

THE IHS PRIMARY CARE PROVIDER



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

September 1997

Published by the IHS Clinical Support Center

Volume 22, Number 9

The Accreditation Association for Ambulatory Health Care: An Option for Ambulatory Health Centers

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Introduction

In February 1997, the Chemawa Indian Health Center of the Western Oregon Service Unit became the first facility in the Indian Health Service to be accredited by the Accreditation Association for Ambulatory Health Care (AAAHC). Achievement of accreditation by the AAAHC was a result of many months of work in evaluating various accrediting organizations and, then, requesting a special exception from the Indian Health Service (IHS) to seek an alternative method of accreditation other than the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

This is not the first time that the Chemawa Indian Health Center has blazed the trail for Ambulatory Health Centers in the IHS. Chemawa was one of the first Ambulatory Health Centers in the IHS to be accredited by the JCAHO. This accreditation occurred 16 years ago, in 1981, and we have remained JCAHO-accredited since. Following our last JCAHO survey in 1993, we were awarded accreditation with commendation.

Why Seek Alternative Accreditation?

Since the 1993 JCAHO survey, many of our staff questioned the need to continue to be accredited by JCAHO. We felt that the JCAHO (which is primarily hospital-based in focus) really did not meet our needs as an ambulatory health center, and that there must be a more appropriate accrediting

body that focused on ambulatory care rather than hospital care. Additionally, we were looking for an organization that had "deemed status" from the Health Care Financing Administration, which is a requirement of IHS.* Concurrently, Service Unit Directors in the Portland Area were expressing concern about the burden, both financial and workload, placed upon their health care programs by the JCAHO accreditation process. They were seeing JCAHO accreditation becoming more expensive (most ambulatory surveys cost in the neighborhood of \$10,000) and increasingly more complex with

* The "deemed status" of an accrediting organization allows entities that it accredits to collect Medicare reimbursement

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regard to documentation requirements that placed a heavy burden on their health care providers. This was occurring despite the fact that the JCAHO accreditation process had established a separate ambulatory component.

In late 1995, the Chemawa Indian Health Center asked the Area Director, Portland Area IHS, for permission to explore alternatives to JCAHO, with the understanding that we would continue to maintain some type of nationally recognized accreditation to assure both ourselves and our patients that we truly do provide high quality health care. We researched a number of possible accreditation services, and selected the Accreditation Association for Ambulatory Health Care (AAAHC). At the same time, the Portland Area Chief Medical Officer was working at the IHS Headquarters level to get the IHS regulations modified to formally allow this.

In January 1996, the Portland Area Director approved the Western Oregon Service Unit to be a pilot project and undergo an AAAHC survey, stating that there would then be evaluation of the process and outcome of that survey before other service units in the Portland Area might be allowed to pursue similar accreditation. Over several months, the Western Oregon Service Unit proceeded with preparation for such a survey and contacted the AAAHC to arrange the details of the survey process. The Application for Accreditation, Presurvey Questionnaire, and supporting documents were submitted to AAAHC in September 1996. In October, AAAHC contacted the service unit with the scheduled dates of the survey, and the service unit was surveyed on February 3 and 4, 1997.

What is the AAAHC?

The Accreditation Association for Ambulatory Health Care is a private, not-for-profit organization that was formed in 1979 to assist ambulatory health care organizations in improving the quality of care they provide to their patients. It accomplishes this by setting standards, which are similar to JCAHO standards, measuring performance, providing consultation and education where needed, and, ultimately, by awarding accreditation to those organizations that are found to be in compliance with its standards. AAAHC surveyors are clinical health care professionals who practice in settings similar to those that the AAAHC surveys. All surveyors are volunteers, serving without pay because they believe in promoting high quality ambulatory health care. They conduct an on-site survey, and the results, with the facility self-assessment, are sent to the AAAHC board which renders the final decision. This board is appointed by 13 of the nation's leading health care associations (see Table 1). Accreditation may be awarded for either one or three years, depending on the level of compliance with the standards.

Table 1. Organizations that appoint members to the AAAHC Board of Directors.

- Medical Group Management Association
- Federated Ambulatory Surgery Association
- American College Health Association
- National Association of Community Health Centers
- Outpatient Ophthalmic Surgery Society
- American Academy of Facial Plastic and Reconstructive Surgery
- American Society of Outpatient Surgeons
- American College of Occupational and Environmental Medicine
- American Academy of Dental Group Practice
- American Association of Oral and Maxillofacial Surgeons
- American Academy of Cosmetic Surgery
- Associations of Freestanding Radiation Oncology Centers
- American Society for Dermatologic Surgery.

The Standards

AAAHC has 8 Core Standards and 14 Adjunct Standards. The titles of the standards (see Table 2) are very similar to the 1992 Joint Commission Standards for Ambulatory Health Care. The core standards are a requirement that every ambulatory health center must meet. These standards are more general than those of the JCAHO, and AAAHC does not specifically tell the organization being accredited what they have to do to meet these standards. For example, AAAHC requires the organization to be able to show how it meets the standard, not what type of activity to do to meet it. The adjunct standards refer only to specific services for unique ambulatory care environments, such as dental, pharmacy, laboratory, or surgical services. Thus, a health center only has to prepare for the specific services they provide. This philosophy of how to comply with the standards is the main difference between AAAHC and JCAHO.

Findings

The following are some of the important lessons from both the preparation process and the survey itself at our service unit:

- The costs of our AAAHC survey were \$375 for the application fee and \$3,825 for the survey fee. An additional cost that we incurred was a separate survey of our laboratory by a laboratory accreditation organization, for a fee of \$1200. For this we used the Commission on Laboratory Accreditation (COLA), and that survey was conducted separately about a month after our AAAHC survey. This was necessary because AAAHC does not have deemed status for the Clinical Laboratory Improvement Act (CLIA).
- The standards of the AAAHC and the JCAHO are nearly identical. Our process of preparing for the survey, though,

Table 2. The AAAHC standards.

Core Standards	Adjunct Standards
<ul style="list-style-type: none"> • Rights of Patients • Governance • Administration • Quality of Care Provided • Quality Management and Improvement • Clinical Records • Professional Improvement • Facilities and Environment • Diagnostic Imaging Services • Radiation Oncology Treatment Services • Occupational Health Services • Other Professional and Technical Services • Teaching and Publication Activities • Research Activities 	<ul style="list-style-type: none"> • Anesthesia Services • Surgical Services • Overnight Care and Services • Dental Services • Emergency Services • Immediate/Urgent Care Services • Pharmaceutical Services • Pathology and Medical Laboratory Services

was not as intensive as it had been previously when preparing for a JCAHO survey. The AAAHC preparation did include a review of our policies and procedures, updating of manuals and minutes, assigning individual staff members to review our compliance with the chapters in their field of expertise, and, of course, the apprehension and near panic that immediately precedes an important survey such as this.

- The primary difference between AAAHC and JCAHO seemed to us to be a difference in philosophy: a difference in the way that the standards are looked at and evaluated. The JCAHO has always used the philosophy that “if it’s not documented in writing, we assume it didn’t happen, and the standard is not met.” AAAHC’s philosophy is that “if you can explain to us how you meet the standard and show us that you do meet it, you are in compliance with the standard.” They state, appropriately, that a small ambulatory health program should not be held to the same documentation standards as a large hospital.
- The actual survey went very well and we were pleased with both the more relaxed process of the AAAHC survey and the helpfulness of the AAAHC surveyor. (Even though more relaxed, however, we felt he was very thor-

ough and complete in his review of all areas.) At the closeout, he complimented us on the quality of our program and stated that he found no substantial problems.

- We received the final report in 8 weeks, and it was more thorough than that done in the past by the JCAHO. We received a bound report of all of the surveyors’ comments and the rating we received from the committee. We did not have any areas of noncompliance. If there had been areas of non-compliance, the AAAHC does not require the organization to respond in writing. They do expect that these areas will be corrected before the next survey.

Recommendations

We felt that our pilot project was very successful and were pleased with the process and outcome of the AAAHC survey. Quality was not compromised with AAAHC, but rather we feel it was enhanced. The AAAHC gives more freedom to improve quality and has less tendency to require a specific activity be measured to fulfill a standard. We would recommend that all Ambulatory Health Centers in Indian Country consider this organization prior to preparing for their next accreditation survey. □

Injuries and the Ten Leading Causes of Death for Native Americans in the U.S.: Opportunities for Prevention

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Introduction

Identifying the leading causes of death for American Indians and Alaska Natives (also referred to in this article as Native Americans) by age-group and sex is one way to help prioritize public health needs and to determine the main causes of premature mortality. To study the effect of injuries among Native Americans and to demonstrate the need for prevention programs, the authors have highlighted the unintentional injury- and violence-related causes of death, by age group, for Native Americans for the years 1992-1994. These data should also prove useful for identifying other important causes of death among Native Americans.

Methods

These data are from Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS) and include all deaths of American Indians and Alaska Natives who resided in the United States during 1992-1994. In a few instances for the tenth leading cause of death, there were ties among two or more causes, and such instances are footnoted. The standard cause-of-death groupings used by the NCHS from the International Classification of Diseases, 9th Revision (ICD9) were used to define the causes of death, except that alcohol abuse (ICD9 code 305.0, *nondependent alcohol abuse*^{*}) was separated from *alcoholism*. We used the

* Nondependent alcohol abuse includes drunkenness not otherwise specified (NOS), excessive drinking of alcohol NOS, alcohol "hangover," and inebriety NOS.

† Deaths due to alcoholism include alcoholic psychoses, alcohol dependence syndrome, alcoholic cardiomyopathy, alcoholic gastritis, alcoholic fatty liver, acute alcoholic hepatitis, alcoholic cirrhosis of the liver, unspecified alcoholic liver damage, excessive blood level of alcohol, and accidental poisoning by alcohol.

following ICD9 codes to define deaths due to *alcoholism*: 291, 303, 425.5, 535.3, 571.0-571.3, 790.3, and E860.[†]

Because motor vehicle crashes are such a significant primary cause of death, the authors have identified their impact separately from the rest of the unintentional injury category. The category *other unintentional injury* includes all deaths due to unintentional injury except those that are related to motor vehicle crashes.

Key Findings

Figures 1 through 3 show the ten leading causes of death in American Indians and Alaska Natives during the years 1992 through 1994, by age group, and by sex. Key findings include:

- Unintentional injury, of which motor vehicle-related injury is the greatest contributor, is the leading cause of death for Native Americans age 1-44 years.
- The number of American Indian and Alaska Native youth and young adults age 15-24 years who were killed by injuries and violence is 10 times greater than the combined number who died of the next six leading causes.
- When combined, unintentional injury (including injury due to motor vehicle crashes), homicide, and suicide are the leading cause of death among males, and the second leading cause among both sexes combined. Unintentional injuries are the third leading cause of death among females.
- Suicide outranks homicide as a cause of death, especially among males.
- Over four times more Native American men than women died from suicide.
- Over a third (37.3%) of all suicides occurred before the age of 25.
- More Native American men died of injuries related to motor vehicle crashes, other unintentional injuries, suicides, and homicides than from heart disease or cancer.

Discussion

American Indians and Alaska Natives are at risk for injury-related death for several reasons. First, on average this

Figure 1. Ten leading causes of death in American Indians and Alaska Natives, by age group, 1992-1994.*

RANK	AGE GROUPS										Total
	>1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	≥65	
1	SIDS 258	Other Unint. Injury 94	Other Unint. Injury 45	Motor Vehicle 49	Motor Vehicle 563	Motor Vehicle 495	Alcoholism 421	Heart Disease 676	Heart Disease 1,123	Heart Disease 4,229	Heart Disease 6,454
2	Congenital Anomalies 247	Motor Vehicle 77	Motor Vehicle 39	Other Unint. Injury 45	Suicide 272	Other Unint. Injury 360	Motor Vehicle 329	Malignant Neoplasms 529	Malignant Neoplasms 992	Malignant Neoplasms 2,558	Malignant Neoplasms 4,471
3	Prem./Resp. Distress Synd. 92	Homicide 31	Malignant Neoplasms 15	Homicide 22	Homicide 189	Suicide 238	Heart Disease 271	Alcoholism 385	Diabetes 361	Cerebro-vascular 945	Motor Vehicle 2,002
4	Other Unint. Injury 43	Congenital Anomalies 30	Heart Disease 8	Suicide 21	Other Unint. Injury 185	Homicide 215	Other Unint. Injury 268	Motor Vehicle 188	Alcoholism 230	Diabetes 765	Other Unint. Injury 1,627
5	Pneumonia & Influenza 42	Pneumonia & Influenza 15	Congenital Anomalies 7	Malignant Neoplasms 17	Malignant Neoplasms 34	Alcoholism 164	Malignant Neoplasms 220	Other Unint. Injury 178	Cerebro-vascular 178	Pneumonia & Influenza 709	Alcoholism 1,381
6	Placenta Cord Membranes 36	Malignant Neoplasms 13	Homicide 5	Congenital Anomalies 7	Alcoholism 24	HIV 124	Homicide 147	Diabetes 169	Other Unint. Injury 140	Bronchitis Emphysema Asthma 585	Diabetes 1,354
7	Maternal Complications 25	Heart Disease 12	Pneumonia & Influenza 4	Heart Disease 3	Heart Disease 24	Malignant Neoplasms 88	Suicide 144	Liver Disease 78	Motor Vehicle 137	Other Unint. Injury 266	Cerebro-vascular 1,286
8	Perinatal Infections 22	Meningitis 6	Meningitis 3	Pneumonia & Influenza 3	Congenital Anomalies 13	Heart Disease 80	HIV 100	Cerebro-vascular 76	Bronchitis Emphysema Asthma 135	Nephritis 253	Pneumonia & Influenza 1,021
9	Homicide 21	Bronchitis Emphysema Asthma 4	Septicemia 3	HIV 2	Alcohol Abuse 12	Alcohol Abuse 35	Liver Disease 70	Suicide 61	Liver Disease 93	Alcoholism 157	Suicide 784
10	Intrauterine Hypoxia 20	Cerebro-vascular 3†	Benign Neoplasms 1†	Septicemia 2	Pneumonia & Influenza 9	Pneumonia & Influenza 30	Pneumonia & Influenza 66	Homicide 53†	Pneumonia & Influenza 90	Septicemia 150	Bronchitis Emphysema Asthma 783

Source: NCHS Mortality Tapes, 1992-1994. Includes all American Indians and Alaska Natives in the United States.

* Motor vehicle fatalities separated from other unintentional injury category. Number of deaths during the 3 year period for each cause is shown in the appropriate box.

† Tied with at least one other cause of death category.

Figure 2. Ten leading causes of death in American Indian and Alaska Native females, by age group, 1992-1994.*

RANK	AGE GROUPS										Total
	>1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	≥65	
1	Congenital Anomalies 124	Other Unint. Injury 36	Motor Vehicle 21	Motor Vehicle 18	Motor Vehicle 172	Motor Vehicle 152	Alcoholism 164	Malignant Neoplasms 279	Malignant Neoplasms 451	Heart Disease 2,052	Heart Disease 2,713
2	SIDS 101	Motor Vehicle 34	Other Unint. Injury 13	Other Unint. Injury 11	Suicide 44	Alcoholism 73	Malignant Neoplasms 126	Heart Disease 161	Heart Disease 382	Malignant Neoplasms 1,228	Malignant Neoplasms 2,138
3	Prem./Resp. Distress Synd. 36	Congenital Anomalies 15	Malignant Neoplasms 7	Suicide 8	Other Unint. Injury 37	Other Unint. Injury 60	Motor Vehicle 92	Alcoholism 139	Diabetes 203	Cerebro-vascular 551	Diabetes 795
4	Other Unint. Injury 19	Homicide 14	Congenital Anomalies 3	Malignant Neoplasms 7	Homicide 30	Homicide 53	Heart Disease 68	Diabetes 83	Cerebro-vascular 87	Diabetes 484	Cerebro-vascular 716
5	Placenta Cord Membranes 17	Malignant Neoplasms 8	Homicide 3	Congenital Anomalies 5	Malignant Neoplasms 16	Malignant Neoplasms 44	Other Unint. Injury 48	Motor Vehicle 59	Alcoholism 83	Pneumonia & Influenza 359	Motor Vehicle 644
6	Pneumonia & Influenza 16	Pneumonia & Influenza 8	Benign Neoplasms 1	Homicide 2	Heart Disease 6	Suicide 38	Homicide 36	Cerebro-vascular 40	Bronchitis Emphysema Asthma 67	Bronchitis Emphysema Asthma 271	Alcoholism 517
7	Maternal Complications 10	Heart Disease 3	Heart Disease 1	Pneumonia & Influenza 2	Congenital Anomalies 5	Heart Disease 26	Liver Disease 34	Other Unint. Injury 35	Liver Disease 49	Nephritis 143	Pneumonia & Influenza 475
8	Homicide 9	HIV 3	Meningo Coccal 1	Septicemia 2	Pregnancy Complications 4	HIV 16	Suicide 24	Liver Disease 28	Motor Vehicle 48	Other Unint. Injury 97	Other Unint. Injury 393
9	Intrauterine Hypoxia 9	Meningitis 3	Pneumonia & Influenza 1	Anemias 1	Alcoholism 3	Pneumonia & Influenza 15	Pneumonia & Influenza 21	Bronchitis Emphysema Asthma 23	Other Unint. Injury 37	Septicemia 86	Bronchitis Emphysema Asthma 371
10	Perinatal Infections 7	Benign Neoplasms 2	Speticemia 1	Heart Disease 1†	Cerebro-vascular 3†	Alcohol Abuse 13	Cerebro-vascular 20	Suicide 19	Pneumonia & Influenza 33	Liver Disease 68	Liver Disease 192†

Source: NCHS Mortality Tapes, 1992-1994. Includes all American Indians and Alaska Natives in the United States.

* Motor vehicle fatalities separated from other unintentional injury category. Number of deaths during the 3 year period for each cause is shown in the appropriate box.

† Tied with at least one other cause of death category.

Figure 3. Ten leading causes of death in American Indian and Alaska Native males, by age group, 1992-1994.*

RANK	AGE GROUPS										Total
	>1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	≥65	
1	SIDS 157	Other Unint. Injury 58	Other Unint. Injury 32	Other Unint. Injury 34	Motor Vehicle 391	Motor Vehicle 343	Alcoholism 257	Heart Disease 515	Heart Disease 741	Heart Disease 2,177	Heart Disease 3,741
2	Congenital Anomalies 123	Motor Vehicle 43	Motor Vehicle 18	Motor Vehicle 31	Suicide 228	Other Unint. Injury 300	Motor Vehicle 237	Malignant Neoplasms 250	Malignant Neoplasms 541	Malignant Neoplasms 1,330	Malignant Neoplasms 2,303
3	Prem./Resp. Distress Synd. 56	Homicide 17	Malignant Neoplasms 8	Homicide 20	Homicide 159	Suicide 200	Other Unint. Injury 220	Alcoholism 246	Diabetes 158	Cerebrovascular 394	Motor Vehicle 1,358
4	Pneumonia & Influenza 26	Congenital Anomalies 15	Heart Disease 7	Suicide 13	Other Unint. Injury 148	Homicide 162	Heart Disease 203	Other Unint. Injury 143	Alcoholism 147	Pneumonia & Influenza 350	Other Unint. Injury 1,234
5	Other Unint. Injury 24	Heart Disease 9	Congenital Anomalies 4	Malignant Neoplasms 10	Alcoholism 21	HIV 108	Suicide 120	Motor Vehicle 129	Other Unint. Injury 103	Bronchitis Emphysema Asthma 314	Alcoholism 864
6	Placenta Cord Membranes 19	Pneumonia & Influenza 7	Meningitis 3	Congenital Anomalies 2	Heart Disease 18	Alcoholism 91	Homicide 111	Diabetes 86	Cerebrovascular 91	Diabetes 281	Suicide 640
7	Maternal Complications 15	Malignant Neoplasms 5	Pneumonia & Influenza 3	Heart Disease 2	Malignant Neoplasms 18	Heart Disease 54	Malignant Neoplasms 94	Liver Disease 50	Motor Vehicle 89	Other Unint. Injury 169	Cerebrovascular 570
8	Perinatal Infections 15	Bronchitis Emphysema Asthma 3	Homicide 2	HIV 2	Alcohol Abuse 10	Malignant Neoplasms 44	HIV 89	Suicide 42	Bronchitis Emphysema Asthma 68	Nephritis 110	Diabetes 559
9	Homicide 12	Meningitis 3	Septicemia 2	Bronchitis Emphysema Asthma 1	Congenital Anomalies 8	Alcohol Abuse 22	Pneumonia & Influenza 45	Homicide 39	Pneumonia & Influenza 57	Alcoholism 102	Homicide 554
10	Intrauterine Hypoxia 11	Meningo Coccoal 2†	Suicide 1†	Meningitis 1†	HIV 6†	Liver Disease 17	Liver Disease 36	Pneumonia & Influenza 36†	Liver Disease 44	Motor Vehicle 69	Pneumonia & Influenza 546

Source: NCHS Mortality Tapes, 1992-1994. Includes all American Indians and Alaska Natives in the United States.

* Motor vehicle fatalities separated from other unintentional injury category. Number of deaths during the 3 year period for each cause is shown in the appropriate box.

† Tied with at least one other cause of death category.

population is younger than the total U.S. population (median age: 24 years versus 33 years¹), and young persons are at higher risk for injury because of risk taking behaviors such as drinking and driving; not wearing seat belts; and, especially for Native Americans, alcohol abusive drinking styles (sporadic binge drinking).² Second, about half of all Native Americans live in rural or non-metropolitan areas,³ which means that they may have limited access to advanced emergency medical care when an injury occurs (such as from a motor vehicle crash) and their treatment may be delayed. In addition, because alcohol is not legally available in many Native American communities, to obtain alcohol, those residents who drink may drive long distances and then return on isolated two-lane highways while impaired. Third, numerous studies have shown that, for many Native American communities, alcohol plays a substantial role in injury occurrence and premature mortality.⁴⁻⁶ The role of alcohol in unintentional injuries, homicides, and suicides could not be determined from these data. However, other researchers have estimated that in states with reservations, 75% of suicides, 80% of homicides, and 65% of motor vehicle-related deaths among Native Americans involve alcohol.⁷ Although alcohol and abusive binge drinking appear to be important risk factors for injury death among Native Americans, we must note that a substantial proportion of the population, especially older adults, do not drink.^{2,6}

Preventing Motor Vehicle-Related Injuries

In terms of prevention, important steps have been taken to reduce injuries through the efforts of tribes, the Indian Health Service (IHS), and others. Effective injury prevention strategies, such as increasing occupant restraint use by passing tribal occupant restraint laws (or adopting the state law) combined with strict enforcement, and highway lighting projects to target pedestrian injuries are well documented.^{8,9} The Navajo Nation is a good example of a tribe that successfully increased occupant restraint use through this type of program.⁹ However, a 1995 survey of tribal traffic laws found that of 174 tribes reporting, 63 still did not have a seat belt law and 56 did not have a child passenger restraint law.¹⁰

Even in instances where tribes have laws, they are not always rigorously enforced. In one example, from a tribal community in New Mexico with a child passenger restraint law but very little enforcement, toddler child restraint usage was only 9% (unpublished survey data, New Mexico Department of Health, 1996). Passage of occupant restraint laws in combination with public information campaigns, low cost child restraint programs, and strict enforcement of the law by police and tribal judges are still vital to reducing motor vehicle-related injuries among Native Americans. Enforcing tribal seat belt laws will also help police target drunk driving, because those drivers who drink are much less likely to wear seat belts than those drivers who do not drink. One recent study in Washington found that only 36% of intoxicated Native Ameri-

can drivers involved in a crash reported using seat belts.¹¹ In a similar study in New Mexico, only 4% of drivers involved in an alcohol-related motor vehicle crash were wearing seat belts (Philip May, PhD, personal communication, 1996).

Our data for 1992-1994 show that 36% of the Native Americans who died in motor vehicle crashes were children or young adults less than age 25. Teenage drivers are particularly at risk from dying in a car crash for at least three reasons:

- Driver inexperience: Nationally, most passenger deaths among teenagers (65%) occur in crashes in which another teen is driving.¹²
- Nighttime driving: About half of all deaths among teenagers due to motor vehicle crashes occur between 9 p.m. and 6 a.m.¹² Research has shown that cities with curfew laws prohibiting teens 13-17 years old from being out between 9 p.m. and 6 a.m. have had a 23% reduction in teen motor vehicle deaths.¹³
- Alcohol use: The combination of driver inexperience and alcohol is a deadly mix: female teenage drivers are 54 times more likely to die in a motor vehicle crash when their blood alcohol concentrations are between 0.05 g/dl and 0.10 g/dl. Male teenage drivers are 18 times more likely to die under such circumstances.¹² Parents can enforce a zero tolerance of alcohol with their teen drivers and not allow their children to ride with others who have been drinking. Many tribes have the authority to revoke or restrict driving privileges on the reservations, enforce zero alcohol tolerance for underage drinking, and set curfew ordinances. Tribes should consider adopting components of new legislation being adopted by states on graduated licensing,¹⁴ impaired driving, and nighttime curfews to help reduce deaths related to motor vehicle crashes among teenagers.

Preventing Violence-Related Injuries

Many promising programs and resources are available for preventing suicide, family and intimate violence, and youth violence.¹⁵⁻¹⁷ The April 1997 issue of *The IHS Primary Care Provider* included articles^{18,19} on and references²⁰ to preventing violence in Native American communities, and resource contacts¹⁸ for tribes interested in suicide prevention programs, and family violence programs.

Suicide among Native Americans has the greatest impact among youth and young adults. From 1992 through 1994, 37.3% of all suicides occurred before age 25, and 67.7% before age 35. There are promising strategies to prevent suicide such as training school and community gatekeepers; educating the community; screening for suicide risk in schools and clinics; developing peer support projects; and restricting access to lethal means.^{15,20} The American Indian and Alaska Native Community Suicide Prevention Center and Network of the Jicarilla Apache Tribe, in Dulce, New Mexico, is a good

example of a community-based program that has shown promising results in reducing suicides among youth and young adults.¹⁸ The Center staff provides training, technical assistance, and program support to tribes who are interested in developing their own suicide prevention programs. Restricting access to lethal means for those considered at risk for suicide may be an effective, yet underused, strategy for preventing suicide. Firearms are used in approximately 59% of suicides by Native American males, and 41% of females.²⁰ In some areas, Alaska for example, the rates are much higher.^{20,21} Friends and relatives of persons at risk for suicide, and the public at large, should be made aware of research findings indicating that having a firearm in the home is associated with approximately a five-fold increase in the risk of suicide among household residents.²²

A Multifaceted, Community-Based Approach

Preventing injuries among people living in Native American communities often requires a comprehensive, community-based approach tailored to specific local settings and involves many partners. The Native American communities that bring the necessary partners together and work collaboratively will be the most successful at reducing injuries. Some of the key components of a successful community injury prevention program are these:

- Availability of local injury data that can be used to target high risk groups, set program priorities, and evaluate the effectiveness of intervention programs.
- Local programs to screen people for alcohol abuse and, when necessary, to provide counseling, and treatment.
- A system for referring victims of family and intimate violence to social services, law enforcement, and safe homes.
- Youth services and crisis response programs.
- Strong community support for the police and judges to aggressively enforce occupant restraint, drunk driving, and family violence laws.
- Tribal leaders who are engaged and supportive.
- Support from and participation by community members and local health professionals.

Although Figures 1 through 3 present national data, IHS Areas or service units and tribes can develop their own similar profiles of leading causes of death as a means for supporting local prevention programs. Such approaches have worked well in other settings.²³ In order to meet *Healthy People 2000*²⁴ objectives for reducing injuries and violence, these types of concerted efforts are needed, as well as directing resources toward effective or promising intervention programs that can further reduce injuries as a leading health problem among American Indians and Alaska Natives.

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Pre-Medical Students Interested in Volunteering With IHS

Duquesne University, a Catholic institution of higher learning, located in the heart of Pittsburgh, PA, stands tall in its mission: to develop the minds and hearts of each generation of youth entering through its corridors. Students from the Schools of Pharmacy, Nursing, Health Sciences, and Pre-Medical programs travel abroad to Tanzania, Kenya, and Nicaragua to volunteer their services in local health care clinics. Some pharmacy and pre-medical students have traveled to Belize to learn about medicinal plants and healing from the Mayan medicine men and women.

As the University prepares for its mission in the 21st century, one of its important goals is the education of future physicians and other health care professionals, particularly in the United States, regarding all segments of its population. For too long, the health and education of the American Indian and Alaska Native population has received less than the attention they deserve. The Indian Health Service (IHS) has served as a step in the right direction. We would like to do our part in the education of future physicians, starting from their undergraduate years as pre-medical students. We would also like to educate our pre-medical students on the cultural sensitivities and Native American tradition. Working with the IHS, they will be able to learn about the traditional and historical knowledge about health, illness, and death from the Native American perspective. As part of their volunteer work, they will have an opportunity to understand the unique nature of Indian health programs, where the IHS, tribal leadership, and community members participate in dealing with the distinctive health care needs of each segment of the population.

To begin with, we would like to have four to five of our pre-medical students work in IHS clinics (one per clinic) during the summer of 1998. Our students would be able to learn under the tutelage of the IHS clinic professionals. This learning and volunteer experience would help them to serve in the future, either with the IHS or similar health service organizations. If anyone from the Indian health program clinics is interested in providing volunteer, preceptor, or pre-medical clerkships, please contact Dr. Tata Subhas, Director, Pre-Health and Post-Baccalaureate Pre-Medical Programs, Duquesne University, B101 Bayer Learning Center, Pittsburgh, PA 15282 (phone: 412-396-6335; e-mail: subhas@duq2.cc.duq.edu).

Tata Subhas, D.V.M., Ph.D.
Duquesne University

Secretary's Quality of Work Life Initiative

The Initiative

On December 23, 1996, the Secretary of the Department of Health and Human Services, Donna E. Shalala, distributed a Quality of Work Life Strategy developed in response to concerns about employee commitment and morale during this period of unprecedented change and uncertainty.

The Quality of Work Life Strategy has three objectives: improve employee satisfaction, strengthen workplace learning, and better manage ongoing change and transition. It is believed that when these objectives are met, individual and organizational performance will improve and even better service to our customers and partners will be provided.

To meet these objectives and achieve these outcomes, the Secretary has reconfirmed her commitment to streamline and modernize without involuntary separations, and plans to:

- establish a model work and family center, at headquarters, to coordinate work and family programs and serve as a catalyst for improving work and family programs across the Department.
- establish a Quality of Work Life site on the DHHS Home Page to provide a convenient location for information about this strategy and related efforts to improve the quality of employee work life.
- commission an annual survey of employees, to begin in January 1997, to assess employees' views of organizational effectiveness and the quality of work life.
- ask the DHHS Union-Management Partnership Council to serve as the steering group for implementation of the Quality of Work Life Strategy, and report at least annually on the status of the quality of work life of DHHS employees.
- ask that sign-in sheets (and similar systems for collecting time and attendance information that are incompatible with a work culture based on trust) be eliminated within sixty days of the date of this memorandum (12/23/96).

Agencies of the DHHS were asked to develop their own quality of work life strategy, and submit it to the DHHS Union-Management Partnership Council. As a minimum, the strategy to be designed is to accomplish the following:

- improve communication with employees;

- strengthen family-friendly work programs;
- provide all employees Internet access by the end of Calendar Year 1997;
- increase the Agency's investment in workplace learning, to include development of knowledge and skills that employees need to achieve strategic goals and objectives, perform differently, become a learning organization, and improve the effectiveness of supervisors and team leaders;
- evaluate the effectiveness of the Agency's diversity management practices, and make appropriate improvements;
- better plan and manage change and transitions, including briefing all members of your leadership team on change and transition, providing more extensive training when change and transition is imminent, and evaluating and learning from change efforts.

The Secretary's Quality of Work Life Strategy offers a unique opportunity to send a strong signal to DHHS employees that we value and support them.

Quality of Work Life Week

The Department of Health and Human Services celebrated Quality of Work Life Week May 12-16, 1997. During that week the DHHS acknowledged and honored our colleagues and our accomplishments. At the various meetings and events during Quality of Work Life Week, The Secretary reported on what has already been accomplished:

- we renewed our commitment to avoid involuntary separations;
- sequential sign-in sheets are becoming a thing of the past;
- the Quality of Work Life site has been established on the DHHS Internet home page;
- the model Work/Life Center is now open;
- the DHHS Union-Management Partnership Council, which is chaired by the Deputy Secretary, is helping me lead this initiative;
- we completed the first annual employee survey;
- Operating Divisions have developed and are implementing their own plans to improve the quality of work life for their employees, and they can already point to solid achievements.

Results of the Employee Survey

The survey, which establishes a baseline that will be used to measure progress, was distributed in January to a random sample of 12,000 employees; almost 5,000 employees completed it (a 41% response rate). Responses came from employees at all grade levels and throughout the Commissioned Corps.

Seventy-five percent of the survey participants said they were able to balance work and family life by taking advantage of flexible scheduling, flexiplace, leave provisions, and other options. Sixty-nine percent reported that managers and co-workers were supportive of them when they did so. Seventy-five percent felt that they were generally treated fairly. A majority felt that their work was seen as highly effective, that they were encouraged to try new approaches to getting the job done, and that they had the authority they needed to do their jobs.

A majority also said that there was a need for change, with 48% reporting signs of discontent within their work group. Almost two-thirds said there were at least some continuing problems that interfered with efficiency, and just under half said that management practices were generally or very ineffective. Delays in communicating what is happening in the organization were noted by 49% of the respondents. There is room for improvement.

The Secretary, Deputy Secretary, and the Union-Management Partnership Council heard what employees said and are working to identify the appropriate steps to make those improvements. The DHHS Union-Management Partnership Council has been briefed on the survey results. Each of the OPDIVs has received its results, and you [the reader] either already have or should soon hear about them as well. OPDIVs will address issues that were identified through the survey, and will report back to the Partnership Council on follow-up actions. The DHHS will survey a random sample of employees again early next year to help us gauge our progress.

Work/Life Center Opens

A model Work/Life Center opened in the Mary Switzer Building on May 12, 1997. A joint effort of the Program Support Center and the Office of the Assistant Secretary for Management and Budget, the Work/Life Center brings together the employee assistance and career management programs, and creates a new one: the Work and Family Resource Program. The Work and Family Resource Program (temporarily located in Room 1416) has collected and will maintain information on family friendly work policies and programs and updated, accurate referral lists. It will sponsor fairs; support groups; and workshops and seminars on dependent care, parenting, wellness, balancing work and family, and

aging/retirement planning. Headquarters staff will be served directly, and telecommunication technology will be used to bring services to regional and field staff. The Work/Life Center will move into its permanent location (Room 1250 in the Switzer Building) in the Fall of this year.

Telephone numbers for the programs that comprise the Work/Life Center are: the Employee Assistance Program: 202-205-5790; the Career Management Program: 202-205-9401; and the Work and Family Program: 202-690-5622.

OPDIV Accomplishments

Operating Divisions (OPDIVs) of the Department of Health and Human Services are taking actions to improve the quality of work life for their employees. A few examples:

- The Centers for Disease Control and Prevention (CDC) published and distributed to all employees a "Career Enhancement Guide." This Guide explains the options CDC offers to help employees improve their careers and current job skills. The Guide contains information on training opportunities; internships; childcare and eldercare; flexiplace; and alternative work schedules.
- The Indian Health Service and the Food and Drug Administration are making organization development consulting services available to managers in order to better manage change and transition.
- The Administration on Aging (AOA) has engaged all employees and key stakeholders in an effort to redesign the way work gets done in AOA.
- The National Institutes of Health is developing an Internet training management and delivery system that will allow employees to receive computer-based training at their workstation (office, home, or other suitably equipped location) at any time that is convenient.
- The Health Resources and Services Administration (HRSA) has established a Career Resource Center to provide employees assistance in planning and managing their career within the context of the HRSA mission and goals.

The Deputy Secretary, on behalf of the DHHS Union-Management Partnership Council, will keep employees informed of some of the best practices to improve the quality of work life for DHHS employees through periodic messages via e-mail.

Suggestions/Comments/Questions

An electronic mail box has been established for the quality of work life initiative so employees have a place to send suggestions, comments, and questions. The Internet address is qwl@os.dhhs.gov. Take advantage of it! □

First Indian Doctors Graduate from the SIHB Family Practice Residency Program

The Seattle Indian Health Board (SIHB), an urban Indian health program located in Seattle, Washington, is pleased to announce the graduation of its first two family practice residents at a ceremony held on June 20, 1997. Dr. Michael H. Trujillo, Director of the Indian Health Service, joined approximately 75 guests to witness the graduation and traditional blanket ceremony to honor these new Indian physicians.

Arne Vainio, MD, and Shannon Weigand, MD, were the first two physicians to enter the three year program conducted in partnership with Providence Hospital Family Practice Residency in Seattle. Both of native heritage, they are returning, in essence, to their homes to practice. Dr. Vainio will be joining the staff at Fond-du-Lac Health Center in Wisconsin, and Dr. Weigand will become a staff physician at the Alaska Native Medical Center in Anchorage.

The Seattle Indian Health Board is the only ACGME-approved residency targeting Indian health. The program,

started in 1994, can accommodate six residents, two for each of the three years of the program. The curriculum includes didactic and practical experience in Indian health including opportunities to work with traditional Indian medicine practitioners from different tribes. The goal of the residency is to prepare family physicians for careers in Indian health.

In addition to Drs. Vainio and Weigand, the SIHB recognized the accomplishments of two Indian physicians who worked at SIHB during their pediatric residency with the Seattle Children's Hospital. Recognized were Dr. Angela Erdich and Dr. Kent Saylor. Dr. Erdich will be going to the Oneida Native Health Center, and Dr. Saylor will be completing a fourth year of training in Montreal, Canada.

For information about the residency program, contact the Seattle Indian Health Board, P.O. Box 3364, Seattle, WA 98114 (phone: 206-324-9360; fax: 206-324-8910; e-mail: www.sihb.org). abstracts and the publishers of full-text articles.

Free MEDLINE

On June 26, 1997, the National Library of Medicine (NLM) began to provide all Americans with free access to MEDLINE, the world's most extensive collection of published medical information, over the World Wide Web. The web address for NLM is: www.nlm.nih.gov. Prior to June 26th, only registered users who paid for the service could search MEDLINE, an index of over 8.8 million articles from over 3800 biomedical journals. The opening of MEDLINE at no cost to all who can access it means that individuals can search for medical information on topics of interest to them and their families. As consumers become more informed about diseases and the courses of treatment available, they can use

that knowledge in making health care choices.

"PubMed," a free on-line service, will provide direct Web links between MEDLINE abstracts and the publishers of full-text articles.

Training on MEDLINE is currently being discussed. If you are interested in MEDLINE training, send an e-mail to SHELBY.L.ZWICK@OHP.1TUC@IHS so we can assess the amount of interest in this training.

Note: This does not change the prearranged Lonesome Docs program for the IHS *Information Portal Project* participants.

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The Provider is published monthly by the Indian Health Service Clinical Support Center (CSC). Telephone: (602) 640-2140; fax: (602) 640-2138; e-mail: provider@smtp.ihs.gov; timely meeting notices and "Information for Authors" available via the CSC Fax Retrieval Service: 602-640-2140. Previous issues of *The Provider* (beginning with the December 1994 issue) can be found on the CSC Internet home page (www.csc.ihs.gov).

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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.

Circulation: *The Provider* (ISSN 1063-4398) is distributed to more than 6,000 health care providers working for the IHS and tribal health programs, to medical schools throughout the country, and to health professionals working with or interested in American Indian and Alaska Native health care. If you would like to receive a copy, send your name, address, professional title, and place of employment to the address listed below.

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