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Health Cares About Domestic Violence Day/Domestic Violence Awareness Month: I/T/U Hospital and Clinic Activities

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On October 8, 2003 Rosebud Indian Health Service in South Dakota will begin routine domestic violence screening on female patients seen in their Emergency Department as part of Health Cares About Domestic Violence Day. This screening highlights Rosebud's ongoing efforts as part of a nine-site IHS interagency pilot project to improve the health care response to domestic violence.

Another pilot project site, Choctaw Health Center, will have several "brown bag" lunches during the month of October with clinic physicians and nurses providing education regarding domestic violence. There will be posters, educational, and resource materials displayed throughout the clinic, and on October 8, the staff will be wearing purple ribbons to help raise domestic violence awareness.

These and other efforts help mark the fifth annual *Health Cares About Domestic Violence Day*. October 8 is the national domestic violence awareness day, organized by the Family Violence Prevention Fund (FVPF), designed to promote routine health screening of patients for abuse. In addition, many health care facilities recognize October as Domestic Violence Awareness Month with patient and staff education activities focusing on increasing awareness and promoting routine screening.

Definition and Impact of Domestic Violence

Domestic violence (DV), or intimate partner violence (IPV) as it is widely becoming known, is an urgent public health problem. DV/IPV is not confined to any ethnic, religious, racial, socioeconomic, or age group. It occurs among heterosexual women, men, and adolescents and also among lesbian, gay, transgender, and bisexual (LGTB) individuals.

The devastating impact of DV on women, children, and families has been well documented. It is the leading cause of injuries to women between the ages of 15 and 44. While men

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are also victims of IPV, the U.S. Department of Justice indicates that in 2001, 85% of victimizations by intimate partners were against women. Each year, thousands of American children witness DV/IVP within their families with devastating short- and long-term consequences.

Intimate Partner Violence has been defined by the Family Violence Prevention Fund as a "pattern of purposeful coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation, and threats. These behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent victim and are aimed at establishing control of one partner over another."

DV/IPV is associated with both short- and long-term problems, including physical injury and illness, psychological symptoms, economic costs in lost wages and the provision of health care, and death. Research has found that domestic violence is connected to eight of the ten leading health indicators selected by the U.S. Department of Health and Human Services to measure the health and well-being of Americans – including access to health care, responsible sexual behavior, and substance abuse. These health indicators are part of *Healthy People 2010*, a prevention agenda for the nation developed by the U.S. Department of Health and Human Services' Office of Disease Prevention and Health Promotion.

IHS/ACF Domestic Violence Pilot Project

The Indian Health Service (IHS) and Administration for Children and Families (ACF) Domestic Violence Pilot Project is designed to help Indian, tribal, and urban program (I/T/U) health care facilities improve their responses to domestic violence in their communities. Other Pilot Project partners include the Family Violence Prevention Fund, Mending the Sacred Hoop Technical Assistance Project, and Sacred Circle. In 2003, the Pilot Project funded a total of nine I/T/U pilot sites: Ketchikan Indian Corporation, Ketchikan, AK; Feather River Tribal Health, Inc., Oroville, CA; Houlton Band of Maliseet Indians, Houlton, ME; Mississippi Band of Choctaw Indians, Choctaw Health Center, Choctaw, MS; Rosebud Health Service, Rosebud, SD; Gerald L. Ignace Indian Health Center, Milwaukee, WI; Zuni Comprehensive Community Health Center, Zuni, NM; Warm Springs Indian Health Center, Warm Springs, OR; and Crownpoint Healthcare Facility/Family Harmony Project, Crownpoint, NM.

Through collaboration with one another and with experts in community-based health care delivery and domestic violence, the pilot sites will develop culturally appropriate training materials and resources for health care providers and victims. They will also increase awareness of domestic violence as a public health issue, and promote public education and outreach within Native communities. The Pilot Project sites will receive training in the development of policies and procedures and the screening and documentation of DV/IPV. They will serve as models to other AI/AN clinics and hospitals and be a resource for other I/T/U health care facilities.

IHS GPRA Domestic Violence/Intimate Partner Violence Indicator

The DV/IPV GPRA indicator is a clinical indicator that focuses on ensuring that DV/IPV policies and procedures exist in all I/T/U clinical facilities and that education of clinical staff about DV/IPV occurs. In 2003, 2004, and 2005 the emphasis will be on the development of a DV/IPV screening code within RPMS, routine screening, and the documentation and reporting of screening outcomes.

Future articles will provide additional information about the IHS/ACF DV Pilot Project, the RPMS exam code for DV/IPV screening, and the DV/IPV GPRA Indicator.

Health Care Providers Can Help!

Health care providers are in a unique position to help victims of DV/IVP who seek routine or emergency care. But, too often, health care providers miss this golden opportunity because they are not trained to screen patients for abuse. Simply by routinely screening patients for DV/IVP and providing them with appropriate information and referrals, health care providers can make an enormous difference for victims and their children. In some instances, lives can be saved by addressing both the acute medical needs of victims as well as the chronic long-term health conditions associated with a history of abuse.

Properly trained doctors, nurses, and other health care providers are uniquely qualified to intervene to help victims. Yet, a study published in 1999 in the *Journal of the American Medical Association* found that less than ten percent of primary care physicians routinely screen patients for partner abuse during regular office visits.

Resources

Rosebud's screening program, and the activities of the other DV Pilot Project sites will be guided in part by materials from the FVPF's National Health Resource Center on Domestic Violence. The Resource Center has developed consensus guidelines regarding screening and intervention applicable to a variety of health care settings. To obtain these consensus guidelines and other educational materials you can visit the Family Violence Prevention Fund's website at *www.endabuse.org\health*, or call the National Health Resource Center on Domestic Violence at 1-888-Rx-ABUSE; TTY: 1-800-595-4899.

Sample hospital and clinic policies and procedures, tools for screening and intervention, and other resources can be found on the IHS Maternal and Child Health Domestic Violence website at *http://www.ihs.gov/MedicalPrograms/MCH/W/DV00.cfm.*

If you are a victim of domestic violence, call the National Domestic Violence Hotline at 1-800-799-SAFE; TDD: 1-800-787-3224.

An Annual Editorial Calendar for The Provider

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

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

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

IHS Annual
Editorial Calendar

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

Asthma Prevalence and Care for American Indian Youth in North Dakota

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Introduction

Asthma is the most common chronic disease among children.[1] The prevalence of diagnosed childhood asthma increased dramatically during the last two decades of the 20th century.[2] The direct cost of caring for asthma in the U.S. is enormous, and indirect costs such as missed school days and loss of parental work days are also substantial.[3, 4] Both the personal burden and economic cost of asthma should decrease when health care is delivered in a systematic way.[5] Evidence-based guidelines exist, and several Healthy People 2010 objectives concern asthma and asthma care.[6]

Few estimates of the prevalence of asthma in American Indian youth and even fewer assessments of care provided to these youth have been published.[7-9] In this report we describe the prevalence of diagnosed asthma in youth receiving care on an American Indian reservation in North Dakota. We also compare the care patterns for these youth to the National Asthma Education and Prevention Program (NAEPP) 1997 guidelines for care.

Methodology

The subject reservation is located in North Dakota and had a 2000 census population of less than 5,000 people. Approximately 48% of the reservation population was less than 21 years of age in the 2000 census. There is no local hospital, but one Indian Health Service Clinic serves this reservation. This clinic is the setting for this study.

We reviewed the medical records of patients age 20 years or younger, who had a diagnosis of asthma (ICD 493), or a closely related respiratory condition (ICDs 306, 466, 491, 495, 506, 508, 786, 995), and who had at least one clinic visit from January 12, 2001, to January 11, 2002. Two hundred forty-one patients were identified. For the purpose of this investigation we adopted the Council for State and Territorial Epidemiologist (CSTE) definitions for asthma,[10] and classified cases into one of four categories based on information found in the medical record review. These categories were: confirmed, probable, possible, and not asthma.

Data from the U.S. Census Bureau were used to determine the denominator. In 2000, the estimated population for Spirit Lake Reservation inhabitants under 21 years of age was 2,110, representing approximately 48% of the reservation's total population (4,435).[11]

In order to assess patterns of care provided to patients with diagnosed asthma, we sought the following information from the medical records: assessment to describe the severity of the patient's condition; documentation of use of inhaled corticosteroids if patient had persistent asthma and is age 5 years or older; spirometry (initial assessment, then every 1-2 years); written self-management plan given or updated; patient's metered dose inhaler or nebulizer technique assessed; determining whether follow-up appointment was scheduled; and documentation of smoking status. Data analysis was conducted using SPSS software.

Results

Of the 241 medical records reviewed, 110 did not meet our case definition for asthma, 55 were possible asthma cases, 74 were probable asthma cases and two were confirmed asthma cases. We limited our subsequent analysis to the probable and confirmed cases (N=76). These patients were predominantly males (58%) and had an average and median age of 6 years and 3 years, respectively. Of 22 patients age 10 to 20 years, nine (41%) were current smokers. Among 65 patients for whom smoking exposure status was known, 60% (39) were currently exposed to second-hand tobacco smoke. The estimated prevalence rate for probable and confirmed asthma was 36 cases per 1000 persons under the age of 21 years.

Twenty-three (30%) patients had one or more emergency department visits in the past year due to respiratory symptoms. Among these patients, the total number of visits ranged from one to seven. Half (50%) had only one ED visit. Regarding inpatient care, 15% (11) of patients had one or more hospital stays in the past year.

The purpose of the most recent clinic visit for these patients was "urgent care" (69%; 52), "follow-up" (17%; 13), and "physical exam" (13%; 10). During the most recent office visit, a peak flow meter was rarely used (only one patient) and a spirometry test was not used.

Patients were currently on the following asthma medications: short-acting beta-agonist (66%; 50); nebulized beta-agonist (26%; 20); oral steroid (9%; 7); inhaled steroid (8%; 6); antihistamine (4%; 3); long-acting beta-agonist (3%; 2); mast cell stabilizer (3%; 2); leukotriene inhibitor (1%; 1).

A number of health care techniques were used infrequently or not at all. Few patients had received instructions for making a follow-up appointment (5%; 4); or written asthma plan (4%; 3). Measurement of FEV_1 and assessment of patients' metered dose inhaler or nebulizer technique had not been recorded for any of the patients.

Discussion

The asthma prevalence of 3.6% in this pediatric population was lower than anticipated. A study conducted by the North Dakota Department of Health titled, "Childhood Asthma Prevalence in North Dakota" estimated the pediatric asthma prevalence using Medicaid billing data to be 7.0%.[12]

Several important opportunities to improve asthma care for these patients were identified. In this section, we will describe limitations of this study, highlight the findings in light of the current evidence for care of asthma, and offer recommendations for further work with the population focused upon in this study.

Readers should be cautious when interpreting the results reported here due to several limitations of the investigation. The asthma prevalence we estimated in this study is less than recently published estimates for the U.S. pediatric population (5.3%)[13]; North Dakota's Medicaid eligible pediatric population (7.0%)[12]; and American Indian youth (>12.0%).[8] There are several possible explanations for this finding. First, asthma prevalence in this American Indian clinic population may, in fact, be lower than that in other areas of the state and the country. Second, ascertainment of asthma cases in the clinic's population would underestimate the true number of cases in the clinic's population if patients with asthma sought asthma care at nearby clinics (one town is 15 miles away) even while seeking care for other medical conditions at this American Indian clinic. We think this possibility is unlikely. In fact, American Indians eligible for care at this clinic, and with the chronic disease asthma, may come to the clinic for asthma care even if they lived outside the immediate community served by the clinic.

Third, the documentation in the medical records may not fully reflect the diagnosis and treatment services provided. Since our method of ascertaining cases relied on documentation in medical records, it is likely that we did not include some asthma cases because documentation was incomplete. However, even if we were to include the 55 "possible" case identified in this study, the resulting prevalence estimate would still only be 6%. Fourth, using a staged ascertainment technique (i.e., patients could be classified as confirmed, probable, possible, or not asthma) we are probably able to increase or decrease the sensitivity, and inversely affect the specificity by changing the parameters by which we identify "asthma cases." In this study we only counted confirmed and probable asthma cases. This probably increased the specificity of our ascertainment, but may have led to an underestimate of true asthma cases.

There were also limitations regarding our denominator (i.e., "population at risk" estimate). In this study, we had the option of using pediatric population estimates from any of the following sources: U.S. Census data; Indian Health Service user data; or the clinic's clinical records. Each of these population estimates has limitations. For example, the U.S. Census may generate underestimated population figures due to survey non-response. This is a phenomenon believed to be particularly prevalent on American Indian reservations. Both the IHS user population and clinic patient data represent underestimates, as the numbers are generated from IHS facility users only; thus, eligible Indians who choose to utilize non-IHS health services will not be counted.

Despite the limitations of the prevalence estimate, we feel that much can be learned from the assessment of practice care patterns in the cases identified. The results suggest that adherence to the NAEPP practice guidelines was quite limited. While we feel that substantial opportunity to improve care exists, it is possible that care provided was not fully reflected in the medical records. Even if this were the case, however, it is likely there is room to improve care for asthma patients. Care for chronic diseases, such as asthma, requires considerable coordination among members of a health care team. Each visit is strongly connected to services/education provided in past visits, and to services planned for future visits. This coordination of care can only be accomplished when appropriate documentation occurs in medical records.

Many studies conducted in this country and elsewhere have demonstrated effective ways to diagnose, assess, and manage patients with asthma. This is the focus of the NAEPP. The NAEPP guidelines were first published in 1991 and revised in 1997, using an evidence-based approach to treating patients with asthma. In instances of uncertain evidence, the report gave recommendations from "expert opinion."[5] When examined, a number of studies have found that health care providers are not fully adhering to the guidelines.[14] Underusage of written asthma management plans,[15-18] lack of observation of patient inhaler technique,[17, 18] not providing an influenza vaccination,[19] not using spirometry for diagnosis,[17,18] and not using inhaled corticosteriods[18] in appropriate patients are just some of the important areas in which care needs to be improved. Patient education has been associated with better asthma management and patient outcomes, yet only 8.4% of persons with asthma has received formal patient education.[6]

The results of our study are consistent with the above reports. Practice patterns at this clinical setting show infrequent adherence with the NAEPP guidelines. This is not a unique situation.[20, 21] Previous studies have shown that publishing guidelines does not guarantee changes in clinical practice.[22] While good evidence may be available, translating this evidence into practice can be a challenge for busy clinicians. With this in mind we offer the following three recommendations.

First, based on expert opinion, the NAEPP recommends that children with asthma should have a written asthma management plan (WAMP), as outlined in the NAEPP guidelines. The WAMP would include a wide variety of situation-specific action steps, including: use of daily anti-inflammatory therapy (particularly inhaled steroids for patients greater than 5 years of age with persistent asthma); instructions for patients and parents regarding steps to take when asthma worsens (e.g., when to increase treatments, use oral steroids, or visit a physician office or emergency room); daily use of a peak flow meter for specified patients; and the correct use of a spacer with an asthma inhaler. There is much room for improvement in each of these categories for this cohort of patients.

Second, improvements could be made in compliance with some guidelines among patients and parents. For example, a large portion of the patients either smoked and/or lived in a home environment with smokers. Contact with indoor allergens and irritants can aggravate asthma symptoms and may lead to the development of asthma.[23-25] Patients with asthma would benefit from efforts to reduce smoking prevalence among both patients themselves and persons living with these patients.

Third, despite the fact that clinicians often know what is supposed to be done, the management of chronic disease suffers from process problems, i.e., intended clinical actions are not accomplished because the process-of-care in clinical settings is not designed systematically to achieve these actions. Busy practices, limited time for patient education, fragmentation of health care, and other issues may all lead to guideline recommendations being underutilized. Tools that help the busy practitioner coordinate care through a team-based approach have been shown to be beneficial for care of chronic diseases.[26] It is likely this will also be true for asthma.

In conclusion, primary and secondary prevention steps for asthma among American Indian youth should be an area of high priority. Reservation health officials should consider increased efforts in public education regarding asthma and the promotion of efficient communication and collaboration among clinicians, patients, and parents to strengthen asthma management strategies.

Acknowledgement

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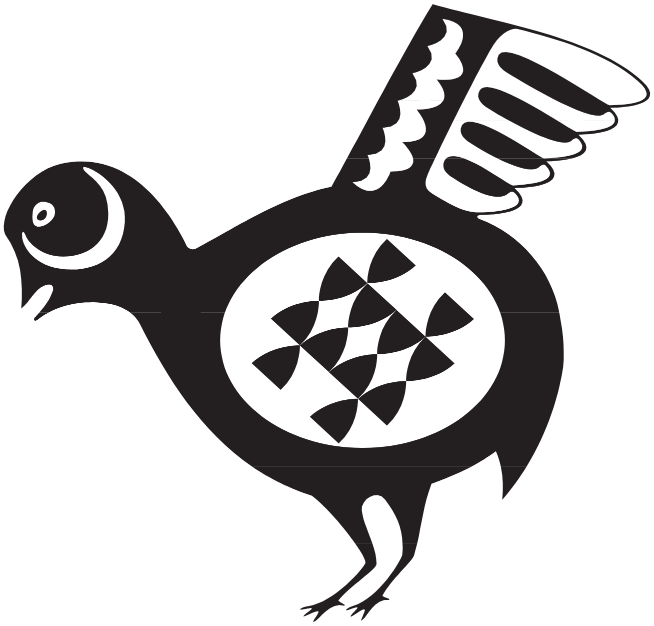

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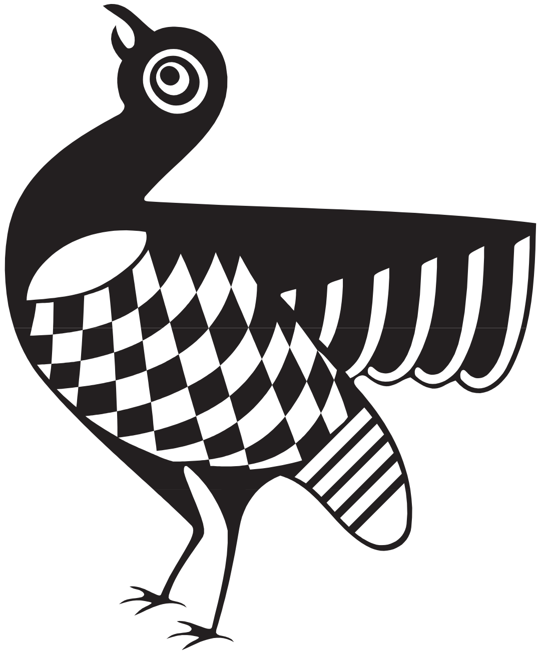

PCC+: Addressing the Concerns of Providers

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The PCC+ application provides a comprehensive tool to document and code the services and procedures that occur during a patient encounter visit. However, with all the steps and reminders built into the data capture process for PCC+, providers have voiced their concerns regarding the increase in time required to complete the form, the availability of space to document, and other related complaints.

This article summarizes key provider questions regarding the use of PCC+ and tries to address each issue based on today's PCC+ design as well as the planned changes for the future.

Question: ***Wasn't PCC+ primarily developed to improve insurance billing and collection?***

The PCC+ application was designed by a provider for a provider for multiple purposes. The original intent was to eliminate multiple-copy, "hard-to-read" PCC forms *and* to eliminate the need for multiple forms (PCC and superbill). Additionally, the PCC+ form was to provide short excerpts of the patient's previous visit as a quick resource tool to the provider during the patient visit. It also was designed to incorporate helpful reminders to improve documentation and data capture; improve communication between coding and data entry; decrease the amount of handwritten orders for procedures, lab, x-ray, or pharmacy, and reduce the number of handwritten diagnoses, by using check boxes.

With that said, a secondary benefit was also realized — improved data documentation with imbedded codes enhanced data capture in RPMS, resulting in improved billing and reimbursement. The secondary benefit led to decreased business office man-hours, enhanced coding clarity between the clinic and insurer, improved data capture for the GPRA+ reports, and reduction of identified "weaknesses" in the business process. In a short response, PCC+ was primarily designed to assist the provider but other add-on benefits have been derived.

Question: ***Why has the space for provider documentation been so drastically reduced?***

When the PCC+ form was introduced in the clinical setting, *all* providers complained about the limited "real estate" available to document information about the patient's visit. No provider was happy with the restricted space. The issue for providers was not only the small font size and space to document, but also the time required to complete the entire form.

To assist the provider, simplified areas and customization were incorporated into the form to save time and reduce unnecessary written documentation. All PCC+ forms are customized to each clinic so that it includes only relevant information pertinent to that clinic. This customization includes relevant CPT codes (professional services like evaluation and management visits), ICD9 codes (diagnosis), HCPCS codes (supplies), health factors (tobacco and alcohol), domestic violence documentation, patient education coding, injuries, allergies, and so forth.

Therefore, instead of having to write out in longhand lab, x-ray, injections, procedures, immunizations, tobacco and alcohol health factors, prescriptions, etc., the provider only needed to check a box and initial it. It was assumed the provider's notes relating to the visit would become shorter, thereby requiring less space. On the other hand, if a more extensive note was needed (i.e., the patient presents with multiple problems during the visit), a supplemental PCC form could be used.

The secondary complaint regarding "space" was the restrictive area for ordering new or re-ordering existing prescription drugs. Currently a small, single line with a limited number of characters per line is available for each drug. In addition, only fifteen drugs can be listed on the form. This space restriction potentially may leave no space to list all the drugs (i.e., if a patient is using more than 15 drugs) and/or ample space to order new drugs.

Several solutions have been offered to the providers and clinics to assist with the restricted pharmacy space:

- The health summary should always be printed – this summary can list all drugs, active and chronic.
- A supplemental PCC or pharmacy PCC+ second sheet can be used or designed for pharmacy, allowing more space.
- The PCC+ system can be designed to list only the active or the chronic drugs, limiting the number drugs printed on the form.

Question: ***Why are they trying to make providers coders?***

As a secondary benefit, as mentioned previously, PCC+ was designed to improve communication between a physician and a coder by providing a more defined mechanism of linking the written documentation to the correct and most accurate code. Many times, the provider's written notes or abbreviations are misinterpreted by a coder or data entry staff or are altogether missed by being sandwiched in the provider's notes. The results: missed data, missed billable services, and incorrectly coded encounters.

One of the intents in incorporating coding into the PCC+ was to educate the providers on what types of information are needed by the coder or data entry staff to accomplish their job.

Example: *Is the diabetes Type 1 or Type 2?*
Is the diabetes complicated or not?
Does the diabetes include retinal problems, hyperlipidemia, or elevated blood pressure?

By providing more defined codes, "fill in the blank areas," and/or "circle areas" to further describe the diagnosis or procedure, the business office will be able to more easily understand and correctly interpret each service, procedure, and diagnosis.

The overall, underlying objectives are twofold: 1) to improve the timeliness of data entry; and 2) to improve data quality for the facility, Area Office, national reports, and Health and Human Services.

Question: ***How are follow-up appointments and referrals that are documented on PCC+ accurately communicated to the appointment desk or the patient?***

With a centralized appointment desk, the ease of communicating this information has become a problem. Previously, providers gave the yellow tear-off appointment copy from the PCC to the patient, but with a single form (which is the original and the legal document for the visit), it cannot be separated from the medical record.

Several solutions have been offered to resolve this problem:

- Develop an appointment form that includes names of various clinics and a space for next appointment, such as 2 months or 3 months. The provider would need to check the clinic box and state timeframe for return visit.
- Design a second sheet to the PCC+ form that can be used as an appointment form.

Both solutions provide the patient and the appointment desk with the needed information; however both solutions are duplicative of the information already listed on the original PCC+ form.

Question: ***Why has a more complicated process been developed with PCC+ instead of just moving forward with an Electronic Medical Record application?***

PCC+ was designed as an interim step to consolidate and enhance data collection related to the encounter. An electronic medical record is being developed by the Information Technology Support Center in Albuquerque.

Conclusion

All new applications create change — some more than others, some for the better; some make things more complicated, and some are appreciated by certain groups while others may feel that it creates unnecessary work. Overall, the intent of any new application is to try to improve the data captured, improve the process, and ultimately improve the quality of patient care. PCC+ is an attempt to move clinics and facilities to a more comprehensive, integrated record, preparing each and every site for new and more extensive applications.

If your site is having problems or concerns with PCC+, please forward your comments to the help desk or the PCC+ user group for review.

The help desk is available at *http://www.ihs.gov/Cio/RPMS/TechSupp.asp* or by calling (505) 248-4371 or (888) 830-7280.

If anyone needs to subscribe/unsubscribe to the PCC+ listserv, you should go to *http://www.ihs.gov/cio/listserver/index.cfm*.

Note the new address for the PCC+ listserv *pccplus@listserv.ihs.gov*.

GPRA Indicator: Cardiovascular Disease

Mary Wachacha, BS, CHES, Acting Director, Division of Clinical and Community Programs, Chief Consultant, Health Education, Indian Health Service, Rockville, Maryland; and Frank Grayshield, MPH, Public Health Advisor, National Institutes of Health, National Heart, Blood and Lung Institute, Bethesda, Maryland

Native Americans and Alaskan Natives (AI/AN) have witnessed an epidemic rise of heart disease. According to Dr. James Galloway, IHS Cardiologist, “Although cardiovascular disease (CVD) was quite uncommon among American Indians and Alaska Natives until relatively recently, CVD has now become the leading cause of death in this population.”

The publication, *Regional Differences in Indian Health* states that Diseases of the Heart are the Leading Cause of Death in eight of the 12 IHS Areas. Dr. Galloway states, “Recent data have now shown that the incidence of AI/AN cardiovascular disease is almost double that of the general U.S. population, and this has resulted in a higher CVD mortality rate than in the general population. This increase in cardiovascular disease is clearly related to the rapidly developing rates of risk factors, including obesity, hypertension, dyslipidemia, and tobacco use, as well as the epidemic of diabetes occurring among AI/AN. Indeed, approximately 65% of these individuals with cardiovascular disease also have diabetes.”

In response to these trends, the NIH, National Heart, Lung and Blood Institute (NHLBI), in conjunction with the Indian Health Service and tribal communities, developed a cardiovascular heart project, the “NHLBI/IHS Partnership for Strengthening the Heartbeat of AI/AN Communities.” This project included the development of a training manual entitled *“On the Wings of Eagles: Soaring for Heart Healthy Living”* to be used as a key interventional tool for conducting training for AI/AN community health professionals on cardiovascular disease. The goal of this project was to provide communities awareness and activities related to cardiovascular disease.

Initially, three communities were selected to participate in the project: the Laguna Pueblo, Laguna, NM; the Bristol Bay Corporation, Dillingham, AK; and the Ponca Tribe of Ponca, OK. In FY 2003, two new sites were chosen: the Santa Fe Indian Hospital and the Clinton Service Unit. In FY 2004 new sites will be the Crow Agency, Crow Agency, MT and the Northern Cheyenne Service Unit, Lame Deer, MT.

Consequently, the Indian Health Service decided to strengthen its CVD efforts by including the CVD project as a GPRA Measure. The current GPRA Indicator is as follows:

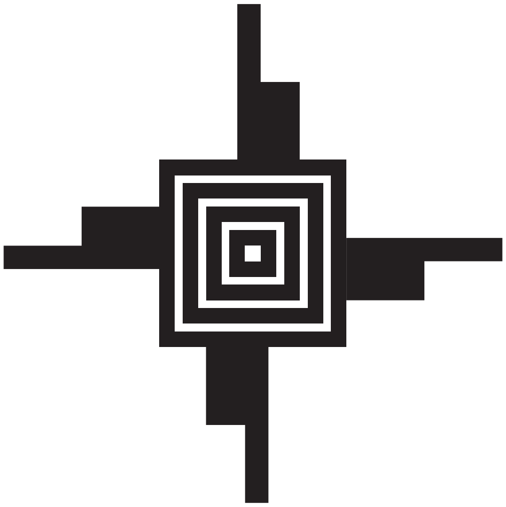
> Indicator 30: During FY 2003, the IHS will continue collaboration with NIH to assist five AI/AN communities to implement culturally sensitive, community-directed pilot cardiovascular disease prevention programs.

Tracking Measures

While the intent of the project is to provide community-directed interventions targeting CVD, the efficacy of those initiatives will be tracked by two methods: 1) a community assessment of cardiovascular disease and, 2) by the tracking of seven GPRA+ clinical cardiovascular disease indicators. These GPRA+ Clinical Tracking Measures (included in the ‘03 GPRA+ software) include the following:

1. Obesity rates
2. Dyslipidemia levels
3. Hypertension rates
4. Tobacco use
5. Diet and exercise counseling/education
6. Medication education
7. Diagnosis of depression/stress

The IHS believes that the provision of community interventions will improve clinical outcomes for clients. GPRA+ allows for ongoing assessment of the impact of these interventions.



Community Assessment

There are few culturally-specific community assessment tools available to AI/AN communities. Tina Tah, the Albuquerque Area Office contact for this project at Laguna, recognized the need for the development of a unique CVD community assessment tool. Mike Gomez, from the Indian Health Performance Evaluation System (IHPES) Program, and Natalie Thomas, the Laguna Project Director, developed a web-based Community Assessment Survey in response to this need. Although this particular assessment tool captures CVD information, the assessment can be redefined as needed to examine other health care areas.

The tool is valuable because it can yield a "community health profile" documenting the community's understanding of CVD, and can also provide an individual participant's "profile" including blood pressure, body mass index (BMI), blood glucose, and other relevant lab test results. These data can be analyzed over time to determine what community activities most favorably impact participants' improved "outcomes." The data can also assist community intervention efforts to target programs or other community needs to reduce or eliminate complications related to CVD.

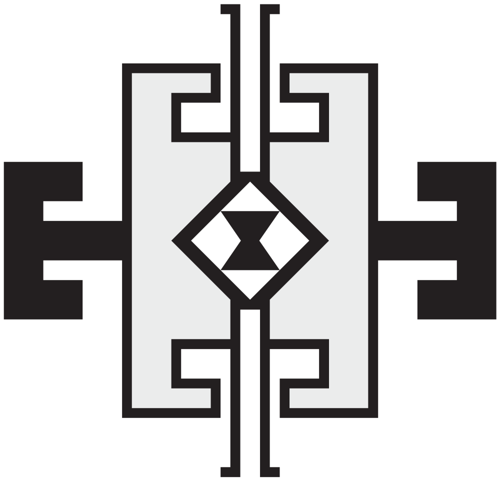
The Community Health Assessment tool provides a mechanism for tribal programs to enter data for the intent of defining baseline indicators — from which they can objectively measure their interventions regarding primary prevention activities (especially the patient education portion once this is completed). Among other things, it can do the following:

- Provide data with which to monitor preventive health projects and support grant/program goals and objectives
- Measure objective outcomes; if this tool is applied at the beginning of a program intervention and then at the end, this will provide data to reflect any changes as a result of the intervention
- Provide a means of "tracking" program implementation and possibly overall program progress
- Undergo modification to be used for other community-based projects

Ongoing Improvement

As these five AI/AN communities continue to strive to eliminate cardiovascular disease within their communities, the Indian Health Service and the National Heart, Blood and Lung Institute are moving forward to increase awareness of the escalating rates of cardiovascular disease in AI/AN. Currently, the IHS is working with NHBLI to offer a national "Train the Trainers" skills building workshop in Phoenix, Arizona, December 8 – 12, 2003. This training would be beneficial for health professionals including nutritionist/dietitians, health educators, CHRs, HP/DP coordinators, PHNs, and other tribal/IHS health staff.

The purpose of this training will be to train several individuals from selected AI/AN communities in CVD prevention. Ultimately, these individuals would then return to their respective communities and host their own community education activities including health fairs, CVD prevention days, and general education focused on the prevention on heart disease. For additional information about the CVD community projects, contact Mary Wachacha by telephone at (301) 443-9531; e-mail *mwachach@hqe.ihs.gov*.



Nurse Anesthesia Training Opportunity For PHS Nurse Corps Officers

This training is intended to fill critical positions within the Indian Health Service or tribal health programs by providing intramural training for qualified PHS Nurse Corps Officers to meet national certifying examination requirements for Certified Registered Nurse Anesthesia (CRNA). Selected candidates must meet admission requirements for the Uniformed Services University of the Health Sciences (USUHS), Bethesda, Maryland. Pending availability of funds, two nurse corps officers will be selected annually for this training opportunity.

Application requirements include the following:

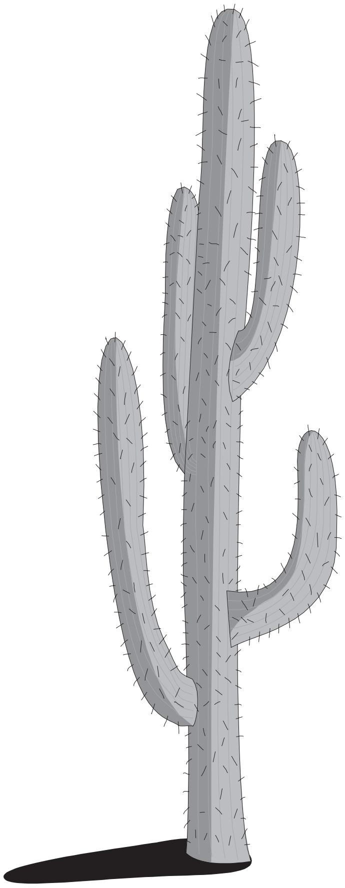
1. Time on Duty Station: none;
2. Rank: Lt. Junior Grade through Lt. Commander;
3. CV must reflect a minimum of one year of ICU, ER, OR, or PACU nursing experience (preferably obtained within the last five years);
4. Copy of undergraduate or graduate transcripts. Undergraduate grade point average (GPA) of 3.0 on a 4.0 scale or graduate GPA of 3.5 on a 4.0 scale; to include Organic or Biochemistry course (B or better, taken within the last five years);
5. Proof of current ACLS-Provider or Instructor certification;
6. Graduate Record Examination (GRE) taken within the last five years. A minimum combined verbal, analytical, and quantitative score of 1500;
7. IHS intramural training form #6374. For downloadable form go to *http://dcp.psc.gov/DCPFORMS.asp*;
8. Letter of recommendation from ICU, ER, OR, or PACU Nursing Supervisor.

Submit application to:

Celissa G. Stephens, RM, MSN
Sr. Nurse Consultant, Hospitals, Clinics and Recruitment
Indian Health Service
Division of Nursing
801 Thompson Avenue, Suite 300
Rockville, MD 20852

If you have any questions please call (301) 443-1028.

Other requirements: concurrently submit an application to USUHS. Go to *http://cim.mil/gsn* to download a Masters Application pdf file.



Online STD Case Series

The National Network of STD/HIV Prevention Training Centers is pleased to announce that the first two cases in its "Online STD Case Series" are now available online at *www.STDcases.org*. We would greatly appreciate your sharing this announcement with others who may be interested in this new STD training resource.

The STD Case Series is designed to provide continuing education for practitioners in primary health care, family medicine, emergency medicine and other specialties who provide care to persons with or at risk for sexually transmitted diseases. Continuing education credits will be offered without a charge (CME, CNE, CEU). Each case includes a visually engaging, interactive patient presentation which simulates an actual clinic encounter. Users will be asked to take a sexual history, conduct a physical exam, order diagnostic tests, decide on treatment for the patient and partner(s) and provide counseling to the patient on risk reduction and prevention strategies.

Each case was written and developed by leading experts in STD clinical care and prevention and includes links to current references, CDC treatment guidelines, and other STD resources.

The Online STD Case Series is published by the National Network of STD/HIV Prevention Training Centers. Publication is made possible by a cooperative agreement with the Department of Health and Human Services, Centers for Disease Control and Prevention.

NCME VIDEOTAPES AVAILABLE

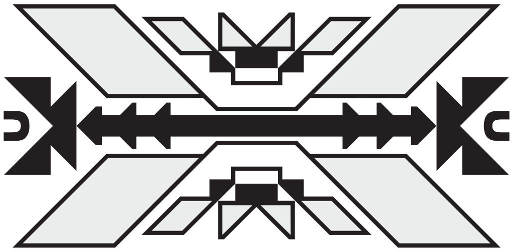
Health care professionals employed by Indian health programs may borrow videotapes produced by the Network for Continuing Medical Education (NCME) by contacting the IHS Clinical Support Center, Two Renaissance Square, Suite 780, 40 North Central Avenue, Phoenix, Arizona 85004.

These tapes offer Category 1 or Category 2 credit towards the AMA Physician's Recognition Award. These CME credits can be earned by viewing the tape(s) and submitting the appropriate documentation directly to the NCME.

To increase awareness of this service, new tapes are listed in The IHS Provider *on a regular basis.*

NCME #820

The Management of Psoriasis Today *(60 minutes)* This video program opens with a discussion of the pathogenesis and triggers for psoriasis and the distinctive clinical features of the various types of psoriasis. Special attention is given to the treatment of patients with mild localized psoriasis in the primary care setting. Recommended follow-up for the patient with mild psoriasis is provided. Also addressed are conventional options to treat moderate-to-severe psoriasis in a specialized dermatologic clinic and the selective use of biologic agents that target the underlying pathogenesis of psoriasis, now viewed as the most prevalent t-cell-mediated disease of the skin. The program includes recommended websites from the American Academy of Dermatology and the National Psoriasis Foundation that provide updates on the clinical evaluation and care of patients with psoriasis.



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THE IHS PRIMARY CARE PROVIDER

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

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