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Functional Assessment in the Elderly

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Introduction

Most of us have been taught to focus our clinical evaluation on diagnosis and treatment — i.e., what is wrong and how can we fix it. Even when the emphasis is on prevention, we still try to assess risk status and direct diagnosis and intervention accordingly. The measurement and assessment of function is often relegated to workers compensation, disability determination, work hardening programs, and physiatry or rehabilitation medicine. Upon entering the realm of geriatric care, however, the busy clinician will be confronted by elders who, along with their families, often express considerable dismay at the potential or real loss of function with age.

Modern clinical assessment, diagnosis, and treatment rely heavily on evidence accumulated through clinical trials. Clinical trials tend to use "hard" endpoints such as cure, mortality, complication, or some other objective measure, such as blood pressure, cholesterol level, etc. Even though function may be seen as an essential element of well-being, it is viewed as being too subjective or "too unreliable to merit serious scientific consideration."[1] In fact, among the elderly, physical function may be one of the most important aspects of well-being.

A Brief History

Always at the heart of geriatric care, functional assessment is a challenge to measure accurately and reliably. One of the most extensively validated and studied (not to mention marketed) functional assessment tools is the Medical Outcomes Study (MOS) SF-36™.[2] You will see this referenced in articles and used in population data bases but it is not very useful for the busy clinician, or even the thorough geriatrician. The short form of the MOS SF-36 is a self-administered questionnaire that may be more practical. Katz developed one of the earlier tools for assessing the ability to perform activities of daily living (ADL).[3] The Older Americans Resources and Services Instrumental Activities of Daily Living (OARS - IADL) expanded the ADL to include higher levels of functioning.[4] The Katz and OARS are done by interview. The Rosow-Breslau and Nagi scales are other interview scales.[5] Another self-administered questionnaire is the Functional Status Questionnaire that divides ADL into basic and intermediate.[6] Finally, performance-based assessments such as the Physical Performance Test are scored by direct observation.[7] If you are really interested in this subject, Reuben et al published a comprehensive review of these measures.[8]

Utility

Functional assessment has been shown to be important in predicting mortality, hospitalization, and health care cost.[9] Premorbid functional level predicts function as an outcome in a variety of acute illnesses. Improving functional outcome may reduce the need for further institutionalization and long-term care following hospitalization.[10] Functional assessment has recently been shown to be an important predictor of mortality after hospitalization, and therefore an important

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element of risk adjustment.[9] Risk adjusted outcome measures are scrutinized closely by government agencies and third party payers. Another study determined that three patient characteristics were independently associated with functional decline after medical illness: older age, lower scores on mental status exam, such as the mini-mental state exam (MMSE), and lower instrumental activities of daily living (IADL).[10]

Problems

Although there appears to be an emerging consensus that functional assessment has important clinical and research applications, the method of measurement is a matter of considerable controversy, as are problems of variability, predictive value, and responsiveness or sensitivity to change. Stability over the short term has been shown to be quite good among tools of the same type.[7] A more in-depth study comparing different types of tools reveals only weak to moderate associations among them.[8] One explanation for this is that the tools use different terminologies: e.g., in three tools "dependence," "limitation," and "difficulty" are each used to describe impairment. Caution is particularly in order if only a subjective questionnaire is used in the absence of confirmation by direct observation.

Geriatric Assessment

Despite these limitations there is probably no more clinically important aspect of geriatric care than functional assessment. Even before you ask about falls, medication, and incontinence, you should find out about recent changes in functional status. Not only is it an important measure of disability and frailty, but it is an essential element, as well as an outcome, for comprehensive geriatric assessment (CGA). CGA and geriatric assessment teams will be discussed more specifically in future *Provider* articles.

Incorporating Functional Assessment Into Practice

Providers at our health center are encouraged to use the Adult Functional Assessment form for all adults as they age. The assessment can provide a useful baseline and monitor for ongoing health maintenance.

The Geriatric Assessment Flow Sheet (Figure 1) is used to determine which elders might benefit most from comprehensive geriatric assessment. As can be seen in this flow sheet, ADLs and IADLs are pivotal in assessing the elusive concept of frailty. Frailty may also be indicated by caregiver burden, polypharmacy, recent falls, recent loss or grief, confusion, or changes in domicile. The Adult Functional Assessment form (Figure 2) was adapted from Katz[3] and further details the items used to assess function. This chart becomes a permanent part of the medical record as a "working form."

The functional assessment is done by interview directly with the patient and often with the help of the primary caregiver or family member. It can be done quickly at any visit by any provider. Although designed to be scored, we have found its greatest utility is in determining functional changes over time. Loss of ADLs or IADLs is one factor that may lead to more comprehensive assessment or specific intervention.

Loss of ADLs or IADLs often assumes prominence when generating a problem list to prioritize interventions. For example, the need for help with cooking may generate increased family participation, meals on wheels, or home care services. Impaired transferring ability may require intensive physical therapy, assistive devices, or home modifications. The ADLs are listed in the order in which they may be lost as an elder becomes more frail and dependent. Bathing usually goes first, then dressing, etc. Loss of bathing independence as an initial event may therefore be a sign of progressive senescence, whereas initial loss of feeding or transferring may signal a problem outside the realm of usual aging.

When possible, direct observation can be important in verifying functional loss, measuring its degree, or determining appropriate intervention. Specific appliances, home modifications, and therapeutic modalities may come to mind by watching the elder perform, especially IADLs. Large perturbations in function, either in individual activities or as a whole, may lead to a more comprehensive assessment by physical or occupational therapy.

Conclusions

Functional assessment is an essential component of elder care. Research suggests that a composite measure is likely to be the most accurate, comprising an interview or questionnaire and the direct observation of physical performance. It is recommended that Indian Health Service, tribal, and urban programs adopt a standard form for documenting the functional assessment of elders. Although CGA is an important aspect of elder care, it need not be a prerequisite for functional assessment. □

References

1. Hutchinson et al. Scientific problems in clinical scales, as demonstrated in the Karnofsky Index of Performance Status. *J Chron Dis* 1979;32:661-666
2. Ware JE, Sherbourne CD. The MOS 36-Item Short-Form Health Survey (SF-36), conceptual framework and item selection. *Med Care* 1992; 30(6):473-483
3. Katz et al. Progress in development of the index of ADL. *Gerontologist* 1970;10:20-30
4. Fillenbaum GG. Screening the elderly. A brief instrumental activities of daily living measure. *J Am Geriatr Soc* 1985;33:698-706
5. Smith et al. Short-term variability of measures of physical function in older people. *J Am Geriatr Soc* 1990;38:993-998
6. Jette et al. The Functional Status Questionnaire. Reliability and validity when used in primary care. *J Gen Intern Med* 1986;1:143-149
7. Reuben DB, Siu AL. An objective measure of physical function of elderly patients. The physical performance test. *J Am Geriatr Soc* 1990; 38:1105-1112
8. Reuben et al. Measuring physical function in community-dwelling older persons: A comparison of self-administered, interviewer-administered and performance-based measures. *J Am Geriatr Soc* 1995;43:17-23
9. Inouye et al. Importance of functional measures in predicting mortality

among older hospitalized patients. *JAMA* 1998;279(15):1187-1193
10. Sager et al. Hospital Admission Risk Profile (HARP): Identifying older patients at risk for functional decline following acute medical illness and hospitalization. *J Am Geriatr Soc* 1996;44:251-257

Additional Reading

1. Landefeld et al. A randomized trial of care in a hospital medical unit especially designed to improve the functional outcomes of acutely ill older patients. *NEJM* 1995;332(20):1338-1344
2. Boult et al. Outpatient geriatric evaluation and management. In: Reuben DB, ed. *Models of Geriatrics Practice*, J Am Geriatr Soc 1998; 46:296-302
3. Stuck et al. Comprehensive geriatric assessment: a meta-analysis of controlled trials. *Lancet* 342:1032-1036

Figure 1. Geriatric Assessment Flow Sheet

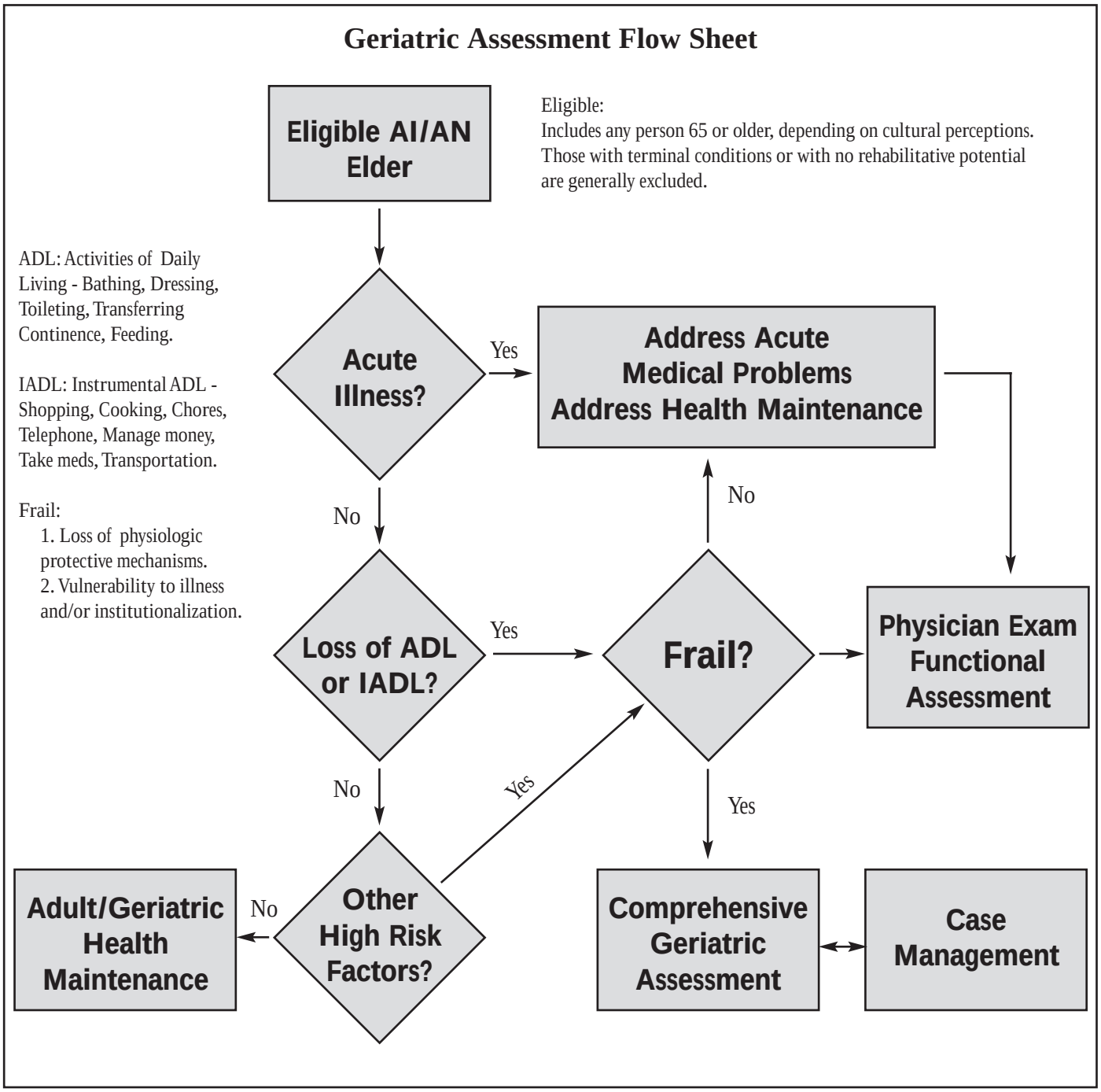

Figure 2. Adult Functional Assessment

Adult Functional Assessment

Activities of Daily Living						Comments
1. Bathing: going to and from shower/tub, washing and drying.						
2. Dressing: picking out clothes, buttoning, zipping, tying, etc.						
3. Toileting: going to and from toilet on time. Continent?						
4. Transferring: get up, down from bed and chair.						
5. Feeding: cutting, swallowing, using utensils, drinking.						
Instrumental Activities of Daily Living 1. Hygiene/Grooming: comb/brush hair, shave, brush teeth.						
2. Cooking: planning, preparing, cooking full meals.						
3. Walking: in and around home, even and uneven surfaces, steps. Cane, walker, aids?						
4. Home Chores: make beds, garden, vacuum, mop, laundry.						
5. Get To and From: places not within walking distance by using car, cab, bus, others.						
6. Shopping: groceries, clothes, necessities.						
7. Use Telephone.						
8. Manage Money: paying bills, cash transactions, checks.						
9. Taking Medication: identifies type, dose, times to take.						
Date:						
Provider:						

Levels:
1. Independent
2. Needs some help
3. Dependent on others

Identification

Advocating Impaired Driver Laws:

The Adoption of 0.08 BAC in Indian Country

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Impaired driving is the most frequently committed violent crime in America.[1] In 1993, an estimated 123 million episodes of alcohol-impaired driving occurred among U.S. adults.[2] Every 30 minutes someone in the U.S. dies in an alcohol-related motor vehicle collision. For every five-day period, alcohol-related motor vehicle events are responsible for the number of deaths equal to one fully-loaded Boeing 737 airplane crash in which all passengers are killed. Annually, this is equivalent to 81 such plane crashes, totaling more than 16,000 deaths.

In 1997, 38.6 percent of all motor vehicle crash-related deaths in the U.S. involved alcohol.[3] There were 16,189 deaths in 1997 alone. The statistics are worse in Indian Country where American Indians and Alaska Natives (AI/AN) die from alcohol-related motor vehicle crashes at rates two to three times higher than other Americans.[4-7] It is estimated that 65 percent of all motor vehicle deaths involving AI/AN are alcohol-related.[8]

In an effort to combat the excess morbidity and mortality associated with drinking and driving in this country, President Clinton signed the landmark Transportation Equity Act of the 21st Century (TEA-21) into law on June 9, 1998. One important provision of this bill is its authorization of more than $700 million in federal incentive grants to states over the next six years to combat drinking and driving. New incentive programs are aimed at increasing the use of safety belts and promoting the enactment and enforcement of 0.08 blood alcohol concentration (BAC*) as the national legal limit for impaired driving. Although TEA-21 has not established 0.08 BAC as the standard for impairment, it has specifically allocated $500 of the $700 million in incentive grants to states that have enacted, and are enforcing, a 0.08 BAC per se law.**

President Clinton has specifically addressed the role of impaired driving in Indian Country. Inherent in the development of a plan to promote the adoption of 0.08 BAC, the President has explicitly encouraged tribal governments to adopt, enforce, and publicize a 0.08 BAC standard on highways in Indian Country that are subject to tribal jurisdiction. Adoption of the 0.08 BAC standard by tribes will create opportunities for these tribes to receive desperately needed federal funding. These federal grants can be used to implement programs to reduce the incidence of impaired driving and motor vehicle-related injuries. Currently, an inventory of tribal traffic safety laws is being conducted to update a similar inventory prepared in 1995. One component of the inventory is an analysis of tribal DUI (Driving Under the Influence) laws, which will provide the IHS with a database of tribes that have adopted and are enforcing per se laws.

Making 0.08 BAC the national legal limit for impaired driving will make a major contribution in reducing deaths and injuries on our nation's highways. Lowering the BAC limit to 0.08 sets the legal limit at a point at which driving skills are proven to be compromised. At 0.08 BAC, a level reached by a 160-lb male consuming four drinks in one hour on an empty stomach, there is "reduced peripheral vision, poorer recovery from glare, poor performance on complex visual tracking, and reduced divided attention performance".[9] Furthermore, the risk of being in a crash rises gradually with each BAC level, but increases dramatically after a driver reaches or exceeds 0.08. The Insurance Institute for Highway Safety indicates that the relative risk of being killed in a single vehicle crash for drivers at BACs between 0.05 and 0.09 is 11 times greater than for drivers with no alcohol in their system. These finding have been supported by a national study, which found that each two-percent increase in BAC nearly doubles the risk of fatal crash involvement.[10] Sixteen states have already established the 0.08 BAC as the legal limit.

To date, four studies have evaluated the effect of 0.08 BAC laws in the U.S.[11-14] Each study has demonstrated that lowering the legal limit to 0.08 BAC was associated with reductions in alcohol-related fatal crashes. These studies have shown that the adoption of a 0.08 BAC limit can reduce alcohol-related crashes by up to 40 percent (range is 4%-40%). The significance of these findings is that not only are the 0.08 laws associated with a reduction in the incidence of alcohol-related fatal crashes overall, but they also reduced the fatalities at the higher BAC levels. In fact, one study found that the reduction was greatest among the extremely impaired drivers (those with BACs of 0.15 or greater).[14] According to this study, if all states lowered BAC limits to 0.08, alcohol-related highway deaths would decrease by 500-600 per year. This would result in saving an estimated 13,200 lives by the year 2005.

IHS primary care providers must advocate for the adoption and enforcement of 0.08 BAC laws in Indian Country. As Indian health advocates, it is our responsibility to articulate the

*BAC, or blood alcohol concentration, is the amount of alcohol in a person's body and is measured by the weight of the alcohol in a certain blood volume. This measurement is expressed in grams per deciliter (g/dl) of blood. Breath testing is the primary method for measuring BAC.

**A per se law makes it illegal, in and of itself, to drive with an alcohol concentration measured at or above the established legal level.

importance of adopting 0.08 BAC laws by highlighting the financial incentives as well as the expected health and social benefits. Indian health advocates must also be involved in the policymaking process. It is essential that we ensure that policymakers at the tribal, state and Federal levels are aware of the benefits associated with the 0.08 BAC laws and will pursue the adoption of these stringent laws. The morbidity and mortality associated with impaired driving in Indian County is preventable, and the adoption of 0.08 BAC laws by tribes is one very important step in reducing the epidemic of alcohol-related crashes occurring in Indian communities.

Additional information on 0.08 BAC can be requested from your IHS Area Injury Prevention Specialist or from the National Highway Traffic Safety Administration (NHTSA). To contact your Area Injury Prevention Specialists, please call the IHS Area Office closest to you or visit the IHS Injury Prevention web site at *www.injprev.ihs.gov*. Information on 0.08 BAC can be found on the NHTSA web site by visiting *www.nhtsa.dot.gov*. □

References

1. National Highway Traffic Safety Administration. Recommendations from the Secretary of Transportation, 9 September 1998. *www.nhtsa.dot.gov/people/injury/alcohol/limit.08/PresInit/overview.html*
2. Liu S, Siegel PZ, Brewer RD, et al. Prevalence of alcohol-impaired driving: results from a national self-reported survey of health behaviors. *JAMA* 1997;277(2):122-125
3. National Highway Traffic Safety Administration. Recommendations from the Secretary of Transportation, 9 September 1998. *www.nhtsa.dot.gov/people/injury/alcohol/limit.08/PresInit/overview.html*
4. May PA. Overview of Alcohol Abuse Epidemiology for American Indian Populations. In: Sandefur GD, Rundfuss RR, eds. *Changing Numbers, Changing Needs: American Indian Demography and Public Health*, Eds. Washington, DC: National Academy Press; 1996:235-261
5. May PA. Motor Vehicle Crashes and Alcohol Among American Indians and Alaska Natives. In: *The Surgeon General's Workshop on Drunk Driving: Background Papers.* Washington, DC: U.S. Department of Health and Human Services; 1989:207-223
6. National Center for Health Statistics. Healthy People 2000 Review, 1997. Hyattsville, Maryland: Public Health Service, 1997
7. Oken E, Lightdale JR, Welty TK. Along for the ride: the prevalence of motor vehicle passengers riding with drivers who have been drinking in an American Indian population. *Am J Prev Med* 1995;11(6):375-380
8. May PA. Overview of Alcohol Abuse Epidemiology for American Indian Populations. In: Sandefur GD, Rundfuss RR, eds. *Changing Numbers, Changing Needs: American Indian Demography and Public Health*, Eds. Washington, DC: National Academy Press; 1996:235-261
9. Hingson R, Heeren T, Winter M. Lowering state legal blood alcohol limits to 0.08%: the effect on fatal motor vehicle crashes. *Am J Public Health*. 1996;86:1297-1299
10. Zador P. Alcohol-related relative risk of fatal driver injuries in relation to driver age and sex. *J Stud Alcohol*. 1991;53:301-310
11. National Highway Traffic Safety Administration. *The Effects Following the Implementation of an 0.08 BAC Limit and an Administrative Per Se Law in California.* Springfield, VA: National Technical Information Service; 1991. DOT Report no. HS 807 777
12. Johnson D, Fell J. *The Impact of Lowering the Illegal BAC Limit to .08 in Five States in the U.S.* Washington, DC: National Highway Traffic Safety Administration; 1995. Paper presented at the 39th Annual Proceedings of the Association for the Advancement of Automotive Medicine, October 16-18, 1995, Chicago, Illinois
13. California Department of Motor Vehicles. *The General Deterrent Impact of California's 0.08% Blood Alcohol Concentration Limit and Administrative Per Se License Suspension Laws.* Sacramento, CA: Office of Traffic Safety; 1995. CAL DMV Report no. CAL-DMV-RSS-95-158
14. Hingson R, Heeren T, Winter M. Lowering state legal blood alcohol limits to 0.08%: the effect on fatal motor vehicle crashes. *Am J Public Health*. 1996;86:1297-1299

Doulas: Holding Women

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Toonova'hehe (Holding Women) is the name I was assigned to use during my Northern Cheyenne Language class in 1996 when I attended Dull Knife College on the Northern Cheyenne Reservation in Lame Deer, Montana. Each person who did not have a Cheyenne or other Indian name was given a temporary name that suited their character or profession for use in this class. When I tried explaining my role as a "doula," the instructors talked among themselves and came up with my name, Holding Women.

"Holding Women" is an appropriate word picture for a doula. "Doula" is the Greek word for a woman who serves. Internationally it has come to mean a "woman experienced in childbirth who provides continuous physical, emotional, and informational support to the mother before, during, and just after childbirth."[1]

Historically, anthropologists have found that in 126 of 127 cultures studied so far, mothers in labor have a "continuous, caring woman present at a birth with the laboring woman" in one fashion or another.[2] As childbirth moved into the hospital, mothers became isolated physically, emotionally, and spiritually by sterile protocols instituted to ensure the positive outcome of the mothers and their babies. The medical aspect of birth continues to receive attention not only in professional research, but also in the lay media, as the outcomes for mothers and babies are still of primary concern. Fortunately, as knowledge of the nonmedical needs of laboring women has increased, so the doors to the labor rooms have slowly opened to allow in the father, a friend, or other family members, as well as the doula, to help the mother with her labor.

Review of Research on Supportive Companions at Birth

Researchers, foremost Dr. John Kennell and Dr. Marshall Klaus, in an attempt to improve the birth experience, conducted the first randomized controlled doula trials in 1980. The doulas were untrained and unknown to the mothers to whom they were assigned, which made the results even more surprising, as well as encouraging. A combined analysis of the results from that first study and from five additional well-designed, controlled trials show compelling results.[3] Table 1 is a list of the benefits of a doula.

Other significant, immediate outcomes include a reduction in the frequency of maternal fever, as well as fewer newborn days in the newborn intensive care unit (NICU) and fewer septic work-ups for the neonate.[4] Long-term benefits have included improved breast feeding, increased time spent with baby, and more positive maternal assessments of the baby's personality, competence, and health.[5] There was also a decrease in postpartum depression.[6]

Table 1. Abridged list of obstetrical outcomes from the results of six randomized, controlled trials of labor support

Outcome	Lowered by
Cesarean sections	50%
Length of labor	25%
Oxytocin use	40%
Pain medication (narcotic)	30%
Forceps	30%
Request for epidural	60%

How Doulas Affect Physical Outcomes

Doulas "hold women" by supporting them emotionally during their pregnancy, labor, and birth. The doula meets with her expectant mother one or more times before the birth and discusses the mother's expectations or ideas of what the birth will be like, and issues of importance, such as pain medication preferences or infant feeding choices. During these meetings the doula supplements information the mother has learned in prenatal classes and explores misinformation she may have gleaned from what she has heard or read. The doula empowers the client to eat well, observe healthy lifestyle practices, and exercise, all to prepare for a healthy and positive birth experience. A doula may use this time to enhance communication within the woman's support network, including family and partner, and/or may give advice about how to communicate effectively with the medical staff.

During early labor, the doula and her birthing partner stay in close contact until the mother needs additional support, at which time the doula will join her, meeting the mother at her birth place. She will then stay throughout the entire labor and birth and for up to two hours during the postpartum period. She will talk about normal contractions with the mother and will provide an objective viewpoint. Knowledge of what is normal replaces fear of the unknown. The doula listens to the mother and responds to her needs. The presence of the doula, who is calm and committed to the mother's well-being, counteracts the effects of elevated stress hormones (adrenaline and noradrenaline), which are released when the mother becomes anxious, fearful, or insecure. A trusting, relaxed mother is able to continue producing oxytocin, which then keeps the labor in its normal rhythm, with the perception of pain diminished greatly. Most importantly, the doula lessens the anxiety of the

laboring woman with quiet reassurance and enhancement of the unique talents and strengths the laboring mother brings to the birth.

"Holding women" not only applies to the mother, but to other family members present as well. The doula will be responsive to the spouse or partner, and others present, and will respect their level of involvement. Some men are unaccustomed to observing, analyzing, accepting, understanding, and then reacting to the instinctive, normal behavior of the laboring mother. The doula can help them understand the normal course of labor and what they can best do to serve the mother. All family members may be very helpful to the birth and just need to be directed in a positive manner.

Doulas "hold women" physically by holding her hand or by utilizing more therapeutic touch to relieve or reduce pain. Other comfort measure used might include massage, pressure, hot or cold packs, hydrotherapy, or patterned breathing techniques. Often if a woman is walking during labor, she may lean on the doula, who physically supports her during the contraction. A doula uses her understanding of the physiology of birth to aid a laboring woman into more comfortable and efficient positions. To increase the mother's physical comfort, the doula helps obtain juice, ice, blankets, and pillows for the mother.

Doulas "hold women" spiritually as well, as expressed by Polly Perez in her book, *Special Women*. She writes

> Doulas feel their presence helps the mother recognize and appreciate her link with all other mothers — those who have birthed before and those who have yet to birth. The labor assistant is their link with time; this link helps the mother to know that she too can birth her baby. She too has the wisdom of the ages.

Doulas consider themselves protectors of the memory of birth. According to Penny Simkin, women have vivid and detailed memories about their births for the rest of their lives, and it is clear that the birth experience can have a powerful positive or negative long-term effect on a woman.[7] A woman's emotional reaction to the birth experience needs to be expressed and discussed after the birth so that the she integrates the experience into her life. The doula, in her postpartum contacts, can provide a compassionate ear and also has the opportunity to contribute to the mother's self-esteem and confidence in her parenting abilities.[8]

A doula works side by side with clinical caregivers by practicing only non-medical skills. She is quick to obtain consultation when the laboring woman so requests or when the doula reaches the limits of her scope of practice. DONA (Doulas of North America; an international organization for doulas, founded in 1992) is one of the major bodies training and certifying doulas in the United States and abroad today. It has set standards of practice (see Table 2) for DONA certified doulas (CD-DONA), specifying the limits of their care.

Doulas work in a variety of practices and settings. In the Seattle, Washington area, for example, the human services system provides a doula for each pregnant woman who requests one. These women are paid by the county human services program. Private practice doulas work with women on an individual basis and charge $250-$800 per birth. Some doctors and midwives have chosen to hire doulas to work with their patients. There are volunteer programs in various parts of the country, sometimes targeting a specific population such as teens or low income mothers. Hospital-based doula programs are gaining popularity. The doula may be on call and come into the hospital as needed when a woman enters labor, or she may meet clients in the prenatal period and join them in labor. Community-based doula programs have also filled a niche in many areas, often working through women's centers or community outreach organizations.

Conclusion

"Holding Women" — a doula — proves to be more than just a nice thought. Not only is it an effective way to lower obstetric expenses and improve the outcome for mothers and babies, it is a concept rife with potential for enhancing mothers' abilities to confidently and capably parent the next generation of caretakers of our earth. □

References

1. Klaus MH, Kennell JH, Klaus P. *Mothering the Mother.* Reading, Massachusetts: Addison-Wesley Publishing Co., 1993:4
2. Klaus, Marshall. Personal Communication, October, 1998
3. Kennell JH, Klaus MH, McGrath SK, Robertson SS, Hinkley CW. Continuous emotional support during labor in a US hospital. *Journal of the American Medical Association.* 1991:265:2197-2201
4. Sosa R, Kennell JH, Robertson S, Urrutia J. The effects of a supportive companion on perinatal problems, length of labor, and mother-infant interaction. *New England Journal of Medicine.*1980;303:597-600
5. Hofmyer GJ et al. Companionship to modify the clinical birth environment: effects on progress and perceptions of labor and breastfeeding. *British Journal of Obstetrics and Gynaecology.* 98(1991):756-764
6. Wolman W, et al. Postpartum depression and companionship in the clinical birth environment. A randomized, controlled study. *American Journal of Obstetrics and Gynecology.* Vol./Issue(May 1993):Pages
7. Simkin P. Just another day in a woman's life? Women's long-term perception of their first birth experience. Part 1. *BIRTH* 18.4 (December 1991):Pages
8. Konrad C. Helping mothers integrate the birth experience. *MCN* 12 (July/Aug 1997);268

Table 2. DONA Standards of Practice

Doulas of North America Standards of Practice

I. **Scope**

A. *Services Rendered*. The doula accompanies the woman in labor, provides emotional and physical support, suggests comfort measures, and provides support and suggestions for the partner. Whenever possible, the doula provides pre- and postpartum emotional support, including explanation and discussion of practices and procedures, as needed.

B. *Limits to Practice.* The doula does not perform clinical or medical tasks such as taking blood pressure or temperature, fetal heart tone checks, vaginal examinations, or postpartum clinical care. DONA Standards and Certification apply to emotional and physical support only. Doulas who are also health care professionals may provide these services within the scope and standards of their professions.

C. *Advocacy.* The doula advocates for the clients wishes as expressed in her birth plan, in prenatal conversations, and intrapartum discussion. She helps the mother incorporate changes in plans if and when the need arises, and enhances communication between client and caregiver. Clients and doulas must recognize that the advocacy role does not include the doula speaking on behalf of the client or making decisions for the client. The advocacy role is best described as support, information, and mediation or negotiation.

D. *Referrals.* For client needs beyond the scope of the doula's training, referrals are made to appropriate resources.

II. **Continuity of Care**

The doula should make back-up arrangements with another douls to ensure service to the client if the doula is sick or unable to be reached. Should any doula feel a need to discontinue service to an established client, it is the doula's responsibility to notify the client in writing and arrange for a replacement, if the client so desires. This may be accomplished by:

A. Introducing the client to the doula's back-up.

B. Suggesting that another member of Doulas of North America (DONA) or other doula may be more appropriate for the situation.

C. Contacting DONA Regional Representative or local doula organization for names of other doulas in the area.

D. Following up with a client or back-up to make sure the client's needs are being accommodated.

III. **Training and Experience**

A. *Training.* Doulas who are certified by DONA will have completed all the requirements as set forth in the DONA Requirements for Certification. This includes training in childbirth and a labor support course which consists of at least fourteen hours of training, reading four books from DONA Reading List, and completion of an essay on the value and purpose of labor support. See the DONA Requirements for Certification for more detail on Training and Experience.

B. *Experience.* Doulas certified by DONA will have the experience as set forth in the DONA Requirements for Certification. This includes provision of support to at least three clients, good evaluations from clients and health care providers, and records of three births, including a summary, observation form, and accounts for each birth.

C. *Maintenance of Certification.* DONA certified doula will maintain certification by participation in a Peer Review process after each three-year period of practice. Doulas must attend at least one continuing education event per year in maternal/child health.

IV. **Record Keeping**

A. *Documentation.* The doula maintains clear and accurate records of each client encounter and the birth.

B. *Data Collection*. The doula collects and submits to DONA on a regular basis data on the clients she provides services to, and the outcomes of their pregnancies and labors.

Doulas of North America (DONA), 1100 23rd Avenue East, Seattle, WA 98112

CAIRE Awarded American Indian Wellness Project Grant

The University of California, Berkeley's Center for American Indian Research and Education (CAIRE) has received a 1.6 million dollar award to conduct culturally sensitive research on factors that influence "wellness" in American Indian people. *Wellness Circles: an American Indian Approach* was funded as a five-year project by the National Institute of Nursing Research. The project is designed to enhance the well-being of American Indians and Alaska Natives residing in rural California counties through comprehensive assessment of their current health behaviors in order to develop a health promotion and disease prevention model in rural Indian communities. The goals of the project are to design, implement, and evaluate a community-based health care model for American Indian families.

The *Wellness Circle* is a three phase project. In the first phase, a health assessment will be administered. Phase 2 will entail development of an intervention model to be tested at eight selected tribal sites. The intervention model will combine American Indian storytelling and traditional beliefs and values, and will incorporate Western health prevention information in a talking circle format. In phase 3, a review of the data will be conducted. Successful implementation of this project will be the result of collaboration between tribal governments, tribal health boards and staff, and the Center for American Indian Research and Education. Participating communities will receive a copy of the final report and assistance in disseminating the information to their communities.

The Center for American Indian Research and Education was established in the early 1990s. The center has conducted research in the areas of breast cancer, diabetes mellitus, cervical cancer, nutrition, and smoking cessation within the American Indian population. The project's principal investigator is the Center's Director, Felicia Hodge, DrPH (Wailaki); the project director is Betty Duran, MSW (Pueblo). CAIRE's mission is to improve the status of American Indians and Alaska Natives by developing, promoting, and evaluating culturally appropriate health, educational, and social policy programs.

For more information on CAIRE or the Wellness Circles project, contact Betty Duran, Project Director, Talking Circles at (510) 843-7694 or (510) 843-8661. □

FOCUS ON ELDERS □

Elder Care: A Call to Action

Bruce Finke, MD, Staff Physician at the Zuni-Ramah Service Unit, and Director of the Elder Care Initiative, Zuni, New Mexico

As many of you know, the month of May is celebrated around the country as Older American's Month. In previous years *The IHS Provider* has devoted the May issue to articles related to Elder Care. As we look forward to May 1999, in the International Year of the Older Person, we propose a novel way to mark the month in the Indian Health Care system. Let's commit time this coming May to an effort to build and nurture interdisciplinary Elder Care teams in our facilities.

There are compelling reasons why the interdisciplinary team approach works well in Elder Care in Indian health, urban, and tribal programs (I/T/U). Elder care is, by nature, an interdisciplinary process. The elder's needs cross boundaries of profession and setting. In addition, relatively rapid staff turnover and the pressure of competing demands often hamper change within our systems. The team approach allows us to proceed with our work without relying on the energy or efforts of a single individual.

For teams to work they need a little care and feeding. They need encouragement and time. In May 1999, set aside time each week for the formation and nurturing of an interdisciplinary team to address issues of enhancing elder care at your site. Each site's capabilities, personnel, and needs are different. Approaches taken at one site may not work at another, and you will know best what you can do at your site. Take this opportunity to sit down together and look at what you can do for your elders.

You may need to take time out of clinic hours. Let your community know what you are doing. Most of our communities will be very supportive when we tell them we need to set aside a few hours to work on improving care for our elders.

In the coming months we will share information about how teams currently operating in the I/T/U settings are addressing elder care needs. We'll look at who is on those teams, how the teams function, and what projects seem to work well.

May 1999 is not all that far away. Start planning now. Let's use Older American's Month in the International Year of the Older Person to build and grow the teams we need to improve care for our elders.

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THE IHS PRIMARY CARE **PROVIDER**

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