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

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

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

The Nature of Anxiety

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

It should be noted that these three channels of response to

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

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

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

Prevalence of Anxiety Disorders

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

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

Epidemiologic data indicate that anxiety disorders are the second most common psychological disorder across the life span, second only to alcohol and drug abuse. Research that has assessed the rate of anxiety disorders in the month prior to evaluation, however, has shown that these problems evidence the highest prevalence of any class of psychological dysfunction[6]. Although the specific prevalence rate for any given anxiety disorder may vary depending on the study, existing literature suggests the one year prevalence rate for all anxiety disorders ranges from 4 to 8%[1]. Because anxiety disorders are often associated with alcohol abuse/dependence and depression, it is also necessary to consider the possibility of these other conditions when assessing anxiety-related problems in American Indians and Alaska Natives. Similarly, clinicians should consider that an anxiety disorder may be a comorbid, secondary condition, even when a patient's principal diagnosis is alcohol abuse/dependence or depression.

It is not uncommon for persons with anxiety disorders to drink excessive amounts of alcohol in order to avoid feeling "anxious" or "worried." Such alcohol abuse is often referred to as "self-medication" and may contribute to alcoholism in American Indians and Alaska Natives[2]. Similar to anxiety disorders, alcohol abuse is associated with poor physical and mental health and a decreased quality life; it may also ultimately prevent an individual from recognizing that he or she has an anxiety problem. As a result, a person with an anxiety disorder who abuses alcohol may be less likely to receive appropriate psychological care.

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

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

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

Assessment

The assessment of fear and anxiety in American Indians and Alaska Natives is only beginning to garner scientific attention. Although numerous anxiety and fear assessment tools exist, such as self-report instruments and structured interviews, the vast majority of these have been developed and tested using only Caucasian populations. The lack of research on American Indians and Alaska Natives may further contribute to this reliance on Caucasian samples to validate assessment instruments. Nonetheless, the potential biases arising from the content and language of Caucasian-based assessments may result in their poor predictive and construct validity in American Indian and Alaska Native peoples[11]. In fact, there is a growing recognition that cultural influences require special consideration in the development, administration, and interpretation of any assessment tools[12]. There is evidence, for instance, that the clinical presentation of certain psychological dysfunctions in American Indians and Alaska Natives may not "match" the clinical presentation of the same conditions in Caucasian samples. For example, behaviors such as social isolation, or impassive or sad facial expressions may signal problems with depression in Caucasian individuals, whereas the same actions in an certain American Indian or Alaska Native persons might instead be associated with specific social roles[2].

With over 500 American Indian and Alaska Native groups, gathering accurate information regarding the presentation of psychological problems in American Indian and Alaska Native peoples is a difficult task. For instance, intertribal differences in the degree of acculturation and cultural involvement contribute to heterogeneity among Americans Indians and Alaska Natives, and may result in unique manifestations of psychological problems. Patterns of cultural differentiation among ethnic groups are apparent in regard to the pathological manifestations of anxiety. There are reports, for example, that decades of cultural trauma have led to an intergenerational Post Traumatic Stress Disorder in American Indians and Alaska Natives that involves anxiety reactions in response to environmental stimuli that have threatened one's life, safety, or personal integrity[14]. American Indians and Alaska Natives may also experience anxiety about the conflict between integrating into the majority culture and retaining strong tribal ties[15], or performing in a primarily Caucasian educational system in academic subjects as mathematics[16].

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

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

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

Treatment

Although it is clear that they are in need of the same effective mental health services as the majority population, American Indian and Alaska Native peoples are seriously underserved [1] and have historically underutilized what mental health care there is available[9]. There are a number of factors that likely contribute to this underutilization, such as a lack of American Indian and Alaska Native mental health providers, inattention to American Indian and Alaska Native treatment issues by service providers, as well as limited financial resources of persons in need of care[15]. Because the American Indian and Alaska Native population is steadily increasing[4], this treatment gap will likely widen unless appropriate actions are taken to better educate mental health professionals to more effectively work with American Indian and Alaska Native peoples[21].

There are many effective psychological treatments for anxiety disorders as recognized by the DSM-IV. In fact, there are standardized protocols for these treatments available for practitioners[22]. Additionally, treatment manuals that contain brief assessment measures, strategies for targeting problem behaviors, and effective techniques aimed at reducing anxiety-related problems are currently available to practitioners and consumers alike[23]. There is also evidence that pharmacological agents can be used successfully to alleviate many symptoms of anxiety disorders[24]. Similar to assessment instruments, however, both psychological and pharmacological[25] treatments for anxiety disorders have predominately been tested on Caucasian populations, leaving unclear their efficacy for American Indians and Alaska Natives. It will be valuable for future researchers to test treatment effectiveness specifically for American Indian and Alaska Native populations. There is good reason to suspect that behavioral and cognitive-behavioral approaches will be successful with American Indian and Alaska Natives[3], much like in the majority culture, because they involve assessing how the *individual* functions in his or her personal environment, and then focus on strategies to promote positive behavior changes in a *situation-specific* manner. Nonetheless, all interventions for psychological problems in American Indians and Alaska Natives should be delivered in a culturally-sensitive fashion and tailored to individuals, considering the context(s) in which they live (e.g., their family and tribal group).

There are a number of additional reasons for culturally-sensitive therapeutic efforts for Americans Indians and Alaska Natives with psychological problems in general, and anxiety-related problems in particular. Research suggests that insensitivity to tribal needs, mistrust, and the imposition of Western ideals on psychological problems may contribute to why American Indians and Alaska Natives so often reject conventional psychological services[11]. Cultural awareness is also critical in the verbal and non-verbal communication that is necessary for efficient progress in therapy, as well as for establishing and maintaining trust with the American Indian and Alaska Native client[26]. In particular, mental health practitioners need to be aware of cultural issues such as the type of role an American Indian and Alaska Native patient will be apt to take in psychological treatment. For example, some American Indians and Alaska Natives may prefer to take more of a passive role in therapy, whereas many forms of Western-based psychological services attempt to encourage the client to take an active role[5]. Similarly, an understanding of individual, family, and tribal history and lore will help to insure accurate assessment and the most ideal treatment strategies. For instance, with a bilingual client, a clinician may want to discuss whether the client wishes to use his or her own tribal language or English (or both) in utilizing cognitive strategies such as coping self-statements. Additionally, culturally-relevant information may benefit mental health professionals in understanding that some American Indians and Alaska Natives may avoid directly speaking of a problem with anxiety[26], expecting the clinician to accurately infer the difficulty from subtle cues or indirectly related stories. Overall, by taking culturally-related information into consideration with American Indian or Alaska Native patients, the practitioner will be better able to find a mutually appropriate interpersonal communication strategy and to discuss therapy issues, thereby helping to insure treatment will be the most beneficial.

An understanding of and respect for the American Indian and Alaska Native peoples' history and current concerns may also help in establishing therapeutic rapport, and therefore increase treatment efficacy[8]. Specifically, cultural sensitivity may help practitioners to apply treatment modalities that are in accord with the American Indian or Alaska Native clients' world view, thereby enhancing the possibility that psychological services rendered will be viewed as credible[12]. For example, by being aware of particular American Indian and Alaska Native beliefs about the origins of their anxiety problem, it may be possible to incorporate those beliefs in a manner beneficial to treatment. In a similar vein, familiarity with tribal-traditional practices may facilitate non-Indian practitioners con-

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

Summary

Anxiety disorders represent a serious mental health problem for American Indians and Alaska Natives[1]. There is nearly an absence of scientific information available, however, regarding anxiety disorders in American Indians and Alaska Natives in general[2], and specifically the culturally unique manifestations of anxiety in this population[28]. We have attempted to highlight the nature of anxiety and present an overview of what is currently known about anxiety problems in American Indian and Alaska Native peoples. It is clearly an important and timely matter to better equip health care providers to effectively deal with this class of psychological disorders. The authors hope the information provided in this article will help inform health professionals working with American Indian and Alaska Native people about these mental/behavioral health problems in these people. In this way, it will be more likely that research will be conducted to better understand anxiety disorders in this population. Moreover, it is hoped that this information will assist practitioners in sensitively and effectively identifying and treating anxiety problems in American Indians and Alaska Natives. □

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

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

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

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

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

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

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

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

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

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

Phoenix Performance Evaluation System Accepted by JCAHO

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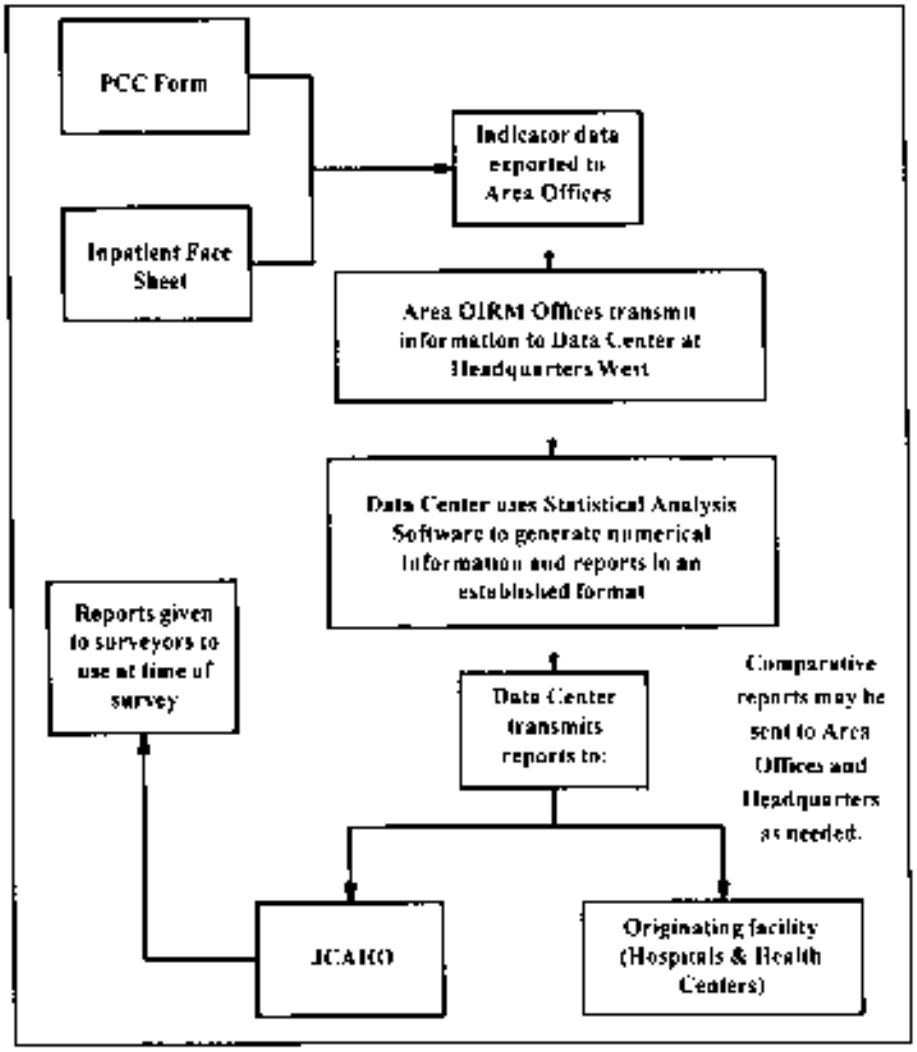
On November 12, 1997 the Phoenix Area Indian Health Service Quality Management Office received notification from the Joint Commission on Accreditation of Health Care Organizations (JCAHO) that the Phoenix Performance Evaluation System will be included on the list of systems that may be selected by health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

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

How the System Works

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

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



Small Hospital Performance Measurement Requirements

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

What are the actual indicators?

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

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

Should a facility select the Phoenix Performance Measurement System and find that it is not comfortable with the cost or other elements of the system, they have the option to change their selection to any of the other more than 100 JCAHO approved performance evaluation systems any time until June 30, 1998.

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

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

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

Table 1. Small hospital Performance Measurement Requirements.

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

Table 2. Ambulatory Care Indicators.

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

*Note: These indicators have not been approved by JCAHO

Table 3. Inpatient Care Indicators.

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

*Note: These indicators have not been approved by JCAHO

IHS Pharmacy Intranet Operational

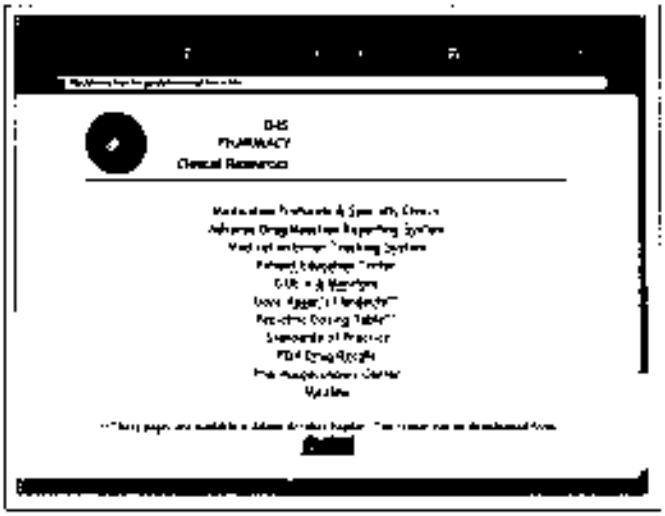
Samuel M. Hope, RPh, MS, Oklahoma City Area Pharmacy Officer and Acting Director, IHS Pharmacy Services, Oklahoma City, Oklahoma

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

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

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

Pharmacists should visit the site often in order to enhance patient care activities and to network with other pharmacists in the IHS. Contributions are strongly encouraged to enhance information sharing and communication among Indian health program pharmacists. For more information, you may contact Carolyn Johnson, RPh, at the Taos-Picuris Indian Health Center; her e-mail address is *cyj@albtan.albuquerque.ihs.gov*. □



MEETINGS OF INTEREST □

Sharing Solutions in a Changing Indian Health Care Environment: The 1998 Meeting of the National Councils
January 5-8, 1998 Phoenix, Arizona

The National Councils (Clinical Directors, Service Unit Directors, Chief Medical Officers, and Nurse Consultants) of the Indian Health Service will hold their 1998 annual meeting January 5-8, 1998 in Phoenix, Arizona. This year's theme is *"Sharing Solutions in a Changing Indian Health Care Environment."* An exciting and informative program is planned to address Indian Health Service/Tribal/Urban program issues and other solutions to common concerns throughout Indian country. Indian Health Program Chief Executive Officers and Clinicoadministrators are invited to attend. The meeting site is the Hyatt Regency Phoenix at Civic Plaza, 122 North Second Street, Phoenix, Arizona. The Clinical Support Center (CSC) is the accredited sponsor of this meeting. Please contact Gigi Holmes at (602) 640-2140 for more information or to request a registration packet. Alternatively, you may use the CSC 24-hour Fax Retrieval Service by calling 602-640-2140 choosing "8," and then selecting document number 4001.

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