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Perceptions of American Indian Caregivers Towards Overweight in Preschool Children

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Abstract

Context The increasing prevalence of childhood obesity in American Indian communities has led to the development of obesity prevention efforts in many programs, including the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). Counseling efforts have not been effective in reducing the prevalence of this problem; therefore other methods or motivational factors may be necessary when counseling American Indian caregivers about obesity prevention in preschoolers. Please note that for the purposes of this article, the term caregiver refers to a parent or extended family member who cares for the child.

Objective To explore caregivers' perceptions concerning overweight in preschoolers and to generate caregivers' thoughts about the causes of overweight in preschoolers.

Design Eleven focus groups were conducted with a total of 77 caregivers of American Indian children participating in the Inter Tribal Council of Arizona, Inc. WIC Program. Transcripts from these discussions were analyzed and a list of themes was generated by the authors.

Results The major themes identified were: 1) caregivers feel that overweight is not a problem for preschoolers unless it is accompanied by other medical conditions or impairs the child's ability to be active; 2) caregivers disagree with the definition of overweight used by WIC and/or their health care provider; 3) caregivers have difficulty applying knowledge of good nutrition and physical activity for their children due to external influences; and 4) caregivers have misconceptions about good parenting practices related to feeding their children.

Conclusions Caregivers of American Indian children do not associate overweight in preschoolers with future health problems; therefore, other motivational strategies to elicit behavior change should be explored. Obesity prevention efforts in preschool children should include teaching caregivers about the parenting aspects of childhood nutrition.

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Introduction

The prevalence of overweight is significantly higher in all age groups of American Indians than in the U.S. population.[1-4] Since most clinical treatment efforts for adults and older children have proven ineffective in the long-term,[5] efforts in the public health arena have shifted toward prevention in children.[6] Due to the high prevalence of obesity in elementary school age American Indian children,[2,7] efforts in this group must target-preschool age children and their caregivers.[6]

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) provides nutrition counseling to the caregivers of low-income preschool children. This is an ideal venue for addressing obesity prevention with caregivers of preschool children. Caregivers play a vital role in prevention efforts aimed at preschool children since they are responsible for the feeding relationship between the caregiver and child as well as the dietary and physical activity patterns of their children.[8,9]

Focus groups conducted by the Inter Tribal Council of Arizona, Inc. (ITCA) WIC program paraprofessional and professional nutrition staff indicated that staff have difficulty counseling caregivers on overweight (unpublished data, 1999). This may be due to the caregiver's lack of interest, as perceived by the staff. Other researchers have found evidence that mothers of overweight preschoolers, from ethnic groups other than American Indians, do not feel that their preschool children are overweight.[9,10] Research has also shown that mothers may not accept the health professionals' definition of overweight.[9] Currently, there is no research available on how American Indian caregivers perceive overweight in their preschool children. This knowledge may assist WIC staff and other health care providers in developing interventions and counseling strategies that are effective in promoting healthy feeding relationships and recommended dietary and physical activity patterns in American Indian preschool children.

The purpose of this study was to obtain an understanding of American Indian caregivers' perceptions of overweight in their preschool child, to examine parental attitudes and behavior toward nutrition and exercise of children, and to identify strategies that may be effective in promoting healthy feeding and physical activity patterns in Indian communities. The focus group methodology was used to gather information, as it is a useful means for gathering rich and meaningful data about the caregivers' attitudes and behaviors.

Methods

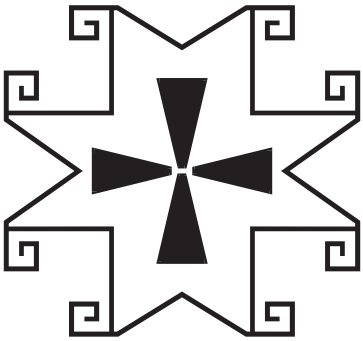
Local agency WIC staff recruited caregivers in the WIC clinics for a first set of focus groups. Caregivers of children aged 1 - 4 who were enrolled in the ITCA WIC program were eligible to participate. Caregivers were compensated $35 for their participation. The first round of focus groups took place in April and June 2000 and were moderated by an Alaska Native MPH student who had been trained to facilitate focus groups. An American Indian doctoral level professional with extensive experience in conducting focus groups moderated a second round of focus groups in February and March 2001.

The questions asked in the first set of focus group were designed to obtain a better understanding of how the caregivers felt about overweight preschoolers, what causes preschoolers to become overweight, and what WIC and their community could do to address childhood overweight. The second set of focus groups was held as a follow-up to obtain a better understanding of the caregivers' attitudes and behaviors toward feeding their children and the physical activity patterns of their preschoolers.

The focus groups were tape recorded and transcribed verbatim. The first set of focus group transcripts was reviewed by the authors as well as two PhD level social scientists, including one who was not involved in planning or conducting the focus groups and who has experience working with qualitative analysis and American Indian tribes. The second set of focus group transcripts was reviewed by the authors. Each member of the review team independently recorded the themes that occurred during each focus group and provided supporting evidence for each theme. The team then agreed on the major themes from each set of focus groups through group discussion.

Results

Eleven focus groups were conducted in three tribal communities in Arizona and at one urban Indian health center. The first set of eight focus groups consisted of a total of 44 participants, with two to eight individuals in each focus group. The second set of three focus groups included 33 participants with ten to twelve participants in each group. There were a total of 72 mothers, three grandmothers, and two fathers who participated in the focus groups.



Four major themes were described in the focus groups: 1) caregivers feel that overweight is not a problem for preschoolers unless it is accompanied by other medical conditions or impairs the child's ability to be active; 2) caregivers do not believe the definition of overweight used by WIC and/or their health care provider; 3) caregivers have difficulty applying knowledge of good nutrition and physical activity for their children due to external influences; and 4) caregivers have misconceptions about good parenting practices related to feeding their children.

Caregivers Feel Overweight Is Not a Problem for Preschoolers

The majority of caregivers did not express a concern about overweight in preschool children. Caregivers felt that their children would grow out of the weight as they got taller or became more active. However, caregivers expressed that they would be concerned about the weight of a preschool child if a medical problem related to the weight was identified (asthma was often cited) or if the child's activity level was impaired by their weight. Caregivers also expressed concern for older children who may get teased when they started school.

> ". . . Yeah, the kid is twenty pounds overweight . . . somebody else is looking at this as a problem . . . and unless it was some health issue did come up, I don't think a lot of people would do anything about it. I mean, I don't, I really don't. Unless something came up that where, you know, asthma or something, and a doctor said, ok, something's wrong."

> "Well, all mine are overweight. But I don't see a problem with it when they are little. And the father, he's big too. My oldest one, he was a big baby. He was real chunky. And now that he's growing he's losing it all. So that's why I'm not concerned about my middle child. He eats a lot and he's really big. But he plays and he runs. Now I see he's stretching out and kind of losing it."

> "My youngest, he's considered overweight, you know, but he does a lot of things. He's very energetic. He can do a lot of things."

> "With her I'm not so much concerned because she's pretty active. She's not lazy or a couch potato. So, some people will naturally hold more weight than others and that is the norm for them. And I think that she is going to be one of those types of people. She's big boned compared with the other kids. And those types of people hold more weight. As long as she feels good and nothing hurts. Or if she started not wanting to play or not wanting to be active or I had to take her to the doctor often, then I would get concerned. But right now I'm not bothered . . . right now she's a big boned and chunky girl because that's the way she is."

Caregivers Disagree with Definition of Overweight

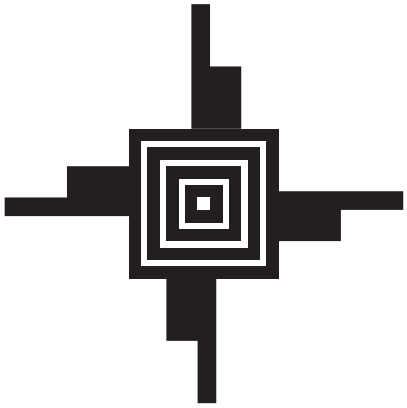
Caregivers disagreed with the definition of overweight used by WIC. The focus group comments indicate that the definition of overweight in American Indian communities conflicts with that used by the health care community. Caregivers often stated that they knew of a preschool child (their own or a relative) who was identified as overweight at WIC but who did not look overweight. Larger body sizes in preschoolers that would be considered overweight on the growth charts used by WIC would be defined as normal in these communities. Some caregivers felt that their children were tall and therefore the growth charts did not apply to their children.

> "When I look at, well when people look at him they don't think he's overweight. But according to WIC graphs, you know, he's way overweight for his height and his age. But then he's a very active kid."

> "It depends on their height. Because this one has, he's big boned. They say he's overweight, but I don't think he's overweight."

> "My daughter, she's overweight, but she doesn't look like she's overweight. She looks average to me. But when I take her here they say she's overweight. But she don't look like she's overweight."

> ". . . they said she was overweight. But she doesn't look overweight. She looks skinny to me . . . she looks just right for her age . . . And I think she's not overweight. And they do say she's overweight. To me she's not."



"I think my daughter, she just turned 4, but she looks like, compared to others that go to school where my son is going, she looks she could be a first grader or kindergartner. You know, she's not fat, like [x] said. She don't look fat, you know. She's just big. You know, and one thing that I kind of have a disagreement with the program here at WIC when both of my children were weighed and everything. And taken on that scale and compared with the other children, my kids in height were like way off the scale, but yet they still measured my son and daughter with the weight scale with the scale that they had that they're supposed to fall in. But, they didn't match it with where they were off the scale . . . And it, it made me feel like they were . . . severely overweight.

Caregivers Have Knowledge of the Importance of Good Nutrition and Physical Activity but Have Difficulty Applying Knowledge Due to External Influences

Caregivers in the focus groups did understand that good nutrition and physical activity were important for the health of their child. However, they were inconsistent in applying this knowledge in the daily activities of child rearing. Caregivers indicated that external influences such as others living in the home, older children, attending daycare, visiting with relatives, and television interfere with the healthy eating habits and activity patterns that WIC caregivers are trying to establish.

". . . sometimes it's hard for her, um, when I feed her. Like, the older sister . . . and brothers, like the way they eat now. They (dentists) look at them (teeth) and they haven't had a problem with them, but my oldest daughter . . . she eats pickles with Kool-Aid on it and she starts eating like that and I said don't, don't . . . hide that from her. 'Cause she's going to want it."

"She stayed with my sister for two days and somewhere somebody gave her fries, so she wants fries all the time. She's never had sweets, or pop or candy or suckers or anything. Now when she sees it she'll cry for it."

". . . But during the weekends, they love candy and sodas and even during the weekday, cause my husband has to have soda and candy, so they see him with it, they attack him and I have to get them the soda, too, and the candy."

"He'll go to his father's house and all they feed him is like chips or pop. And then when he comes back to me, he has a hard time . . ."

". . . when she sees my teenage daughter drinking soda. If she sees a soda, she'll throw a fit until she gets it. She can just drink it down."

Caregivers Have Some Misconceptions About Good Mealtime Parenting Practices

Although caregivers were not directly questioned about their knowledge of good parenting practices while feeding their children, caregivers consistently reported using poor feeding practices such as using food as a reward, making children finish everything on their plates, and having few structured meal and snack times. These practices were perceived as being beneficial to their child's nutritional health.

"I don't buy sweets for my kids at all. The only times I buy them sweets, if, you know, they're doing real good. As my son, my oldest son, he's five, he's barely in Kindergarten, he can't have any sweets unless he's doing good in school. Other than that he doesn't have it."

"But, like my son, he gets in his fits, and he wants, juice, you know, like those squeeze-it juices and stuff. Like the same thing, I say pick up your toys or do something, or eat this first and you can have your juice."

"(I tell them) like you gotta sit down to eat. You want to go play, then you gotta eat your plate first. You know, if you want to watch your videos, you better eat first. So, they do."

"They eat whatever they want, I don't know. I'm not really there. And I work long hours."

". . . the one that's on WIC right now, she's 2 years old. She's . . . overweight . . . its kind of funny because she hardly eats. We all sit, we've all tried to sit down and eat together but, it's like if a good movie is on or something everybody eats toward the TV you know . . .."

Discussion

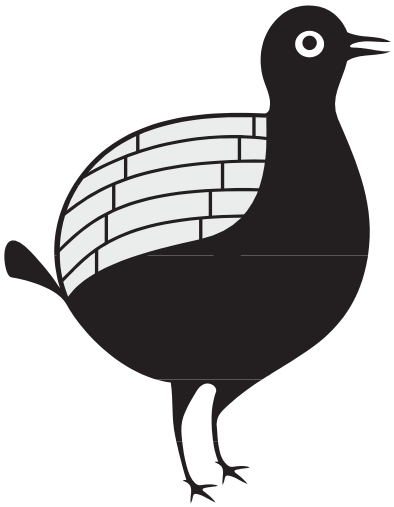
A majority of the caregivers in the focus groups do not see overweight in preschoolers as a problem. Overweight was only seen as a problem if it impaired the child's ability to participate in physical activity or if the child had a medical problem related to being overweight. This is consistent with the results other researchers have found in different ethnic populations.[9,10] Caregivers are aware that children become overweight because of poor dietary behaviors and low physical activity levels. They had a good understanding that nutrition and activity are important for the health of their children, but many reported having difficulty imposing limitations on eating and television viewing due to the influence of other family members or their lack of parenting skills. Caregivers reported the use of inappropriate feeding practices, but viewed these as positive techniques to use to make sure their children were eating well. These practices included using food as a bribe or reward and controlling the amount of food the child eats. Caregivers desire their children to be healthy and want to do what is best for their children. They readily acknowledge that it is their responsibility to promote good health in their children.

The connection between the difficulty with counseling on overweight and the lack of concern for overweight in preschool children by caregivers is an important issue that needs to be addressed. This is a critical juncture for counseling caregivers on their overweight preschoolers. Motivating individuals to address a problem that they do not recognize presents a tremendous barrier to WIC staff. These results would suggest that it might be more effective to approach childhood obesity prevention by promoting healthy behaviors without addressing the weight of the child with the caregiver. However, if using this approach, another motivating factor such as overall health or "doing the best for your child" may be needed to influence the change.

Caregivers may also need more help in building their parenting skills so they are capable of setting and enforcing limits for their preschoolers. Community wide messages may be important to change perceptions of healthy body weights for children and to educate community members about the relationship between weight during childhood and health problems during adulthood. Health care providers need to work together to provide consistent messages related to preschool overweight, nutrition, and physical activity. Health care providers should also move from the common practice of allowing the child to grow into their weight toward implementing early intervention strategies.

An obvious limitation of the focus group methodology for information gathering is the small sample size that brings into question the generalizability of the findings. In addition, this sample was also only representative of a few American Indian tribes in Arizona. Therefore, extrapolation of this information to other ethnic groups or to all American Indian tribes should be approached with caution. Despite these limitations, there was an overall consistency in the responses to a majority of the questions. There are also important advantages to using this form of data collection. Focus groups provide a rich source of information on a particular topic because the methodology is based on open-ended questions and allows the respondent to elaborate on and provide insight into the topic under study.

Most of the focus groups were well attended, and the majority of caregivers were highly animated and excited about discussing their child's eating and exercise activities. It was evident that the caregivers are very interested in the health of their family. Vocal participation in the first set of focus groups was limited and one or two people did a lot of the speaking. However, in the second set of focus groups, the leader elicited responses from all caregivers and often was able to obtain additional comments. Occasionally, the facilitator asked more direct questions in order to get responses. This, however, may have caused caregivers to provide socially acceptable answers or answers that they perceived were the "right" answers.



Although many of the caregivers indicated that childhood obesity was not a problem, they often provided examples of their own older children or children of relatives who were overweight as preschoolers and continued to be overweight in childhood and adolescence. Caregivers seemed unwilling or unable to connect the overweight preschooler with continued weight gain during childhood and eventually into adulthood. This may be due to concerns that they could be labeled as bad parents or feeling that they are to blame for their children's weight. Caregivers were able to acknowledge the role of weight in health problems, particularly diabetes, for adults. With the exception of one individual, they were unable to connect childhood obesity with either adult obesity or health problems during childhood or as an adult.

It is important to continue exploring factors that will motivate caregivers to make changes to improve the dietary patterns and physical activity levels of their children. Appropriate intervention strategies that may be effective in American Indian communities and in the WIC environment should be investigated to determine which types of interventions are successful.[12]

Acknowledgments

This study is part of the Fit WIC Project, a multi-state project to examine how WIC can be more responsive to the problem of childhood obesity. The participating states include California, Virginia, Kentucky, Vermont and the Inter Tribal Council of Arizona, Inc. The five grantees are working collaboratively with the United States Department of Agriculture, Food and Nutrition Service, and the Centers for Disease Control and Prevention (CDC).

A special thank you goes out to the mothers, fathers and grandmothers who participated in the focus groups. We would also like to thank the WIC staff who assisted with the logistics of the focus groups.

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Clinical Performance Challenges in an Era of Accountability and Performance-based Budgets: Part I

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Introduction

The purpose of this series of articles is to encourage Indian Health Service (IHS), tribal, and urban program (ITU) providers to view the Congressionally required Government Performance and Results Act (GPRA) clinical performance activity as an opportunity to improve patient care. By taking this approach, providers will not only assist IHS in its efforts to achieve budget increases on a national level, but may also achieve real improvements in the quality of care provided to the American Indian/Alaska Native communities that they serve.

This first article describes some of the basic concepts of GPRA and how to use GPRA locally to improve the quality of patient care. The second article in this series will discuss GPRA clinical indicator development, selection, and reporting criteria. The third article will discuss the new GPRA+ Reporting System that electronically reports on clinical performance indicators at both the local and Area levels.

GPRA: A Clinical Quality Initiative

The major goals of GPRA are to:

- Improve the quality of patient care;
- Provide a local, Area, and national IHS report card; and
- Provide a budget tool for Congress to assess the agency's performance.

The IHS, like all Federal agencies, is mandated to demonstrate progress towards achieving its mission and goals in a measurable way. The current administration is actively promoting agency accountability and is tying agency budgets to GPRA performance as one of the five key initiatives within the President's Management Agenda.

The IHS is required to submit a performance plan every year describing specifically what the agency intends to accomplish and how those accomplishments will be measured. These performance measures, or "GPRA indicators," are then assessed and reported on at the end of the year.

Appropriately for a health care organization, most IHS GPRA indicators involve clinical treatment or prevention measures. Since clinical care is provided at the local level, understanding the clinical objectives, reporting the appropriate data, and taking steps to improve performance must have the buy-in of the local health care team. As stated in the IHS Strategic Plan, "the need to better inform and communicate health issues to Congress is essential. This requires the participation of all stakeholders with a consistent and coordinated message."

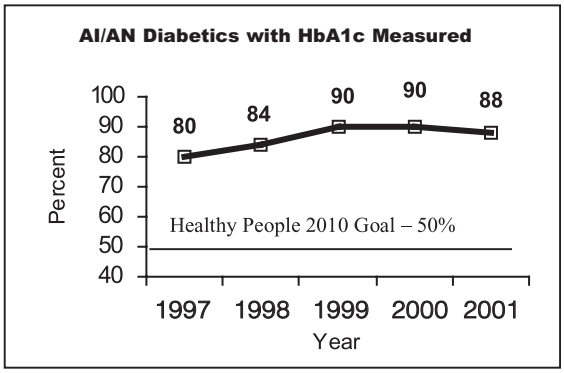
In 2003, the IHS has 40 GPRA indicators in four main categories: Treatment (20), Prevention (12), Capital Programs/Infrastructure (2), and Partnerships/Core Functions/Advocacy (6). The treatment category includes indicators covering diabetes, cancer, behavioral health, oral health, and medication errors. Prevention indicators focus on screening for alcohol dependence, domestic violence, and tobacco use, as well as immunization and obesity rates.

Treatment Indicator: An example

The following is an example of a treatment indicator:

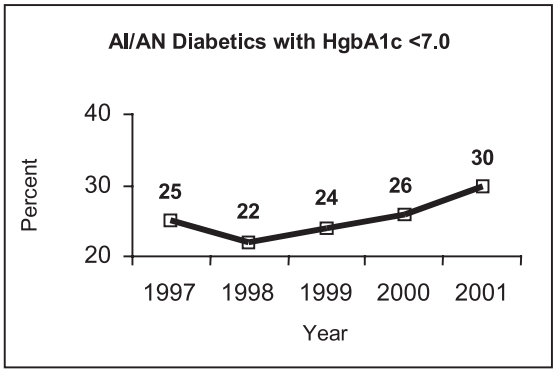
> **Diabetes: Glycemic Control – reduce diabetic complications by demonstrating a continued trend in improved glycemic control in the patients with diagnosed diabetes.**

There are several factors to consider for this indicator. The first factor is the percent of diabetic patients who had their Hemoglobin A1C (HgbA1c) measured in the last year:



The graph above shows that the current IHS clinical programs' performance far exceeds the Healthy People 2010 target of 50%. This information can be used to demonstrate to Congress that the IHS system is able to perform this important clinical activity at an outstanding level even though the agency is not fully funded. The local health programs can use these data as a benchmark for comparing their performance to other facilities within our system. This will allow them to determine if they need to assess their performance and identify problems within their system that can be corrected.

The second factor to consider is the percentage of patients with diabetes whose HgbA1c is less than 7.0, which reflects an ideal level of glycemic control. This information is presented below and shows that in FY 2001, 30% of such patients measured below 7.0.



In addition, the trend for FY 1998 through FY 2001 demonstrates a steady improvement in achievement of this ideal control. This happens to coincide with the start of the Special Diabetes Grant Program for Indians that Congress funded to specifically target improvements in diabetes care for Indian people. The IHS now has data that show how we are effectively using these grant funds as Congress intended. The local health program can use these data as a benchmark for assessing their performance and implementing corrective actions that may be needed.

However, since 30% of the patients with diabetes had a HgbA1c level less than 7.0, the remaining 70% of patients had an HgBA1c above 7.0. This is important information because that group would greatly benefit from decreases in their HgbA1c levels. The current literature suggests that a decrease of 1.0 in the HgbA1c level achieves the following:

- A 14% decrease in mortality;
- A 43% decrease in amputations;
- A 24% decrease in renal failure; and
- An $800 decrease in annual health care costs.

2002 Overall GPRA Performance

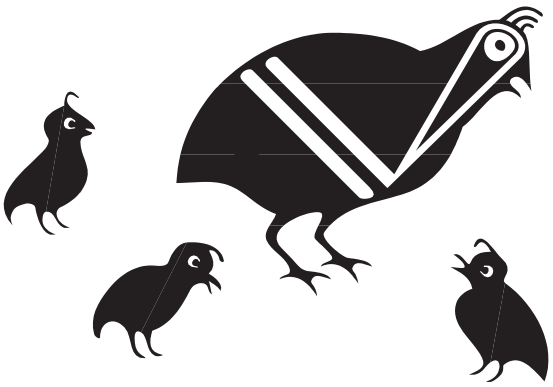
Overall, in FY 2002, the Indian Health Service reported on 32 of 40 indicators. Twenty-five of these 32 indicators were met. This performance report is submitted to the Department of Health and Human Services (DHHS) for review. The IHS did not meet several of the 2002 clinical performance indicators. In order to improve quality of care, ITU providers may want to especially focus on these unmet indicators:

- Childhood Immunization,
- Influenza Immunization,
- Pap Screening, and
- Public Health Nursing Home Visits

By examining your local results related to these and other GPRA indicators, ITU providers will be better able to determine where to concentrate local resources and efforts. For a complete list of IHS GPRA indicators, and for links to GPRA Plans and Performance Reports, go to *http://www.ihs.gov/NonMedicalPrograms/PlanningEvaluation/pe-gpra.asp.*

GPRA Tips

The following pages present a Site Self Evaluation and Facility Checklist. These forms are designed to give you feedback about your program's GPRA preparedness. The completed forms will give you an idea of the strengths and weaknesses of your program. □



Clinical Performance Improvement
Site Self Evaluation

Facility Name: _____

Evaluation completed by: _____ Date completed: _____

1. **Clinical Performance Improvement (CPI) Team (NOTE:** your facility may call this Team GPRA, Quality Assurance (QA), Quality Initiative (QI) or other similar terms)

   Has a CPI Team been identified in your facility? ☐ Yes ☐ No

   Has a Team leader been appointed? ☐ Yes ☐ No

   If you have a CPI Team, do they meet on a scheduled basis? ☐ Yes ☐ No

   Does your Team include a member from the following?:

Facility Director:	☐ Yes ☐ No	Medical Staff Director:	☐ Yes ☐ No
Nursing Supervisor:	☐ Yes ☐ No	Dental Director:	☐ Yes ☐ No
QA/QI Coordinator:	☐ Yes ☐ No	Immunization Coordinator:	☐ Yes ☐ No
Health Records Supervisor:	☐ Yes ☐ No	Computer Site Manager:	☐ Yes ☐ No
Lead Data Entry Operator:	☐ Yes ☐ No		

2. **Are the following RPMS applications currently in use?**

Immunization	☐ Yes ☐ No	Women's Health	☐ Yes ☐ No
Lab	☐ Yes ☐ No	Health Summary	☐ Yes ☐ No

3. **Are there procedures in place to determine if the patient is due for a pap, mammogram, cholesterol, or immunizations when they come to your facility?**

   Pre appointment chart reviews ☐ Yes ☐ No

   Triage review (Visit Planning) ☐ Yes ☐ No

   PCC health summaries (or some other form) are used to list the health maintenance needs of the patients ☐ Yes ☐ No

   Other (specify): _____ ☐ Yes ☐ No

For further information about Clinical Performance Indicators and GPRA+,
www.ihs.gov/CIO/gpraplus/

This form was adapted for use from the IHS California Area Office

4. Are documentation and filing procedures for the medical record standardized in your facility?

Cholesterol labs are filed in an identifiable lab section of your record	☐ Yes ☐ No
Mammograms are filed in an identifiable section of your record	☐ Yes ☐ No
All immunizations are documented in a standard location on the PCC form so that the PCC data entry staff can identify the procedure	☐ Yes ☐ No
Documentation procedures are in place when a patient refuses a recommended exam, test, or procedure	☐ Yes ☐ No

5. How does data flow through your facility?

Procedures have been established that outline how cholesterol tests and pap smear results get to the PCC data entry staff	☐ Yes ☐ No
Procedures have been established that outline how the facility obtains pap smear, mammogram, and/or immunization information when these procedures have been performed by an outside provider.	☐ Yes ☐ No
Pap Smear, mammogram, and/or immunization information received from outside providers is routed to PCC data entry staff	☐ Yes ☐ No
All procedures performed in your facility are routinely documented on the PCC form, in a standard location that has been agreed to by the provider staff and PCC data entry staff	☐ Yes ☐ No

6. Other

PCC data entry function is adequately staffed	☐ Yes ☐ No
PCC data entry is current	☐ Yes ☐ No
Preventive health services are marketed to your patients (i.e. health fairs, senior citizen luncheons, etc.	☐ Yes ☐ No

For further information about Clinical Performance Indicators and GPRA+,
www.ihs.gov/CIO/gpraplus/

This form was adapted for use from the IHS California Area Office

Improving Your Clinical Indicator Performance Results: Facility Checklist

Below are some suggestions to assist your site in improving its clinical indicator performance results. Check ✓ each activity that your site currently performs. If you checked 6 or fewer of these activities, consider incorporating at least 2 additional activities into your clinic's policies and procedures.

- ☐ Implement policies that assign specific staff responsibilities related to GPRA and other clinical performance objectives and to identify how data flows in your facility.
- ☐ Ensure that all staff responsible for documenting and entering data into your systems (paper and computer) are involved in a facility-wide clinical performance improvement effort.
- ☐ Monitor the work quality of the RPMS PCC and Patient Registration data entry staff.
- ☐ Utilize your Quality Improvement (QI) program to monitor clinical indicator performance.
- ☐ Establish standard locations in your health records to record information (e.g., mammogram results filed in radiology section, pap smear results in lab section).
- ☐ Establish standing orders for appropriate clinical performance indicators (e.g., immunizations).
- ☐ Screen health records prior to appointments to assess the patient's need for services.
- ☐ Consider the use of PCC overprints or PCC+ forms to remind providers which procedures are due.
- ☐ Utilize the RPMS Health Summary to assist in compliance with standards of care. The health maintenance reminders section of the health summary will list any deficient clinical procedures:

```
----------------------- HEALTH MAINTENANCE REMINDERS -----------------
                                        LAST          NEXT
BLOOD PRESSURE                        11/08/01       11/08/02
WEIGHT                                10/12/00      MAY BE DUE NOW
PAP SMEAR                             11/14/00       Routine PAP (by 8/31/2001)
BREAST EXAM                           01/15/97      WAS DUE  08/04/2001
BLOOD GLUCOSE                         02/26/01       02/26/03
CHOLESTEROL                           01/14/99       01/13/04
MAMMOGRAM                             08/04/00       WAS DUE  08/04/2001
PHYSICAL EXAM                         03/08/01       03/08/02
Td-ADULT                                            MAY BE DUE NOW
REVIEW OF TOBACCO USE                 11/08/01       11/08/02
```

- ☐ In addition to the Health Summary, utilize automated tracking systems that track patients who need certain services (e.g., RPMS Women's Health package, Asthma Register Management).
- ☐ Identify patterns of missed opportunities to provide needed screenings and/or procedures; then identify and implement needed changes to ensure all opportunities are used.
- ☐ Periodically create patient lists (with GPRA+ or QMan) to identify patients needing certain procedures (e.g., immunizations, pap smear, etc.) targeted by your site as underperforming indicators.

For further information about Clinical Performance Indicators and GPRA+, www.ihs.gov/CIO/gpraplus/

Based on materials developed by California Area Office

Preparing "Advanced CKD" Patients for Renal Replacement Therapy

This article is the eleventh of a series about chronic kidney disease and its management based on the new National Kidney Foundation guidelines. If you missed previous articles in this series, log onto the IHS website. Archived issues may be found from the Clinical Support Center's page.

Andrew S Narva, MD and Theresa Kuracina, RD, CDE, both of the IHS Kidney Disease Program, Albuquerque, New Mexico

The Renal Physicians Association recently published recommendations for "appropriate patient preparation for renal replacement therapy." This group is not part of the National Kidney Foundation Kidney Disease Quality Outcomes Initiative (K/DOQI) referenced throughout this series about chronic kidney disease (CKD). However, the guidelines can assist providers in continuing to improve the quality of care given to chronic kidney disease patients.

"Advanced CKD" is defined as patients with glomerular filtration rates less than 30 mL/min/1.73 m^2 — stages 4 or 5, not on renal replacement therapy (RRT). With recent updates in the IHS Lab Package, you can have the calculated GFR result at your fingertips. The latest patch includes the capability of calculating GFR whenever a serum creatinine is ordered (see article page 163). Patients with "advanced CKD" will be easily identifiable. Ask your site manager and Laboratory Supervisor when your site will implement this patch.

All recommendations listed in the table below relate to patients over 18 years of age with GFR < 30 mL/min/1.73 m^2.

Table 1. Appropriate Patient Preparation for Renal Replacement Therapy

Anemia	• Check hemoglobin (hgb) at least every 3 months • If hgb < 12 mg/dL for a woman or < 13 mg/dL for a man, complete anemia work-up and include iron studies • Treat any identified iron deficiency • If anemia persists despite appropriate evaluation and iron therapy, treat with erythropoietin (EPO) or analogue • Check blood pressure with each dose of EPO
Bone Disease	• Monitor for acidosis at least every 3 months • Treat serum bicarbonate level ≥ 22 mmol/L • Measure serum calcium and phosphorus at least every 3 months, and iPTH at least once. If serum calcium or phosphorus levels are abnormal, measure iPTH at least every 3 months • Place patient on low phosphorus diet (800 - 1000 mg/d) for a month if iPTH > 100 pg/mL (or 1.5 times the upper limit of normal for assay used) OR if serum phosphorus > 4.5 mg/dL. Re-evaluate phosphorus after one month and if still > 4.5 mg/dL start phosphate binding medication. Check iPTH every 3 months after starting phosphate binding medication whether phosphorus is controlled or not • If iPTH > 100 pg/mL (or 1.5 times the upper limit of normal for assay used), measure 25 (OH) vitamin D AND if 25 (OH) vitamin D is < 30 ng/mL treat with 50,000 units of vitamin D_2 orally every month for 6 months • If corrected serum calcium is < 8.5 mg/dL after phosphorus issues are addressed, treat with 1 g/d of elemental calcium between meals or at bedtime • If iPTH > 100 pg/mL (or 1.5 times the upper limit of normal for assay used) after 3 months of treatment, treat with oral active vitamin D (0.25 mcg/d of calcitriol or alfacalcitriol to a maximum of 0.5 mcg/d)

Hypertension	• Check blood pressure every clinic visit (visits should be at least every 3 months) • If blood pressure is elevated (> 130 mm Hg systolic OR 80 mm Hg diastolic) encourage and instruct on therapeutic lifestyle changes and intensify blood pressure therapy • Use an ACE inhibitor or an ARB as a first-line agent
Nutrition	• Monitor nutritional status by measuring weight and serum albumin every 3 months • If weight decreases unintentionally by > 5% or if albumin decreases > 0.3 g/dL or is < 4.0 g/dL (bromo-cresol-green assay) assess for causes. If due to CKD and not other causes, refer for diet assessment and counseling by qualified and experienced personnel • If no response to nutritional intervention in the absence of other causes of malnutrition, patient should begin RRT
Dyslipidemia	• Assess lipids (total cholesterol, LDL, HDL and TG) • If dyslipidemia, evaluate for secondary causes including comorbid conditions and certain medications • Treat LDL to < 100 mg/dL and non-HDL cholesterol to < 130 mg/dL; fasting TG ≥ 500 mg/dL should be treated
Timing	• Discuss RRT • There is no specific level of GFR that indicates need for RRT • If willing to consider transplant, refer for transplant evaluation unless unacceptable surgical risk or does not satisfy the Untied Network for Organ Sharing (UNOS) ethics Committee criteria • Preserve veins suitable for vascular access. No blood pressures or blood drawing on that arm. No PICC lines. • If hemodialysis is chosen, refer to surgery for primary AV fistula construction attempt
Counseling and Rehabilitation	• Counsel and encourage increased physical activity if not already physically active. Refer to physical therapy or cardiac rehabilitation if unable to walk or unable to increase fully mobile physical activity • Patient should receive structured education about preparation for RRT • Encourage to maintain employment and refer to vocational rehabilitation per their preference

By following these guidelines, patients will be better prepared physically and perhaps emotionally for renal replacement therapy.

Editor's Note: The following information may be of interest to the patients you care for, and so you may want to make copies available in your clinics.

Social Security Benefits and Indian Country

Kimberly Irwin, MBA (Rosebud Sioux), American Indian Public Affairs Specialist, Social Security Administration, San Francisco Region, Mesa, Arizona

Social security has benefits and programs those in Indian Country may or may not be accessing. We all may know about the retirement program Social Security administers, but in this article we will present information about a program people in your community might not know about.

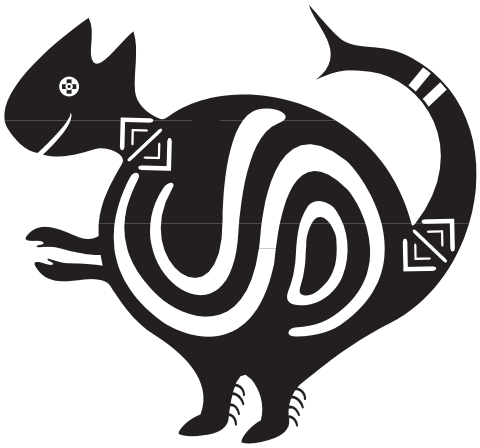
A program many elders benefit from is the Social Security Supplemental Security Income program, also known as "SSI." The SSI program makes payments to people who have a low income and few assets. To get SSI, you must be 65 years old or older, or disabled. If you think you might be eligible, contact a Social Security representative as soon as possible.

The reason it is important to do this as soon as possible is so you won't lose out on any benefits. In order to receive SSI benefits, you must first meet certain requirements established by Social Security. After you provide information to them, they will decide if you can receive benefits, and when those benefits start depends on when you filed your application.

If you receive SSI benefits and information about you changes, you must report this to Social Security. Your reporting responsibilities include contacting Social Security when your living arrangements change or if other changes is your household occur. You may be receiving Individual Indian Monies (IIMs) from the BIA, or maybe they haven't been administered. However, the first month you don't receive those IIMs, contact Social Security and let them know. There is a possibility your SSI dollars may be increased. Remember, if you qualify for SSI, there are reporting responsibilities required to stay on the program.

Social Security also pays benefits to people who have worked long enough under Social Security. Often, people can get both Social Security and SSI benefits. Social Security pays retirement benefits, disability benefits, and survivors benefits. Retirement benefits go mostly to people age 62 or older and their families. Disability benefits go to people with disabilities and their families. Survivors benefits are paid to the families of workers who have died. Your best bet is to contact your local Social Security office and provide them with the information they request to determine your eligibility for all of Social Security's programs.

Questions? Call (800) 772-1213 or access the website at *www.socialsecurity.gov*. You may also contact the author, Kimberly Irwin, at *kimberly.irwin@ssa.gov*; telephone (480) 649- 1430. □



"What Can the RPMS Lab Package Do for Me?"

Catherine Moore, MT, RPMS User Support Specialist, Information Technology Support Center, Albuquerque, New Mexico

Can the RPMS Lab Package have a positive impact on the clinical outcome of patients with chronic kidney disease? Yes!

An automated tool within the RPMS Lab Package allows you to calculate the estimated GFR every time a serum creatinine is ordered. It has been well documented that once GFR is estimated, the patient's kidney disease can be classified, and ultimately tracked over time (see the October 2002 *IHS Provider* article, "Chronic Kidney Disease: Definition and Classification"). Although the estimated GFR could be calculated by the provider each time a serum creatinine is performed, automatic calculation and display of the estimated GFR on the lab report by the RPMS Lab Package ensures that the provider would see the result every time a serum creatinine was performed, taking the burden off of the provider to perform the calculation. The ITSC Lab Team, in conjunction with Andrew S. Narva, MD, developed this tool.

The MDRD (Modification of Diet in Renal Disease) prediction equation, which utilizes the patient's serum creatinine, age, sex, and a standard factor, has been programmed into the Lab Package, making it possible for this estimated GFR to be calculated automatically every time a serum creatinine is performed. To use this automatic calculation, the latest Lab Package patch (#16), which was released to all sites on June 6, 2003, must be installed on your system. The Lab Manager or Lab Application Coordinator must attach the calculation to the serum creatinine test in the Lab Package. Once the patch is installed, instructions for setting up the automatic calculation are available from your site manager or the ITSC Help Desk by telephone at (888) 830-7280; e-mail *rpmshelp@mail.ihs.gov*.

If you have questions or need assistance, contact the Lab Team at (505) 248-4430 or 248-4347. □

Erratum

The information about one of the authors of the article "Art, Age, and Disability" (*The IHS Provider*, Volume 28, Number 5, page 111) was given incorrectly. We apologize to the author and our readers.

The correct information is as follows:
Marie Mitchell, MA, Professor Emeritus of Linguistics and English, Maricopa Community College District

ITSC Releases RPMS Asthma Register System Software

Linza S. Bethea, DataCom Sciences, Inc., IHS Information Technology Support Center (ITSC), Tucson, Arizona

Asthma is a growing health concern. Many of the problems caused by asthma could be mitigated if patients with asthma and their health care providers managed the disease according to established guidelines.[1]

The Asthma Register System (ARS) of the IHS Resource and Patient Management System (RPMS) gives Indian Health Service/tribal/urban program (I/T/U) health care providers another tool for improving the care and management of patients with asthma. The ARS was released for IHS-wide use in March 2003.

The ARS can be used in two ways:

- As a register of patients who can be actively managed for sites with one or more Asthma Case Managers.
- To capture asthma-related patient data and provide appropriate health care reminders to providers.

The development of the Asthma Register System for RPMS resulted from a quality improvement effort in FY 2001 involving nine northwestern tribal clinics, the Childhood Asthma Study team at the University of Washington, the Boston-based National Initiative for Children's Healthcare Quality (NICHQ) and the Indian Health Service. This effort was focused on improving asthma care for pediatric patients at the participating practice sites.

During this project, it became apparent that there was a need for an easy-to-use patient tracking system. Active case management, follow-up visits for asthma patients, and appropriate utilization of medications are essential for effective disease management. Providers, as well as asthmatic patients themselves, must monitor symptoms and comorbidities quickly and appropriately adjust dosages and manage possible side effects.

The RPMS ARS consists of a register with associated reports and forms for patient management, a PCC Data entry mnemonic for capturing asthma-related data items from the PCC form, a health summary supplement, and asthma-specific health summary maintenance reminders. The Register can be autopopulated when a site begins using it, reviewing all of a facility's patients in RPMS and selecting those based on specific diagnoses and on user-defined criteria. The Register can also be set up to add new patients automatically when certain criteria are met.

The following asthma-related data items are captured on a pre-printed PCC form and entered into RPMS PCC through the PCC Data Entry process:

- Severity Of Asthma
- FEV_1
- FEF_{25-75}
- PEF/Best PF
- ETS
- Particulate Matter
- Dust Mite
- Asthma Management plan

These supplemental items are stored in the Patient Care Component (PCC) database. These data values can be captured each time a patient is seen in Asthma clinic. These values are then used in various reports to identify patients who need to have their medications reviewed and/or modified, an asthma visit scheduled, or other activities specific to treatment of their asthma.

Five health care reminders are included in the ARS, based on detailed logic that searches diagnoses, medications, and other PCC data:

- Add or increase inhaled corticosteroids
- Making or reviewing an asthma management plan
- Classifying a patient's asthma severity
- Flu shot reminder
- Assigning a primary care provider

For additional information about this software, including the User Manual, and other new RPMS clinical applications, visit *www.ihs.gov/cio/ca*, and/or ask your Site Manager whether the software has been loaded at your facility. □

Reference

1. US Department of Health and Human Services. *Healthy People 2010*. International Medical Publishing, Inc,November 2000. Chapter 24.

Leadership and Development: Personal Reflection on the ELDP

Sharon Miller, RN, Clinical Nurse, Warm Springs, Oregon

When the topics of management and leadership are discussed the dialogue generally centers on the appointed leaders of an organization: the Chief Executive Officers, the Directors of Nursing, the Clinical Directors, departmental supervisors, etc. In these positions, supervision of employees, time and attendance issues, budgetary management, equipment and supply issues, and managing day-to-day problems are responsibilities that come to mind.

The Executive Leadership Development Program (ELDP) training covers all of the above subjects, but adds a greater depth to the widely accepted notions about the nature of management and leadership. The roles of leadership extend beyond the management activities. Leaders are not necessarily people in appointed management positions. Leaders are people who "make a difference through and with others."[1]

There is an inherent responsibility assumed by participants in the ELDP training. They must be willing to take their newly obtained knowledge and put it into practice in their work setting. They cannot wait for a title or a position but must look for opportunities to offer improvement; They must be a change agent, a catalyst, a cheerleader. That can come from any individual employee.

My role in the Ambulatory Care Department is primarily as a clinical nurse; however, my supervisor provided opportunities for me to put into practice many of the skills and ideas we learned at ELDP.

The management of clinic flow and staff assignments provided numerous chances to incorporate relationship-building, improvement of communication, and develop of a team approach to work, and to begin building a "culture where an appreciation for good service exists and giving good service to both external and internal customers is considered a natural way of life."[2]

We are going through a clinic redesign process and have implemented PCC+, computerized lab ordering, and a paperless appointment system. My roles included being a member of the team instituting the changes, and ensuring that medical and nursing staff are able to participate in changes. This translates into finding coverage so all staff can attend committee meetings on a consistent basis. This is often very inconvenient, but staff participation is critical to successful change.

In January 2003, our Ambulatory Care Supervisor retired and I was appointed Acting Supervisor of Ambulatory Care, which added another dimension to my role in the clinic. The title comes with formal authority to initiate certain changes. It has been a learning process, a great challenge, and a love/hate relationship; I am very grateful for the ELDP training experience. I only wished all of my classmates were here because they provided an incredible amount of positive energy, support, encouragement, laughter, and a great source of knowledge.

Kristopher A. Weatherly, PhD talked to us about the qualities leaders develop – courage, integrity, wisdom, authenticity, and love. I occasionally go through my ELDP notebooks, and this section was one that gave me the impetus to keep trying, to be persistent when faced with resistance during the many changes we have been going through in the clinic. L. Lee Manzer, PhD provided practical applications that I'll incorporate as we move through our clinic redesign process. Thank you to each and every participant, the presenters, the schools, and to Elaine, Wes, Kitty, and Danielle. □

[1] Kristopher A. Weatherly, PhD, Eller College of Business and Public Administration, University of Arizona, Tucson, Arizona

[2] L. Lee Manzer, BA, MBA, PhD, Oklahoma State University

An Annual Editorial Calendar for *The Provider*

The following annual editorial calendar has been prepared by the IHS Headquarters Public Affairs Staff to encourage the coordination of communication efforts with the rest of the Department of Health and Human Services. By promoting these health focus areas, we hope to encourage potential authors to submit relevant articles for submission to *The Provider* and to highlight media awareness efforts by various agency public affairs activities.

Each month has a designated health focus area that has been selected in line with departmental/national activities and focus areas for that month, thereby helping to coordinate our agency messages. By providing a timely approach to health care reporting, we hope to increase awareness of Indian health issues and enhance respect for *The Provider* as a relevant, topical health care publication. The prototype for this effort, of course, is the annual Elders Issue, now in its eighth year, which is published in conjunction with National Older Americans Month.

It may take time to establish these themes, and we will not unduly delay publication of articles in order to place them in a later issue, but we do encourage you to consider this schedule and look ahead to see what is coming up and how you might want to contribute. Remember that it takes considerable time to get an article ready for publication, so you will want to plan far enough in advance. □

IHS Annual Editorial Calendar

Month	Main Focus Area
January	Mental Health
February	Cardiovascular Disease
March	Nutrition
April	Environmental Quality
May	Elder Care
June	Injury
July	Behavioral Health
August	Immunization
September	Substance Abuse
October	Domestic Violence
November	Diabetes
December	AIDS

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THE IHS PRIMARY CARE PROVIDER

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

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Opinions expressed in articles are those of the authors and do not necessarily reflect those of the Indian Health Service or the Editors.

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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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