THE IHS PRIMARY CARE PROVIDER

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1998 IHS Domestic Violence Policies and Procedures Survey Summary Report

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In October 1998 an IHS Domestic Violence Survey was mailed to all IHS sites listed in the 1996 IHS Interim Directory. All hospitals and clinics were surveyed regarding activities related to domestic violence (DV): screening; policies and procedures (P&P); committees; staff training; and state and tribal mandatory reporting requirements.

The survey examined the effect of administrative and legal requirements on screening for DV in Indian Health Service hospitals and clinics. This report summarizes the results of the survey. A more detailed report of the results of this survey has been published elsewhere.[1]

All 223 clinics and hospitals listed in the Directory were targeted. One hundred forty-two responses comprise the data for analysis. Responses were analyzed in Epi-Info, Version 6.

Results

The following are the characteristics of the responding facilities:

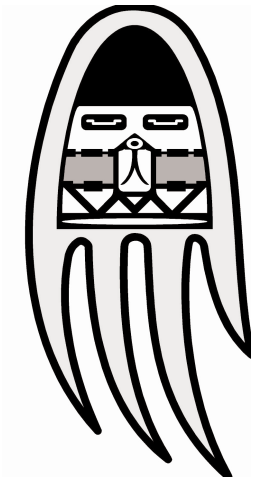
- 76% were clinics, 24% hospitals
- 84% reservation/rural, 16% urban
- 66% IHS-administered, 34% tribally-administered
- 29% have DV committees
- 61% did not know or could not say how many victims of DV were seen in a typical month
- 62% screen for DV
- 64% have P&P for DV
- A facility was more likely to screen if it had P&P for DV
- JCAHO was cited most often as the most important factor influencing the development of DV P&P
- Less than half the sites with P&P report any evaluation of the use of the P&P
- Hospitals were more likely to have P&P than clinics
- IHS-administered sites were more likely to have P&P than tribally-administered sites
- 41% of facilities in a total of 18 states report mandates for physicians to report DV
- 23% of facilities report 31 different tribes mandate reporting of DV

In this Issue...

- Knowledge regarding state and tribal laws is uneven among facilities from a given state or reservation. Some facilities report knowledge of these requirements, while others in the same state or reservation are unaware of these laws.
- No state or tribe required mandatory reporting for baseline or surveillance measures. All mandatory reporting was to legal or social service agencies
- At least one topic of DV training in the past year was mandatory for physicians in 23% of facilities, and mandatory for nurses in 28% facilities
- This survey has no way to verify whether or not the P&P are implemented
- Questions about the fine points of screening, intervention, and staff education simply had too few responses for meaningful analysis.

Recommendations

More than 70% of IHS sites have DV P&P. This satisfies the Government Performance and Results Act requirement at that time that >70% of sites would have DV P&P by the end of FY'99. A recent national survey of health maintenance organizations (HMOs) revealed that 28% had policies, protocols, guidelines, or materials for screening for domestic violence. The National Committee for Quality Assurance does not track any indicators related to domestic violence, despite the recommendations of professional organizations and growing evidence of positive outcomes after clinical interventions. What other "vertically integrated" health care organization besides the IHS can boast such a large proportion of sites with domestic violence policies and procedures? We should be proud of this accomplishment. It is a good starting point from which to begin to address DV in the clinical setting. The following are some recommendations to build on these accomplishments.



Build evaluation into the P&P from the start. This would apply to any policies we develop, and many facilities have already started doing this. For instance, some sites review the chart of any identified DV victim, while others review identified cases to assure that appropriate referrals were recommended. At Albuquerque Service Unit, we audit charts every few months to see how often we are administering the screening questionnaire to patients.

Sites without DV P&P should develop them. Formal P&P increase the chances of screening for DV.

Clinics should team up with hospitals. Smaller facilities may lack the time, knowledge, or clerical support to develop P&P. Hospitals can provide these resources to clinics so that appropriate policies can be implemented in the field.

IHS providers, project officers, and those working with tribes should continue to educate tribal leadership, including health boards, regarding the importance of DV. This will become increasingly important as self-governance accelerates, and more tribes administer health programs.

DV screening and treatment must proceed in tandem with staff education. Many studies have documented medical and nursing provider discomfort with and lack of knowledge about this issue. Very practical guides are available for health care teams wishing to institutionalize the health care team response to DV, such as Warshaw and Ganley's *Improving the Health Care Response to DV: A Resource Manual for Health Care Providers* (available at *http://store.yahoo.com/fvpfstore/resandtrainm.html)*.

Aggregate reporting of DV will enhance the public health function of surveillance, and these efforts should be supported with good data collection.

Clarify your facility's state and tribal reporting requirements. Ask for legal assistance when necessary. DV advocacy groups can be helpful getting answers to these questions, too.

Mandatory reporting of DV is very controversial. Examine the issues involved. These issues are nicely reviewed in an article in JAMA entitled "Laws Mandating Reporting of DV: Do They Promote Patient Well-being?"[2]

Domestic violence affects all aspects of a woman's health. It is a condition suitable for mass screening in the health care setting[3]. Screening for domestic violence is promoted by the presence of relevant policies and procedures.

References

1. Clark D. Domestic violence screening, policies, and procedures in Indian Health Service facilities. *J Am Board Fam Pract*. 2001;14:252-8
2. Hyman, Schillinger. Laws mandating reporting of DV: Do they promote patient well- being? *JAMA*. 1995:273;1781-1787
3. Clark D. Screening for domestic violence in IHS hospitals and clinics: why bother? *The IHS Provider*. 2002;27:5-8

A Combination Problem List/Chronic Medication Profile to Improve Continuity of Care and Patient Safety

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Maintenance of a patient's problem list is an important factor in providing continuity of care in health care facilities where the patient may see multiple medical providers. The use of the PCC (Patient Care Component) form (Form IHS-803) provides one method for maintaining the problem list via the computer-generated health summary. Proper coding by the medical provider on the PCC form and subsequent data entry allow the computer to transfer information to the appropriate areas of the health summary. Accurate provider coding also allows problems to be moved or deleted from the health summary.

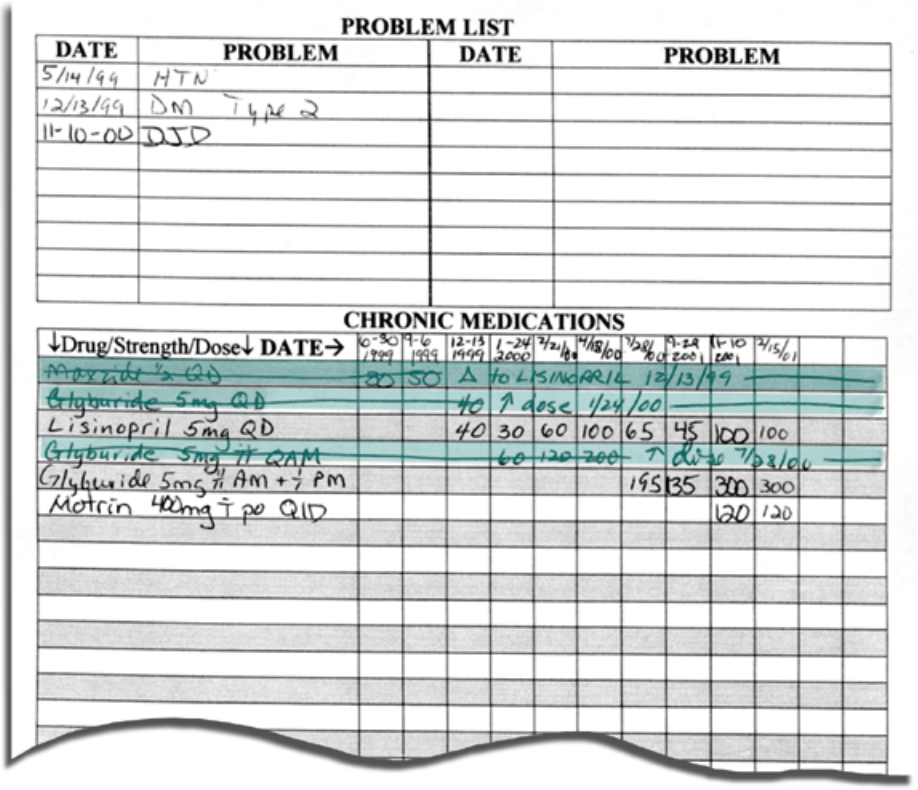
The system requires the acceptance and commitment of the providers who it is designed to assist, and timely input of information into the computer database. As such, medical providers and data entry personnel require a thorough orientation in order to use it properly. Perhaps most importantly, an updated version of the health summary needs to be printed prior to each patient encounter in order for it to be clinically useful.

While potentially providing a comprehensive problem list for a patient, our experience at Inscription House Health Center (IHHC) has been that the computer-generated health summaries are not adequately maintained for a variety of reasons. With the increased complexity of the health care needs of our patient population as a consequence of multiple chronic diseases, the need for a simpler, more accurate, up-to-date problem list became necessary at IHHC.

The prevalence of outpatients receiving numerous medications to control multiple disease states has been increasing steadily. Multiple medications are often necessary to manage common disease states seen at IHHC, including diabetes, hypertension, and their complications. With the exception of a few preprinted areas on some PCC forms, completion of the form at IHHC is a completely manual process. For patients using multiple medications, this means that the medical provider has to recopy all the chronic medications onto the current PCC form each and every time they are ordered, or essentially every patient visit. This is a time consuming and frustrating process for pharmacists and medical providers alike.

A solution to both these problems was found by creating a combination problem list/chronic medication profile (Figure 1). Although a totally manual system, the new form has been well accepted by the medical and pharmacy staffs at the facil-

Figure 1. Sample problem list and list of chronic medications.



PROBLEM LIST

DATE	PROBLEM	DATE	PROBLEM
5/14/99	HTN		
12/13/99	DM Type 2		
11-10-00	DJD		

CHRONIC MEDICATIONS

↓Drug/Strength/Dose↓ DATE→	10-30 1999	9-6 1999	12-13 1999	1-24 2000	7/21/00	9/18/00	11/28/00	1-22 2001	11-10 2001	2/15/01
~~Norvasc ½ QD~~	30	30	Δ to LISINOPRIL 12/13/99							
~~Glyburide 5mg QD~~			40	↑ dose 1/24/00						
Lisinopril 5mg QD			40	30	60	100	65	45	100	100
~~Glyburide 5mg ½ QAM~~				60	120	200	↑ dose 7/03/00			
Glyburide 5mg ½ AM + ½ PM							195	135	300	300
Motrin 400mg ÷ po QID									120	120

ity. It has been used for over a year and has improved patient care and staff satisfaction in many ways.

Improved patient safety has been the overriding benefit that has resulted from using the form. Illegibility, inaccurate medication transcription, and overlooked prescription orders have been reduced significantly. Calling medical providers to inquire about inaccurate transcription of medications, due to errors from frequent recopying, used to be the most common pharmacy intervention, accounting for a third of the interventions recorded by the pharmacy. After instituting the form, transcription queries decreased by over 60%. In the most recent quarter, transcription queries dropped to a distant sixth in the types of interventions recorded by pharmacy. Medical providers make dramatically fewer transcription mistakes when using the form to order chronic medications than before the form was instituted, resulting in less pharmacy intervention.

As IHHC is an outpatient facility, all admissions require the patient to be transferred to another facility. The form has been helpful in this situation by providing a concise clinical resume of a patient's current medications and problems for the accepting facility or provider. This information is essential to provide each patient with the proper continuity and appropriateness of care while at a referral facility. Photocopying each patient's form prior to transfer has saved time in recopying this information, as well as eliminating the problem of incomplete medication and problem lists reaching the receiving facilities or providers.

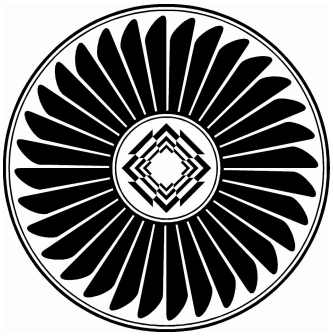
The time savings generated by the form accrue for both the pharmacy and medical staff. Instead of rewriting the list of chronic medications needed to treat the patient, the medical provider can simply write "Refill chronic meds" on the PCC form for the current visit. In the pharmacy, this notation serves as an order to fill the medications listed in the chronic medication section of the form. The pharmacy staff writes the current date at the top of the first open column and calculates quantities to last until the next follow-up appointment. When filling prescriptions, pharmacy finds the form significantly more efficient than working from the cramped medication section of the PCC form. Legibility is greatly improved and the layout of the form simplifies the filling of multiple medications. Likewise, providers are able to spend less time writing the medications to be refilled, which results in more time for patient care. After using the form extensively for over a year, the pharmacy and medical staff remain enthusiastic about its advantages, and find it hard to imagine not having it to work with.

The form needs high visibility to insure routine use. It was agreed to keep it as the top sheet of the PCC section of the medical record so that it can immediately be seen upon opening the chart. In order to remain relevant, it is important that both the problem list and chronic medication sections of the form be continuously updated. This process is much simpler than the coding required to update the computer-generated health summary. Pharmacy reviews each PCC and double checks that all drug and dosage changes are recorded in the chronic medication section of the form. IHHC has the advantage of having no after-hours services where medication dosage changes might not get recorded on the form. The medical staff insures that the problem list section of the form is accurate. The advantages of using the form are such that the time spent keeping it updated is small compared to the efficiency gained from using it.

Implementation of the form was very smooth. The medical staff strongly favored the form from both the standpoints of a more accurate problem list and decreased time spent recopying medication orders. Their buy-in was essential for successful implementation.

No outside printing is necessary to generate the form. It was created using word-processing software and is printed on 67-pound paper stock. This paper is sturdier than regular 8½ x 11 paper but still works in a photocopier. Medical records or any clinical staff member can insert the form into a patient's chart. Discontinued medications or dosage changes require that a new order be written on the form, and that the non-current order be crossed out. We have found that using a blue highlighter to draw through a changed or discontinued medication makes the current therapy, i.e. those lines without a blue highlight, more obvious.

This combination problem list/chronic medication order sheet should only be a temporary solution to the problems it was designed to solve. With the implementation of customizable PCCs and eventually a completely electronic medical record, this form may become obsolete. Until that time, its use provides considerable benefit in many clinical areas, including information sharing, patient care, and risk management.



Project Making Medicine: Specialized Training in the Treatment of Physically and Sexually Abused Native American Children

The Center on Child Abuse and Neglect at the University of Oklahoma Health Sciences Center, through funding from the Department of Health and Human Services (DHHS) Office of Child Abuse and Neglect and the Indian Health Service, offers a training program to provide specialized training to IHS and tribal mental health professionals in the treatment of child physical and sexual abuse.

Project Making Medicine involves training IHS and tribal mental health professionals in a "training of trainers" model. The purpose of the training is to increase the number of mental health providers available to serve child victims. Upon acceptance into the training program, each professional will receive forty hours of training in treatment of child physical and sexual abuse, forty hours of training in clinical supervision and consultation, phone consultation, and one on-site visit (on-site training activity). The training requires at a minimum a 12-month training commitment and two-year follow-up. Each licensed professional (with the support of their agency) selected for training commits to implementing similar services including providing specialized treatment, training, consultation, and clinical supervision in the treatment of Native American children who are victims of physical and sexual abuse at their local site.

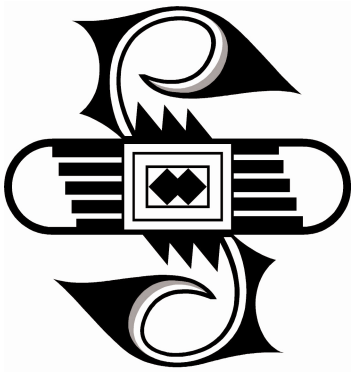
The training is specific to Native American populations and their unique characteristics. Consulting and Core Faculty include traditional Native Healers and Child Clinical and Counseling Psychologists who have expertise in treatment and prevention of child maltreatment in Native American communities.

Funding is available for mental health professionals to be trained over a three-year period (2000-2003) from the twelve IHS Areas. Each year up to 14-18 professionals from four IHS Areas are selected to participate in the training. This year's recruitment will target the following IHS Areas: Nashville, Phoenix, Navajo, and Albuquerque. Applicants from other IHS Areas will be placed on an alternates list. Tribal mental health professionals are eligible for travel expenses, while IHS employees must request funds from their service unit or Area Office. Licensed psychologists, psychiatrists, social workers, and professional counselors are encouraged to apply. Certified alcohol and drug counselors who work with adolescents may also be considered.

Each applicant should submit the following to the address listed at the bottom of this page no later than March 1, 2002:

- a letter of intent with a statement of commitment as outlined above;
- a letter of commitment from their administrative supervisor stating the applicant is permitted to participate in the training for the duration of training and is supported in the requirements as outlined above;
- a letter of support from their tribal or IHS governing entity stating the applicant is permitted to participate in the training for the duration of training, supporting the requirements as outlined above, and committing to sponsor a Project Making Medicine on-site training activity (sponsorship is limited to local facilitating and organization; not travel expenses);
- a copy of licensure; and
- a *curriculum vitae*.

For additional information, please contact Dolores Subia BigFoot, PhD, or Lorena J. Burris, PhD at (405) 271-8858; or e-mail *dee-bigfoot@ouhsc.edu* or *lorena-burris@ouhsc.edu.* The mailing address for applications is Center on Child Abuse and Neglect, CHO 3B3406, P.O. Box 26901, Oklahoma City, Oklahoma 73190.



Internet Site Combines Clinical Performance Indicators with CME

Internet-based tools to improve Indian Health Service (IHS) physician productivity and provide training are no longer a wish for the future. Providers at several IHS sites now have the ability to utilize the "anywhere, anytime" convenience of the Internet to monitor selected clinical performance indicators, and to obtain continuing medical education (CME) credits at the same time, as part of the new "WebEpi" project.

Clinical Performance Indicators

Cereplex, a small company specializing in web-based epidemiology activities, has worked with IHS Headquarters, the IHS Clinical Support Center, the Phoenix Area IHS, and several participating IHS service units to provide these new tools to IHS providers as part of the WebEpi Project. Using cleaned, filtered Resource and Patient Management System (RPMS) data retrieved from participating sites, and database management tools (SQL Server) to process the data, a user-friendly web interface (incorporating the most recent maximum security methods available) enables providers at participating service units to log in and access a variety of patient care indicators.

The clinical performance indicators currently available can be grouped into three subject areas. First, there are 12 infectious disease indicators available (for example, the percent of women seen for first prenatal visit who are screened within 30 days for syphilis; and the percent of women age 15-19 who have been screened for Chlamydia in the last six months). Seven GPRA-mandated indicators are provided (for example, the percent of children age 24-35 months who have completed the recommended American Advisory Committee on Immunization Practices (ACIP) immunization series; and the percent of adults over 64 who have received a pneumococcal vaccine). Finally, 12 diabetes-related indicators are available (for example, the percentage of diabetic patients with good blood pressure control, defined as having two of their last three blood pressures recorded at < 135/80; and the percentage of diabetic patients with Hb_{A1c} recorded at < 7.0 %.

Indicators are provided for a time period specified by the user, and are based on the group of patients seen during that period by the participating physician. Results can be viewed by any month, quarter, or year (data are available beginning January 2000). Furthermore, indicators can be viewed not only by the requesting provider, but also can be categorized by clinic or by service unit. Individual providers can compare their performance to their (anonymous) colleagues' results, or they can compare theirs to the average results for a different participating clinic. Clinical directors can compare performances of their clinic's providers, compare their clinic's performance to that of other clinics, or compare their service unit performance to the performance of other service units. Administration of user access and profiles (by a designated clinic representative) is provided via a set of restricted tools on the website. Because the included indicators summarize data for large sets of patients, minor inaccuracies in the patient data utilized from each site will not unduly affect conclusions drawn from the indicators.

This service is currently in use in six service units, and will be available at ten service units by April 2002. The goal is that by providing the opportunity to make comparisons among and between providers and clinics, this will assist providers and clinical directors to improve clinical care.

Web-based CME

In addition to performance indicators, the WebEpi project also gives providers the opportunity to obtain CME credit through this same web interface. In partnership with the IHS Clinical Support Center, we provide a large number of mini-CME lessons on the web. Each lesson contains text, graphics, references, and links to relevant websites on a given topic (topics are generally related to the performance indicators available). Most lessons take just a brief time to complete, are

designed to provide condensed, useful information, and are packaged in a format to maximize convenience for a busy provider.

Existing topics are varied, with new ones regularly being added. Examples of lessons currently available are the following: "Adding Problems to the Problem List," "Screening for Cervical Cancer," and "Pneumococcal Vaccination Recommendations." Upon completion of a lesson, the user can take a short test and receive CME credit (typically 1/4 CME hour per lesson). All CME lessons are sponsored by the IHS Clinical Support Center. The website will automatically report credits obtained to the IHS CSC after at least one hour of credit is accumulated by the user. The user also has the opportunity to print a CME certificate.

Both functions of the WebEpi application -- CME lessons and performance indicators -- can be implemented at any IHS facility. The web-based utilities are designed to give providers additional tools to improve their clinical care by providing access to epidemiological data about their patients, and by providing up-to-date lessons on topics associated with those data.

In designing and refining these tools, Cereplex has worked closely with key IHS personnel, including Dr. John Saari (establishing web-based CME), Dr. James Cheek (infectious disease indicators), Dr. Charlton Wilson (diabetes indicators), and Dr. Richard Olson (GPRA indicators). Interested readers can try a demo of the utility by visiting *www.webepi.org*. For further information about participating in WebEpi, please contact Cereplex at *info@cereplex.com* or by telephone at (703) 716-0751.

PHS Physician Mentoring Program

The Physician Professional Advisory Committee (PPAC) to the Surgeon General has initiated a voluntary mentoring program for Public Health Service physicians. Initially this program will be limited to Commissioned Officers but the goal is to expand it to Civil Service PHS physicians in the future. The goal of the program is to promote professional growth and career development. Recently commissioned junior physicians ("protégés") with a grade of 0-3 or 0-4 and a call to active duty within the last 2-4 years can be matched with more senior physicians ("mentors") by agency, geographic area, or discipline. The mentors will have over five years experience in the PHS and will be at the grade of 0-5 or above. A description of the program and a mentor or protégé application is available at *www2.IHS.gov/ppac/Mentoring_Intro_page.htm*. Information and applications can also be obtained from CAPT Dean Effler, 401 Buster Rd., Toppenish, Washington 98948; telephone (509) 865-2102, ext. 224; or by e-mail at *usphsmentor@prodigy.net*.

The 6th Annual Elders Issue

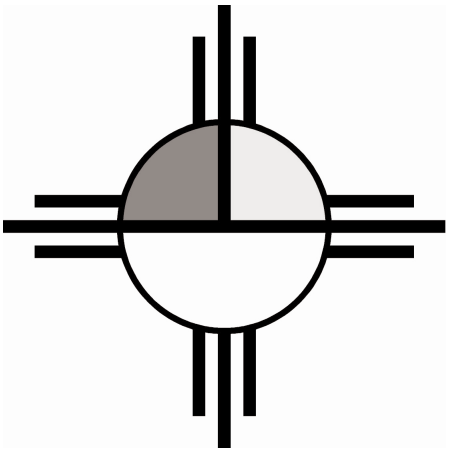
The May 2002 issue of THE IHS PROVIDER, to be published on the occasion of National Older Americans Month, will be the sixth annual issue dedicated to our elders. Indian Health Service, tribal, and Urban Program professionals are encouraged to submit articles for this issue on elders and their health and health care. We are also interested in articles written by Indian elders themselves giving their perspective on health and health care issues. Inquiries or submissions can be addressed to the attention of the editor at the address on the back page of this issue.

The Perinatologist Corner: Case-based, Online CME Available on Maternity Issues

Dr. Neil Murphy, the OB/GYN Chief Clinical Consultant and Maternal Child Health I/T/U (Indian Health Service/tribal/urban program) Website Coordinator, is pleased to announce that evidence-based, online continuing professional education on common, pregnancy-related issues is now available. Called "The Perinatologist Corner," this CE is targeted toward family physicians, OB/GYNs, nurse practitioners, nurse midwives, and nurses, although it is available to all health professionals.

This new CE offering corresponds to the arrival of a perinatologist to the I/T/U system. George Gilson, MD, who is board certified in Maternal Fetal Medicine, has recently joined the medical staff at the Alaska Native Medical Center.

A perinatologist is a physician who has taken a subspecialty fellowship in the care of high-risk pregnancy. Dr. Gilson joins us from the University of New Mexico where he was active with research and teaching. Dr. Gilson has also been active in health care for American Indians and Alaska Natives through his on-site work in Pawnee, Oklahoma and Chinle, Arizona. He has also provided perinatology consultation at Gallup Indian Medical Center, and served as a member of the ACOG Committee on American Indian Affairs. He has extensive field experience working with the indigenous Mayan population in Guatemala.



The advantage of this online system is its reliance on the latest evidence-based materials including:

- The Cochrane Library online
- The Agency for Healthcare Research and Quality (AHRQ) online, evidence-based reviews
- The National Guidelines Clearinghouse online update materials, including the US Preventive Services Task Force Guidelines
- The ACOG/IHS reference text, *Obstetrics, Gynecology, and Neonatology Postgraduate Course* online
- UpToDate online
- ACOG Practice Bulletins and Committee Opinions online

In addition, the latest paper-based materials are also referenced:

- Obstetrics: Normal and Problem Pregnancies. Gabbe SG, Neibyl JR, Simpson JL (Eds.) 4th Edition, 2002
- Williams Obstetrics, Cunningham GF, et al (Eds.) 21st Edition, 2001
- ACOG Practice Bulletins and Committee Opinions

There are three modules currently available online. One new module will be added each month. The current modules include:

- Varicella (Chickenpox) in pregnancy
- Screening and management of HIV in pregnancy
- Triple test screening and second trimester prenatal diagnosis

What other modules would you like to see?

Please inform Dr. George Gilson or Dr. Neil Murphy about other modules you would like to see developed. This is really important to us, as we would like to be able to respond to your true educational needs and address issues that are pertinent to your practice. Your feedback is likewise always welcome and helpful for developing future materials.

Using the modules

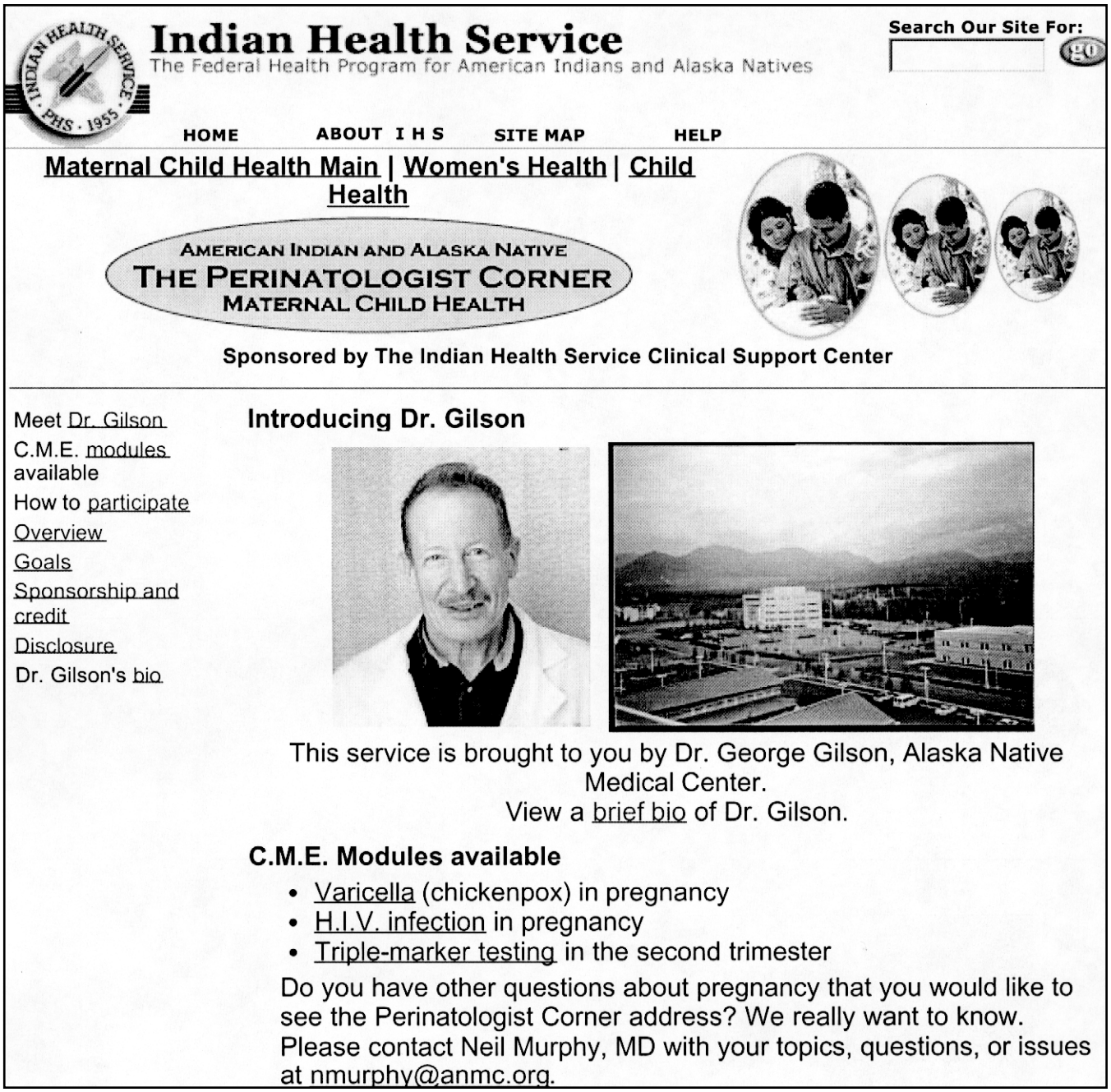
The process is simple. First, read the materials provided, which include the objectives, the case-based scenarios, background material, links to on-line references, and paper-based references. Complete the post-test and evaluation, which reflect back to the case-based scenarios. After this, you will receive feedback from Dr. Murphy and/or Dr. Gilson, MD.

You will then receive one hour of AMA Category 1 credit for each module completed. The IHS Clinical Support Center is the accredited sponsor.

This new CE offering is available through the IHS web site, *http://www.ihs.gov/*. The Maternal Child Health web page can be found on the Medical Programs page at *http://www.ihs.gov/MedicalPrograms/Medical_index.asp*. You will find a link to the Perinatology Corner on the Maternal Child Health main page at *http://www.ihs.gov/MedicalPrograms/MaternalChildHealth/MaternalChild.asp*. Alternatively, you can just go directly to the Perinatology Corner at *http://www.ihs.gov/MedicalPrograms/MaternalChildHealth/MaternalChild/MCHpericrnr.asp*.

The process can be completed online, or the questions can be downloaded and faxed to Neil Murphy, MD at (907) 729-7073. The answer sheet can also be mailed to Neil Murphy, MD at 4315 Diplomacy Drive, ANC-WH, Anchorage, Alaska 99508. If you have any questions, contact Neil Murphy, MD at (907) 729-3154 (voice-mail available); or e-mail him at *nmurphy@anmc.org* or George Gilson at *ggilson@anmc.org*.

http://www.ihs.gov/MedicalPrograms/MaternalChildHealth/MaternalChild/MCHpericrnr.asp



Change of Address or Request for New Subscription Form

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THE IHS PRIMARY CARE PROVIDER

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Publication of articles: Manuscripts, comments, and letters to the editor are welcome. Items submitted for publication should be no longer than 3000 words in length, typed, double spaced, and conform to manuscript standards. PC-compatible word processor files are preferred. Manuscripts may be received via e-mail.

Authors should submit at least one hard copy with each electronic copy. References should be included. All manuscripts are subject to editorial and peer review. Responsibility for obtaining permission from appropriate tribal authorities and Area Publications Committees to publish manuscripts rests with the author. For those who would like more information, a packet entitled "Information for Authors" is available by contacting the CSC at the address below or on our website at www.csc.ihs.gov

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