC Editorial Comment

Outpatient misoprostol has been used successfully in a tertiary care Indian health setting. This small RCT raises further questions as to its utility in outlying Indian health facilities, as was discussed at the August IHS Women's Health Biennial Meeting.

Gynecology

LEEP — not the best for treating young women who have not completed reproduction.

Conclusion: LEEP appears to be associated with subsequent preterm birth, even when smoking status is matched. Studies with adequate sample size are needed to further evaluate the relationship of LEEP and preterm birth, controlling for potential confounders, including depth of the tissue sample.

ACOG Clinical Review Editorial: Five studies with control groups met the criteria for review. For young women who have not yet completed reproduction, LEEP may not be the best therapeutic option for treating CIN, especially of low malignant potential. Women who clearly require surgical intervention may be better served with a procedure such as cryotherapy. Crane JM. Pregnancy outcome after loop electrosurgical excision procedure: a systematic review. *Obstet Gynecol.* 2003 Nov;102(5 Pt 1):1058-62. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=14672487*

Child Health

No benefit seen for suctioning meconium-stained newborns: RCT.

Interpretation: Routine intrapartum oropharyngeal and nasopharyngeal suctioning of term-gestation infants born through MSAF does not prevent MAS. Consideration should be given to revision of present recommendations.

Vain NE, et al. Oropharyngeal and nasopharyngeal suctioning of meconium-stained neonates before delivery of their shoulders: multicentre, randomised controlled trial. *Lancet*. 2004 Aug 14;364(9434):597-602. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15313360*

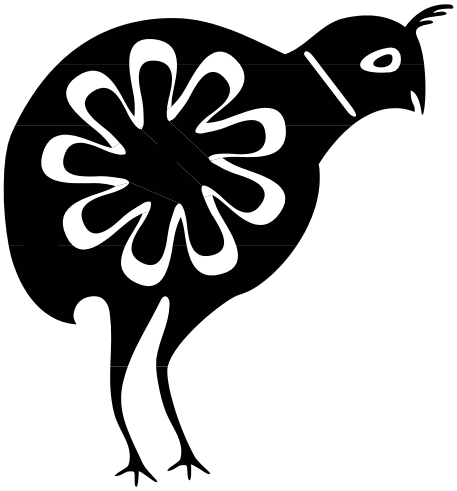
Chronic Disease

Broken Promises - What is the status of American Indian / Alaska Native Health?

The U.S. Commission on Civil Rights has issued a follow-up report to its "Quiet Crisis" report from last year that focused on the lack of Federal funding addressing unmet needs in Indian Country. The new report, entitled "Broken Promises: Evaluating the Native American Health Care System," is now available on the Commission's website at *http://www.usccr.gov/*. "In the end, as a result of our examination of the Native American health care system and the nature of historical relationship between

tribes and the Federal government, it is possible to reduce this report to a single compelling observation. That observation is that persistent discrimination and neglect continue to deprive Native Americans of a health care system sufficient to provide health care equivalent to that provided to the vast majority of Americans."

The report examines health disparities in Indian Country; social and cultural barriers that limit access to care and contribute to the disparities; financial barriers; and proposed legislation changes. In the chapter on legislative changes, the report finds that reauthorizing the Indian Health Care Improvement Act would provide the "most promise for improving the lives of Native Americans" (p. 121) and recommends the passage of the reauthorization as "a priority item on the legislative agenda."



ACOG

Management of Postterm Pregnancy. Practice Bulletin Number 55, September 2004.

Postterm pregnancy, by definition, refers to a pregnancy that has extended to or beyond 42 weeks of gestation (294 days, or estimated date of delivery [EDD] +14 days). Accurate pregnancy dating is critical to the diagnosis. The term "postdates" is poorly defined and should be avoided. Although some cases of postterm pregnancy likely result from an inability to accurately define the EDD, many cases result from a true prolongation of gestation. The reported frequency of postterm pregnancy is approximately 7%.

Accurate assessment of gestational age and diagnosis of postterm gestation, as well as recognition and management of risk factors, may reduce the risk of adverse sequelae. Antenatal surveillance and induction of labor are two widely used strategies that theoretically may decrease the risk of an adverse fetal outcome; maternal risk factors for postterm pregnancy also should be considered. The purpose of this document is to examine the evidence and provide recommendations about these two management strategies.

Summary of Recommendations

The following recommendations are based on good and consistent scientific evidence (Level A):

- Women with postterm gestations who have unfavorable cervices can either undergo labor induction or be managed expectantly.
- Prostaglandin can be used in postterm pregnancies to promote cervical ripening and induce labor.
- Delivery should be effected if there is evidence of fetal compromise or oligohydramnios.

The following recommendations are based primarily on consensus and expert opinion (Level C):

- Despite a lack of evidence that monitoring improves perinatal outcome, it is reasonable to initiate antenatal surveillance of postterm pregnancies between 41 weeks (287 days; EDD +7 days) and 42 weeks (294 days; EDD +14 days) of gestation because of evidence that perinatal morbidity and mortality increase as gestational age advances.
- Many practitioners use twice-weekly testing with some evaluation of amniotic fluid volume beginning at 41 weeks of gestation. A nonstress test and amniotic fluid volume assessment (a modified BPP) should be adequate.
- Many authorities recommend prompt delivery in a postterm patient with a favorable cervix and no other complications.

Management of postterm pregnancy. ACOG Practice Bulletin No. 55. American College of Obstetricians and Gynecologists. *Obstet Gynecol*. 2004;104:639–46.

Non-ACOG members:*http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15339790*

Guidelines for Diagnostic Imaging During Pregnancy

Committee Opinion Number 299, September 2004.

Abstract: Undergoing a single diagnostic X-ray procedure does not result in radiation exposure adequate to threaten the well-being of the developing preembryo, embryo, or fetus, and is not an indication for therapeutic abortion. When multiple diagnostic X-rays are anticipated during pregnancy, imaging procedures not associated with ionizing radiation, such as ultrasonography and magnetic resonance imaging, should be considered. Additionally, it may be helpful to consult an expert in dosimetry calculation to determine estimated fetal dose. The use of radioactive isotopes of iodine is contraindicated for therapeutic use during pregnancy. Other radiopaque and paramagnetic contrast

agents have not been studied in humans, but animal studies suggest that these agents are unlikely to cause harm to the developing human fetus. Although imaging techniques requiring these agents may be diagnostically beneficial, these techniques should be used during pregnancy only if potential benefits justify potential risks to the fetus.

Non-ACOG members:*http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15339791*

Frequently asked questions

Q. Should we perform routine urine dipstick protein screening in our prenatal clinic?

A. No, the urine dipstick tests are not sensitive, nor specific enough to suggest for routine screening for pre-eclampsia. There is more to the story, though.

The old prenatal protocols included performing routine urine dipstick screening for pre-eclampsia and diabetes on all prenatal patients at all visits. Upon further review by the 1989 PHS Expert Panel on the Content of Prenatal Care, neither of those two disorders were well screened by urine dipstick testing.

Urinary protein dipstick values do not correlate well with 24-hour protein excretion values in hypertensive pregnant women (Mercer, Kuo, Waugh). In one systematic review including six studies, the posttest probability for urine dipstick of ≥1+ for predicting 24-hour urine protein excretion, ≥ 300 mg ranged from 53 to 86 percent, and was 23 to 40 percent when the dipstick was negative or trace (Waugh). Thus, a negative dipstick does not necessarily exclude significant proteinuria while many women with positive tests do not have it. However, urine dipstick values of 3+ and 4+ are more helpful as, in one series, all but 9 percent of patients with these dipstick values excreted at least 3.5 g of protein per day (Mercer).

Another approach is to limit initial clinic screening pre-eclampsia screening to patients at higher risk, e.g., BP greater then 140/90 mm Hg, or mean arterial pressure greater than 105 mm Hg; symptoms of pre-clampsia; multiple gestation; symptoms of UTI; or chronic hypertension currently on hypertension medication. Screening of this high risk group could be performed by either a classic dipstick, or a total protein to creatinine ratio.

In any case, the best screen for pre-eclampsia remains a casual BP reading performed in a sitting position after appropriate rest.

Primary Care Discussion Forum

November 1, 2004: Violence against Native women.

Moderator: Terry Cullen

This discussion will include the scope of violence against Native American women, tools for patient evaluation, best practice policies and procedures, and ideas about available resources. *http://www.ihs.gov/MedicalPrograms/MCH/M/PCdiscForum.asp*

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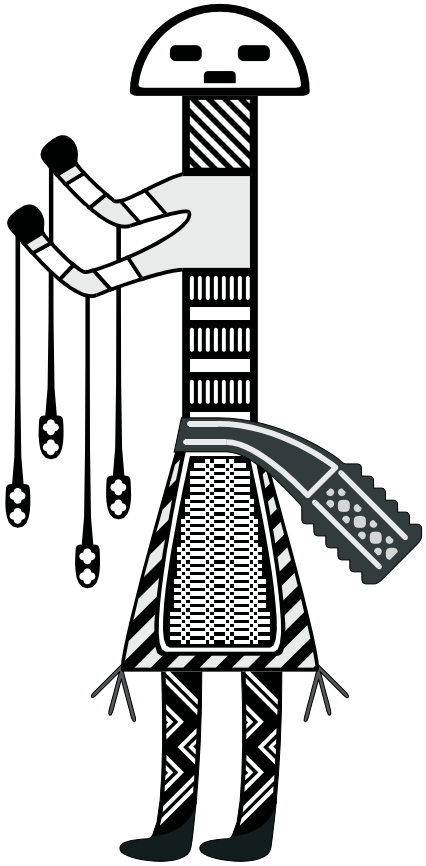

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