THE IHS PRIMARY CARE PROVIDER

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

October 2005 **Volume 30 Number 10**

Processing Federal Malpractice Tort Claims and Reporting To The National Practitioner Data Bank

Stephen W. Heath, MD, MPH, Risk Management Officer, and EY Hooper, MD, MPH, Risk Manager, Office of Clinical and Preventive Services, Indian Health Service Headquarters, Rockville, Maryland

Introduction

The Office of Clinical and Preventive Services (OCPS), Indian Health Service (IHS) Headquarters is the entity responsible for the Agency-level review of all malpractice tort claims filed against the Federal Government that involve care provided at IHS, tribal and urban Indian health facilities. Since the mid 1980s, this office has coordinated the review of more than 1350 malpractice claims. During the past several years, the functions of certain components of the review process have changed. In addition, the IHS is now responsible for the actual submission of National Practitioner Data Bank reports. This article will summarize the current role and responsibilities of the persons and offices responsible for Federal malpractice tort claims review and Data Bank reporting.

Background

Federal Tort Claims Act (FTCA). The FTCA allows for the Federal Government to be sued for any damage to property or for personal injury or death caused by the negligence or wrongful act or omission of Federal employees (and certain contractors) who were acting within the scope of their employment. The FTCA also covers tribal facilities operating under P.L. 93-638 compacts or contracts. The injured party or representative cannot initially commence a lawsuit but must first file an administrative Federal tort claim with the Office of General Counsel, Department of Health and Human Services (HHS). In addition, the injured party's exclusive remedy is to file a Federal tort claim; no legal action can be taken against any IHS or tribal healthcare employee; that is to say, such employees are immune from civil liability.

National Practitioner Data Bank (NPDB). The NPDB opened in 1990, pursuant to the Health Care Quality Improvement Act of 1986 (HCQIA). The NPDB serves as a clearinghouse to collect and release information concerning payments made on behalf of physicians, dentists, and other licensed health care practitioners as a result of malpractice actions and claims. In addition, it maintains information concerning certain adverse actions regarding the licenses and clinical privileges of physicians and dentists. Reports submitted to the NPDB must be made "for the benefit of" (on behalf of) an individual provider, not an institution or health care program.

In this Issue...

The mandatory reporting provisions of the HCQIA do not apply to the Federal Government. However, the Department of Defense, the Department of Veterans Affairs, and the HHS all elected to participate through Memorandums of Understanding and/or Departmental policy. Therefore, the rules and regulations of the NPDB published in the Federal Register (and found on the NPDB website) that govern how individual practitioners are to be reported do not necessarily apply to the Federal sector. In regards to practitioners working for operating divisions of the HHS (and tribal organizations), the policy and procedure for reporting to the NPDB can be found in a 1990 memorandum signed by the then Assistant Secretary of Health, James O. Mason. This policy is currently under review.

Current Functions

Claims Branch, Office of General Counsel (CB). The CB receives notification of all non-medical and malpractice tort claims filed against the Federal Government that involve Indian Health Service (IHS), tribal or urban Indian health programs. The CB is responsible for reviewing the validity of the claim, requesting medical records from the site of the incident, and responding to inquiries and questions about the claim. They also ask for employment information for involved providers to determine if these providers are covered by the FTCA. Once they receive the medical records from the site, the CB forwards the materials to the IHS Risk Management Program for medical review (see below). Upon completion of the IHS review, the CB receives all copies of documents pertaining to the review and forwards the information to the Claims and Employment Law Branch of the Office of General Counsel. The attorneys in this Branch make the decision about whether or not to allow or disallow the claim. The CB also notifies IHS when claims are paid, and maintains a database of all claims filed against the Federal Government that involve any of the operating divisions of HHS.

IHS Risk Management Program (IHS/RM). The review and evaluation of malpractice tort claims is an inherent Federal function that cannot be contracted, and therefore the IHS/RM processes claims arising from care provided at IHS direct care sites as well as tribally operated facilities and urban Indian sites. When the IHS/RM receives the tort claim and accompanying medical records from the CB, the case is assigned to a risk manager (currently Dr. Steve Heath or Dr. EY Hooper, and for dental cases, Dr. Patrick Blahut) to coordinate the medical review of the claim. This case coordinator reviews the case in detail and discusses the need to obtain any missing information with the CB (e.g., outside medical records). Then the clinical director or risk manager at the involved site is contacted to initiate a site review of the incident. In addition to obtaining the site review, the coordinator asks that all providers involved in the care be notified about the claim, and be given the opportunity to respond with a practitioner narrative or to participate in the local review of the claim. He also requests specific practitioner identifying and credentialing information. For providers who may have left the facility, the coordinator requests the service unit send notification to that provider. While the claim is "open," former employees do have the opportunity to participate in the analysis of the claim.

At the same time, the case coordinator will request a peer medical review of the case from an IHS provider distant from the site in question. The coordinator identifies someone with similar training to the individual(s) involved in the case. If a particular case involves care provided by practitioners of various disciplines, then additional reviews are sought. Once all this information is compiled, the case is sent to the Office of General Counsel (OGC) for legal review. At this point a Case Summary sheet is sent to the facility that outlines the background information of the claim, gives a short anonymous statement summarizing the conclusions of the independent review, and includes any risk management recommendations transpiring from that review.

The case coordinator attempts to maintain communication with the OGC attorney who is analyzing the case. If and when it is decided to allow the claim, the OGC attorney will often (but not always) consult with the IHS case coordinator to discuss the settlement. If the case is not allowed by OGC then a suit may be filed. When a suit does occur, the case becomes the responsibility of the Department of Justice in the Federal district in which the allegations occurred. If a payment does occur related to a claim or suit, the IHS/RM is responsible for presenting the case to the Malpractice Claims Review Panel (MCRP) for review (see below). At this point the IHS coordinators will attempt to contact involved parties to inform them of the payment and help determine if additional information is available. Once a determination has been made by the MCRP, the IHS case coordinator will communicate with the IHS/tribal site in question, send an updated Case Summary to the clinical director, and discuss with the provider(s) of record issues related to Data Bank reporting.

The IHS/RM has many other functions related to tort claims including (in part) maintaining a data base, sending Area reports to the chief medical officers, communicating with outside credentialing services and regulatory boards, and assisting providers to submit appeals to the MCRP. The IHS case coordinators attempt to advocate for providers and make every effort to support the position of the IHS or tribal practitioner throughout the process.

Office of General Counsel (OGC). The Claims and Employment Law Branch of OGC assigns an attorney to each malpractice case received. The assigned attorney makes his or her decision to allow or disallow the claim based on the merits of the claim and particularly on all of the medical reviews submitted by the IHS/RM. The attorney will frequently discuss issues with the coordinator before making a final decision. Depending on the amount of money involved, the OGC must communicate with the Department of Justice before agreeing to allow higher cost claims. If after considering the facts, the law, and the medical standards involved, OGC decides that the claim is meritorious, settlement negotiations will be initiated with the claimant (or claimant's representative). If it is determined that there is no liability on the part of the Government, the claim is disallowed and the claimant will be notified; if he/she chooses, the claimant may then institute

court action within six months. Should the OGC fail to take action on a claim within six months after filing, the claimant may also file suit in the appropriate Federal District Court.

Department of Justice (DOJ). Once a suit (civil action) commences, the local U.S. District Attorney (AUSA), who is assisted by a Departmental attorney, will defend the case. At this stage, there is less opportunity for IHS Risk Managers to be involved. The AUSA will often seek outside expert witnesses to defend the case, obtain depositions from involved providers, and procure all private records through inevitable discovery (this discovery is not available at the administrative claim stage). While some cases with little merit are dismissed, the majority of cases are settled before going to trial. When cases do go to trial, they are argued before a Federal judge in the respective U.S. District Court. The applicable medical practice act is that which is in effect in the state in which the incident occurred. The DOJ is not responsible for naming individuals to the NPDB.

To further amplify and clarify the role of the Department of Justice in this process the following points were provided for this article from a DOJ Headquarters counsel and manager, Roger Eiserson.

- Each Federal agency that employs doctors or other health care providers who are reportable to the NPDB is responsible for ensuring that its employees understand the agency's reporting obligations to the NPDB and any rights the employees might have regarding any reporting.
- Unless the Attorney General or his designee has specifically authorized Department of Justice representation for a Federal employee, the Assistant United States Attorney (AUSA) or Civil Division attorney handling a Federal Tort Claims Act (FTCA) lawsuit represents the United States only. The United States is the only proper defendant for claims arising out of the conduct of a Federal employee acting within the scope of his or her employment. Accordingly, the AUSA or Civil Division attorney is not representing the interests of the individual Federal employee or employees whose conduct gave rise to the FTCA suit. Again, the Federal agency that employs the person whose conduct is at issue must make sure that the employee understands that the AUSA or Civil Division attorney is not representing the interests of the employee, whether it relates to the lawsuit or other issues, such as the NPDB or post-employment malpractice insurance issues.
- The Department of Justice is not responsible for naming individuals to the NPDB, nor does the Department have a role in the decision. Whether an individual AUSA or Civil Division attorney thinks the health care provider's conduct was negligent or not is irrelevant. The Federal agency involved has to make an independent determination, based upon the information available, as to whether any payment — whether by way of settlement or judgment — is reportable to the NPDB, based upon that agency's reporting obligations.

Medical Claims Review Panel (MCRP). The original name for the MCRP was the Quality Review Panel (QRP), which was chartered in 1989. The QRP was given the responsibility to review all malpractice claims filed against the Federal Government that involved care provided at facilites operated by various operating divisions of the HHS and to determine if 1) the standard of care was or was not met, or if a system breakdown caused the outcome of the care provided to be outside the control of the involved practitioner(s), and 2) which practitioners were primarily responsible for providing the care in question. Should payment be made on a claim, it is these identified practitioners who would be subject to be named to the NPDB. According to the original HHS policy, a NPDB report was required for every case, *whether or not the standard of care was met*. The only exception was when the Panel had declared a "system breakdown." The IHS is actively trying to get the HHS policy changed to eliminate the requirement of reporting providers in cases where the Panel found no breech in the standard of care. The IHS does not report providers in cases where the standard of care was met or where a breech in standards was due to system problems.

In the past, cases were presented to the QRP prior to being sent to OGC for legal deliberation. Therefore, the Panel's decision was also made available to OGC, in addition to the other reviews obtained by the case coordinators. Over time, the Panel's workload increased to more than 250 cases annually, following the enactment of a law that brought a wide range of federally supported health centers under the auspices of the FTCA. In 2004, the Panel was re-chartered and became the MCRP. Under this new charter, the Panel does not review every malpractice tort claim, only those cases that have been allowed by the OGC or paid by the DOJ (e.g., settled or adjudicated).

The MCRP consists of approximately 15 members of a variety of medical disciplines, including physicians, dentists, nurses, advance practice nurses, and pharmacists. It is responsible for reviewing HHS claims from all of its operating divisions, not just IHS and tribal programs. Meetings are held monthly; an IHS/RM case coordinator presents the IHS/tribal/urban cases. All the reviews and supporting documents are sent to all panel members prior to the meeting. Decisions regarding the standard of care are made by majority vote after the case has been discussed. Providers of record are determined in a similar fashion, with particular reference to the responsibilities of the practitioners involved.

National Practitioner Data Bank Reporting

From 1991 until mid-1997, the CB was responsible for submitting reports to the NPDB for the HHS. Approximately 95 reports were submitted during this period. A small portion of these reports involved cases where it was determined that the standard of care had been met; in accordance with Department policy, a statement was added to each of these reports that the "standard of care was met." During this time period, the IHS

had no input into the information submitted. In 1997, the CB was transferred organizationally to the OGC, and the submission of NPDB reports was interrupted for a variety of reasons; the responsibility to prepare and submit reports was not transferred to another Department entity. Therefore, for more than seven subsequent years, no provider's names from settled HHS cases were submitted to the NPDB.

In 2003, the Office of the Inspector General, HHS, determined that the various operating divisions of HHS that had responsibility for providing health care were no longer following Department policy for NPDB reporting. A long series of discussions and meetings transpired over the next year and a half. Finally, the OIG mandated that the IHS (and other involved operating divisions of HHS) formulate a corrective action plan to reestablish a mechanism to achieve ongoing NPDB reporting, including the elimination of the backlog of cases. In early 2005, the IHS/RM began this required process.

The IHS is continuing to deal with a backlog of reporting, including some cases that date back to care provided in the early 1990s. The IHS has been submitting reports only on cases where it was determined by the Panel (MCRP) that the standard of care was *not* met. *No* reports have been submitted for any case where it was determined by the Panel that the standard of care was met, or that the adverse outcome was a result of a "system failure."

To prepare a NPDB report, mandatory provider, payment, and clinical information has to be identified. Often, it is necessary to consult with the service unit risk manager, credentials coordinator, or clinical director to collect missing provider information. Before a report is submitted, the IHS makes every possible attempt to first notify the provider about this pending administrative action, even when the providers have long left government or tribal employment. If the provider had never been offered the opportunity to discuss their involvement in the case, or if they wish reconsideration, they are afforded the ability to submit an appeal to the Panel. When necessary, attempts are made to retrieve the medical records. Provider appeals are taken back to the Panel only when new or clarified information is present. The Panel then makes a determination whether to sustain or overrule their original decision regarding the standard of care, system issues, or provider(s) of record, whichever is being contested. The decision of the Panel regarding the appeal is final.

Once a NPDB report has been submitted, there are additional processes available to the reported individual in regards to dispute resolution. The provider has the opportunity to submit a "subject statement" that will be added to the NPDB report. Many providers choose to submit additional information further explaining their decision-making or actions relevant to the case. Once reported, an individual practitioner is responsible for informing the credentialing office of the facility or facilities where they practice.

A copy of the registered NPDB report is sent to the respective state licensing board(s) of the reported individual. A state board may wish to further review a particular reported case, depending on the circumstances. The IHS/RM assists the state boards in their investigation to the extent possible, but specific patient identifiers and peer review documents cannot be released.

Issues Regarding NPDB Reporting

1. Large volume facilities, such as the IHS medical centers, have been involved in many tort claims over the years and therefore will have many employees (past and present) who have been identified as providers of record.
2. Service units often do not have forwarding addresses for former employees, making a search for their whereabouts more difficult.
3. Particularly for older cases, we have found it common that providers are either altogether unaware that a claim has been filed, or they were never offered the opportunity to participate in the claim review process. Currently, the IHS/RM is trying to ensure that providers are informed early in the claim review process, and are given every opportunity to tell their story to the Panel.
4. In the past, providers involved in tort claims were often not kept abreast of the progress of a tort claim as it worked its way through the OGC, Panel, and DOJ. This process often takes years to come to a conclusion. Once again, the IHS/RM is attempting to improve its performance in this regard, even as the number of claims being processed increases.
5. Not uncommonly, providers and service unit officials do not understand the role that the Panel's decision has in the overall claim review process. There is confusion over the roles of the OGC, the DOJ and the Panel in determining which providers are named to the NPDB. It is important to realize that the OGC and particularly the DOJ are defending the Federal Government and are not involved in NPDB decisions. In accordance with HHS policy, the MCRP is the sole entity with the responsibility for deciding which practitioners will be named to the NPDB for a particular claim.

Further Information

Additional information about the processing of malpractice claims and NPDB reporting can be obtained by contacting one of the authors of this article. Dr. Heath is stationed at the PHS Indian Health Center, Albuquerque, New Mexico, telephone (505) 248-4000), and Dr. Hooper is at the IHS Clinical Support Center, Phoenix, Arizona, telephone (602) 364-7742. A revised edition of the June, 1996 publication, *Risk Management and Medical Liability, A Manual for Indian Health Service and Tribal Health Care Professionals*, is planned for fiscal year 2006.

An Overview of the RPMS Domestic Violence Screening Exam Code and GPRA Reporting

Don Clark, MD, MPH, Indian Health Service, Epidemiology Division, Albuquerque, New Mexico; Denise Grenier, MSW, LCSW, Center of Excellence, Clinical Informatics Center, Phoenix Indian Medical Center, Phoenix, Arizona; and Theresa Cullen, MD, MS, IHS Office of Information Technology, Tucson, Arizona

What are the current recommendations for screening for domestic violence?

Domestic violence (DV) is a serious and common problem in the patients we serve. A recent report form the U.S. Department of Justice, Bureau of Justice Statistics found that American Indian/Alaska Native women are more than twice as likely to be victims of violent crimes committed by an intimate partner and five times more likely to be a domestic violence homicide victim than the general U.S. population. DV is associated with 8 of the 10 Leading Health Indicators for Healthy People 2010, including tobacco use, substance abuse, injury and violence, mental health, responsible sexual behavior, access to health care, immunization, overweight, and obesity.

Patients appreciate DV screening in the health care setting, as long as the screening is performed confidentially in a safe environment, and in a sensitive and respectful manner. A host of professional organizations, including the American Medical Association and the American Academy of Family Physicians, endorse screening women for DV in the clinical setting. Some courts have considered these professional recommendations to be common enough and strong enough to constitute a standard of care. The Joint Commission on Accreditation of Health Care Organizations (JCAHO) has required DV screening policies and procedures since the early 1990s, and Intimate Partner Violence/Domestic Violence (IPV/DV) has been a Government Performance and Results Act (GPRA) indicator for several years.

What is the current GPRA clinical performance measure for DV screening?

The Government Performance and Results Act requires Federal agencies to demonstrate that they are using their funds effectively toward meeting their missions. Appropriately for a health care organization, most IHS indicators describe clinical treatment and prevention measures. These performance measures are designed to improve clinical care and provide standards for quality care. The current GPRA IPV/DV measure focuses on screening for domestic violence. The inset shows the GPRA standard for IPV/DV screening and the performance measure for 2006.

IPV/DV GPRA Clinical Performance Measure

Objective: IPV/DV *Screening*

Standard:

- Adult females should be screened for domestic violence at a *new encounter* and *at least annually*;
- Prenatal patients should be screened *once each trimester*.

FY 2006 Performance Measure

- During FY 2006, increase the domestic violence screening rate in female patients ages 15 – 40.

The IHS 2010 goal for domestic violence screening rates for female patients ages 15 to 40 is 50%.

How are domestic violence screening results entered into RPMS?

Domestic violence screening is recorded as an "Exam Code" in the Resource and Patient Management System (RPMS). Providers can document results of screening on the Purpose of Visit (POV) line of the RPMS Patient Care Component (PCC) Encounter Form. Included on the POV line should be the name of the exam (IPV/DV Screening), the result, and the initials of the provider who screened. A brief comment related to the screening can also be included here. If a patient declines a screen or if the provider is unable to screen (for example, if the domestic partner is in the room) this should also be documented. Allowable results are:

(**N**)egative – denies being a current or past victim of DV
(**PR**)resent – admits being current victim of DV
(**PA**)st – denies being a current victim, but admits being a past victim of DV
(**R**)efused – patient declined exam/screen
(**U**)nable to screen

Therefore, and entry might read as follows:

POV	DV Exam, Unable to Screen, domestic partner present, <*initials*>

This information is subsequently entered as an Exam into RPMS by Data Entry staff using specific mnemonics.

Electronic Provider Entry

Providers can also enter results of IPV/DV screening electronically via the IHS Electronic Health Record, the RPMS Behavioral Health System (BHS), or in the graphical user interface (GUI) version of BHS in the IHS Patient Chart. Direct provider entry of screening results is easy and efficient, and it provides additional privacy of sensitive patient information. The IPV/DV screening exam code is documented with other exams, health factors, and patient education activities on the Wellness Tab in the above applications. Some providers have indicated that they believe the increase in the documented rate of IPV/DV screening at their facilities can be attributed to the ease of direct provider entry of clinical information in graphical user interface applications like the Electronic Health Record and the BHS GUI in Patient Chart.

Clinical Reporting System

Clinical Reporting System (CRS – formerly known as GPRA+) is the reporting tool used by the IHS Office of Planning and Evaluation to collect and report clinical performance results (GPRA measures) annually to the Department of Health and Human Services and to Congress. CRS is a software application intended to eliminate the need for manual chart audits for evaluating and reporting clinical indicators that depend on RPMS data.

The CRS logic for the domestic violence GPRA indicator is generous. Unsuccessful attempts to screen for domestic violence (recorded as "Refused" or "Unable to Screen") are included in the logic, as well as the results of completed screenings. Additionally, the logic includes domestic violence-related diagnoses (POVs) and DV-related Patient Education. Entry of any one of these items on a qualified patient for a qualified visit is considered as a positive count toward the GPRA indicator.

For further details on the IPV/DV GPRA indicator logic, CRS, and GPRA, visit *http://www.ihs.gov/cio/crs/index.asp*.

IPV/DV Health Maintenance Reminder and PCC Management Reports

The RPMS IPV/DV screening exam also has a corresponding Health Maintenance Reminder (HMR) that appears on the Health Summary. The reminder mimics the CRS logic. The default parameters that control the display of the reminders are as follows: females, 15 years and older, and annual screening. The display will include the "Date Last Done" and a prompt "Due Now" if a screening was not recorded in the last year. For reasons of patient safety, the results of the DV screening do not appear on the HMR or Exam components of the Health Summary. However, results can be accessed electronically in RPMS or by a review of the paper medical record according to the date of the screening as it appears on the Health Summary. The IPV/DV Health Maintenance Reminder should be added to each type of Health Summary that includes the HMR component. To support local policy and procedures for screening (e.g., all female patients 13 and older) the default parameters of the IPV/DV reminder can be changed locally by the RPMS Site Manager at the request of clinicians.

While CRS can provide aggregate data for Area and national reporting purposes, PCC Management Reports can provide a more precise view of domestic violence screening efforts at the local level. Access to the IPV/DV reports is controlled by a security key. Five different reports are available and, by any specified date range, can provide screening rates by gender, age, clinic, provider who screened, primary provider, and associated Purpose of Visit for the encounter in which the screening occurred. Patient lists, including results of screening, can also be generated to facilitate appropriate follow-up and care. Similar IPV/DV reports can also be found in the RPMS Behavioral Health System.

Conclusions

As more data become available over time, the CRS quarterly and annual reports will provide real and meaningful comparisons to past domestic violence screening efforts, allowing the Agency to accurately measure its effectiveness in achieving this very important clinical objective. In addition, the latest version of the RPMS PCC Management Reports gives providers the flexibility to design their own reports and to evaluate locally determined measures of performance. Documenting and retrieving screening results is now easier, and GPRA reporting is becoming increasingly automated. All of these efforts will contribute to the ultimate goal of improved patient care.

For additional information on the prevalence and impact of domestic violence and how healthcare providers can improve their response to DV, visit *http://endabuse.org/programs/healthcare/*.

Concise guidelines for domestic violence screening, developed by physicians and domestic violence advocates at the Family Violence Prevention Fund, are available to be downloaded for use on personal digital assistants (PDA) or printed as a document to be used for provider education and reference. For directions on downloading these guidelines, visit *http://endabuse.org/health/ipv/*.

For additional information on the RPMS IPV/DV Screening Exam Code, contact Denise Grenier at *Denise.Grenier@ihs.gov*.

2006 Native American Child Health Advocacy Award

The AAP Committee on Native American Child Health will be accepting nominations for the **2006 Native American Child Health Advocacy Award** through December 1, 2005. The award will be presented at the 2006 AAP National Conference and Exhibition to recognize an individual who has made a major contribution to promoting Native American child health. If you know of a physician or non-physician who merits this recognition, please submit a letter of nomination, along with the candidate's CV to:

Committee on Native American Child Health
American Academy of Pediatrics
141 Northwest Point Blvd
Elk Grove Village, Illinois 60007
Fax: (847) 434-8729
E-mail *indianhealth@aap.org*

For more information, call Sunnah Kim at (800) 433-9016, ext 4729.

Correction

In the article, "The Tympanic Membrane: See It, Describe It, Treat It" (Volume 30, Number 8; August 2005) on page 202, Table 7, the antibiotic cefdinir should have a frequency of BID (Not DBI). The same thing goes for cefpodoxime, which should also be given BID.

Help Us Establish a Free, Electronic Patient Education Resource Center for the Indian Health Service, Tribes, and Urban Programs

Diane Cooper, Indian Health Service Biomedical Librarian/Informationist, National Institutes of Health Library, Bethesda, Maryland

Studies show that Native Americans react more favorably when educational materials include Native Americans in the pamphlets, videos, and posters. While there is an abundance of patient educational materials out there, few of them are Native American-specific. But now a new project will collect Native American-oriented patient education materials for IHS clinicians. You can help.

The goal is to have an electronic resource that is available IHS-wide. Clinicians will be able to download and print materials in the clinic or hospital setting, at the point of care. Providing patient education materials in conjunction with the clinician's advice strengthens the message and improves health behavior.

This project is the joint effort of Mary Wachacha, IHS Health Education Consultant and Dr. Charles (Ty) Reidhead, Internal Medicine Chief Clinical Consultant. If you have any questions, please contact Mary Wachacha, Dr. Reidhead or myself, Diane Cooper, via e-mail. We are all on the Global Outlook e-mail system.

Help build this IHS-wide electronic National Patient Education Library. Send me any patient education materials that you are using now and have found useful in your patient care. If they are in electronic format you can send them by e-mail. If not, just mail a copy and it can be scanned to make it an electronic version. Please note in your correspondence if the material is copyrighted. I will get the permission from the originating organization if it is used. Contact me, Diane Cooper, MSLS, IHS Medical Librarian/Informationist, NIH Library, 10 Center Drive, MSC 1150, Bethesda, Maryland 20892; telephone (301) 594-2449; e-mail *cooperd@mail.nih.gov*.

Editor's Note: The following is a digest of the monthly Obstetrics and Gynecology Chief Clinical Consultant's Newsletter (Volume 3, No. 9, September 2005) available on the Internet at http://www.ihs.gov/MedicalPrograms/MCH/M/OBGYN01.cfm. *We wanted to make our readers aware of this resource, and encourage those who are interested to use it on a regular basis. You may also subscribe to a listserv to receive reminders about this service. If you have any questions, please contact Dr. Neil Murphy, Chief Clinical Consultant in Obstetrics and Gynecology, at* nmurphy@scf.cc.

OB/GYN Chief Clinical Consultant's Corner Digest

Abstract of the Month

Cesarean delivery in Native American women: are low rates explained by practices common to the Indian Health Service?

Background: Studying populations with low cesarean delivery rates can identify strategies for reducing unnecessary cesareans in other patient populations. Native American women have among the lowest cesarean delivery rates in the US, yet few studies have focused on Native Americans. The purpose of this study was to determine the rate and risk factors for cesarean delivery in a Native American population.

Methods: We used a case-control design nested within a cohort of Native American live births, ≥35 weeks of gestation (n = 789), occurring at an Indian Health Service hospital during 1996-1999. Data were abstracted from the labor and delivery logbook, the hospital's primary source of birth certificate data. Univariate and multivariate analyses examined demographic, prenatal, obstetric, intrapartum, and fetal factors associated with cesarean versus vaginal delivery.

Results: The total cesarean rate was 9.6 percent (95% CI 7.2-12.0). Nulliparity, a medical diagnosis, malpresentation, induction, labor length > 12.1 hours, arrested labor, fetal distress, meconium, and gestations < 37 weeks were each significantly associated with cesarean delivery in unadjusted analyses. The final multivariate model included a significant interaction between induction and arrested labor ($p < 0.001$); the effect of arrested labor was far greater among induced (OR 161.9) than noninduced (OR 6.0) labors. Other factors significantly associated with cesarean delivery in the final logistic model were an obstetrician labor attendant (OR 2.4; $p = 0.02$) and presence of meconium (OR 2.3; $p = 0.03$).

Conclusions: Despite a higher prevalence of medical risk factors for cesarean delivery, the rate at this hospital was well below New Mexico (16.4%, all races) and national (21.2%, all races) cesarean rates for 1998. Medical and practice-related factors were the only observed independent correlates of cesarean delivery. Implementation of institutional and practitioner policies common to the Indian Health Service may reduce cesarean deliveries in other populations.

Mahoney SF, Malcoe LH. Cesarean delivery in Native American women: are low rates explained by practices common to the Indian Health Service? *Birth*. 2005 Sep;32(3):170-8.

OB/GYN CCC Editorial comment

I have always marveled at what great patients AI/AN women are to practice medicine with. I assumed our patients' many favorable obstetric traits were in part genetic and part cultural, plus a degree of genetic homogeneity. Sheila Mahoney and her colleagues became aware of the low cesarean delivery rates in the IHS, and she felt that it would be good to look at possible reasons in a systematic way. This article joins the growing body of literature that raises issues about the ability of AI/AN women to maintain both low rates of cesarean delivery and stable perinatal morbidity/mortality. This trend continues while the US all races cesarean delivery rate has significantly increased with no corresponding improvement in perinatal morbidity/mortality.

Related topics include:

- Do all hospitals need cesarean delivery capability? Leeman(s): Outcome based study: Zuni, New Mexico
- Native American Community with a 7% Cesarean Delivery Rate. Leeman(s): What explains the low rate in Zuni?

Here is some background on the lead author. Sheila Mahoney is a commissioned officer in the USPHS. Sheila joined the PHS directly from nurse-midwifery school in 1990 and went to Gallup, where she worked for four years as a nurse-midwife. She transferred to Santa Fe in 1994 and was there until 2003. The work was completed as part of her MPH thesis which she did at the University of New Mexico in 2002. Sheila transferred to the NIH in 2003 to become more involved in health research. Sheila works on the Gynecology Consult Service for the NIH and is involved in the fibroid and endometriosis trials. Unfortunately there is no obstetrics, which she sorely misses. She can be reached at *mahoneys@mail.nih.gov*.

From Your Colleagues
Judy Thierry, HQE

Maternal morbidity in AI/AN women, 2002-2004.

Purpose: Maternal morbidity, defined as a condition that results from or is aggravated by pregnancy, is a significant economic and public health burden in the United States. The most common morbidities reported in recent studies include

preterm labor, genitourinary complications, hemorrhage, and hypertensive disorders. However, few studies have reported data specific for American Indian and Alaska Native (AI/AN) women. The purpose of our analysis was to examine maternal morbidity in AI/AN women present at delivery hospitalizations using a population-based design.

Methods: Using the Indian Health Service (IHS) National Patient Information Reporting System, we analyzed aggregated data from five IHS medical centers from July 2002 through June 2004. Delivery hospitalizations were identified by the ICD-9 code V27 listed in any of the 15 diagnosis fields. Maternal morbidity was identified by ICD-9 codes 640-677 listed in any diagnosis fields. All analyses were performed using SPSS version 12.0.

Results: Overall, 6,761 deliveries were performed at the IHS medical centers during our study period. The average age of AI/AN women who delivered was 25.5 years, with the youngest being 13 years and the oldest being 47 years. The most common complication was gestational diabetes occurring in 7.4% of women. Pregnancy-related hypertension was reported in 5.3% of women, and 2.3% of women experienced genitourinary infections.

Conclusions: AI/AN women who delivered at these five medical centers had higher rates of some maternal morbidity compared to women in the general population. Our findings stress the need for continual surveillance and etiologic research to understand the elevated health risk among these women.

Stephen J. Bacak, Judy Thierry, Myra Tucker, Edna Paisano. 17th Annual Research Conference, Indian Health Service. For more information, contact Stephen J. Bacak, MPH at *sb897694@ohio.edu*.

OB/GYN CCC Editorial comment

This is a major step forward to help the Indian health system better plan clinical programs and resource allocation. Clearly, there is significant work to be done to improve the health care status of pregnant AI/AN woman. These data should be a lightening rod for us to improve our perinatal care.

The process of analyzing this data set is open to each of the Indian health system Areas. One would simply need to contact Judy Thierry at *judith.thierry@ihs.gov* to participate in analyzing the data from your Area. The possibilities are quite open ended.

Here are just a few comments from Chris Carey, MD, Chairman of the ACOG Committee on American Indian Affairs: ". . . What about mentioning preterm labor/preterm birth or hemorrhage in the AN/AI population? You list them as most common in the general population. Were their rates lower? As you know, some reports show lower rates of preterm birth in AI/AN populations and lower infant mortality, but that may be due to misclassification as Caucasian race. What about stillbirths and neonatal deaths?"

Hot Topics

Obstetrics

Meperidine for dystocia during first stage of labor: limit use.

Conclusion: Because of the absence of any benefits in patients with dystocia in labor and the presence of harmful effects on neonatal outcomes, meperidine should not be used during labor for this specific indication.

Sosa CG, et al. Meperidine for dystocia during the first stage of labor: a randomized controlled trail. *Am J Obstet Gynecol*. October 2004;191:1212-8.

Gynecology

PID: outpatient treatment was as effective in preventing reproductive morbidity.

Conclusion: Among all women and subgroups of women with mild to moderate PID, there were no differences in reproductive outcomes after randomization to inpatient or outpatient treatment. Level of Evidence: I.

Ness RB, et al. Effectiveness of treatment strategies of some women with pelvic inflammatory disease: a randomized trial. *Obstet Gynecol*. 2005 Sep;106(3):573-580.

Child Health

Adolescents prefer honesty and patient-centered care.

Conclusions: Participants rated aspects of interpersonal care (especially honesty, attention to pain, and items related to respect) as most important in their judgments of quality. As in most previous studies of adults, technical aspects of care were also rated highly, suggesting that adolescents understand and value both scientific and interpersonal aspects of health care.

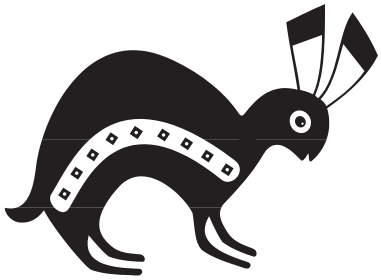
Britto MT, et al. Health care preferences and priorities of adolescents with chronic illnesses. *Pediatrics*. November 2004;114:1272-80.

Chronic disease and Illness

One-third of deaths from GI bleeding due to NSAIDs.

Conclusion: Mortality rates associated with either major upper or lower GI events are similar but upper GI events were more frequent. Deaths attributed to NSAID/ASA use were high but previous reports may have provided an overestimate, and one-third of them can be due to low dose aspirin use.

Lanas A, et al. A nationwide study of mortality associated with hospital admission due to severe gastrointestinal events and those associated with nonsteroidal antiinflammatory drug use. Am J Gastroenterol. 2005 Aug;100(8):1685-93.



Management of abnormal cervical cytology and histology

ACOG Practice Bulletin No. 66, summary of recommendations.

The following recommendations are based on good and consistent scientific evidence (Level A):

- Women with ASC cytology results may undergo immediate colposcopy, triage to colposcopy by high risk HPV DNA testing, or repeat cytology screening at six and twelve months. Triage to colposcopy should occur after positive HPV test results or ASC or higher grade diagnosis. Women with ASC who test negative for HPV or whose HPV status is unknown and who test negative for abnormalities using colposcopy should have a repeat cytology test in one year.
- Most women with ASC who are HPV positive or women with ASC-H, LSIL, or HSIL test results should undergo colposcopy.
- For women with an ASC HPV-positive test result or ASC-H or LSIL cytology result and a negative initial colposcopy or a histologic result of CIN 1, optimal follow-up is repeat cervical cytology tests (not screening) at six and twelve months or an HPV test at twelve months; a repeat colposcopy is indicated for a cytology result of ASC or higher-grade abnormality or a positive high-risk HPV test.
- The recommendation for follow-up of untreated CIN 1 includes cytology tests at six and twelve months with colposcopy for an ASC or higher-grade result, or a single HPV test at twelve months, with colposcopy if the test result is positive.

The following recommendations are based on limited and inconsistent scientific evidence (Level B):

- Endocervical sampling using a brush or curette may be undertaken as part of the evaluation of ASC and LSIL cytology results and should be considered as part of the evaluation of AGC, AIS, and HSIL cytology results.
  - o Endocervical sampling is recommended at the time of an unsatisfactory colposcopy or if ablative treatment is contemplated.
  - o Endocervical sampling is not indicated in pregnancy.
- Endometrial sampling is indicated in women with atypical endometrial cells and in all women aged 35 years or older who have AGC cytology results, as well as in women younger than 35 years with abnormal bleeding, morbid obesity, oligomenorrhea, or clinical results suggesting endometrial cancer.
- Women with HSIL cytology results and negative or unsatisfactory colposcopy results should undergo excision unless they are pregnant or adolescent.
- Women with AGC favoring neoplasia or AIS cytology results and negative or unsatisfactory colposcopy results should undergo excision unless they are pregnant. A colposcopic examination negative for abnormalities after two AGC-NOS cytology results is also an indication for excision in the absence of pregnancy.
- Pregnant women with CIN 2 or CIN 3 may undergo follow-up with colposcopy during each trimester and should be reevaluated with cytology and colposcopy examinations at six to twelve weeks postpartum or thereafter. Treatment of CIN 2 and CIN 3 in pregnancy is not indicated.
- Women with CIN 2 or CIN 3 should be treated (in the absence of pregnancy) with excision or ablation. Management of CIN 2 in adolescents may be individualized.
- Women treated for CIN 2 or CIN 3 with a positive margin on excision may be followed by repeat cytology testing, including endocervical sampling every six months for two years or HPV DNA testing at six months; if these test results are negative, annual screening may be reestablished.
- Women with a cervical biopsy diagnosis of AIS should undergo excision to exclude invasive cancer. Cold-knife conization is recommended to preserve specimen orientation and permit optimal interpretation of histology and margin status.
- After treatment of CIN 2 or CIN 3, women may be monitored with cytology screening three to four times at six-month intervals or undergo a single HPV test at six months before returning to annual follow-up.

The following recommendations are based primarily on consensus and expert opinion (Level C):

- Colposcopic examination during pregnancy should have as its primary goal the exclusion of invasive cancer. Excisions in pregnant women should be considered only if a lesion detected at colposcopy is suggestive of invasive cancer.
- Cervical cytology screening lacking endocervical cells may be repeated in one year when testing was performed for routine screening. Cytology screening performed for a specific indication (i.e., AGC follow-up or posttreatment follow-up after LEEP with a positive margin) may need to be repeated.
- Adolescents with ASC who are HPV positive or with LSIL results may be monitored with repeat cytology tests at six and twelve months or a single HPV test at twelve months, with colposcopy for a cytology result of ASC or higher-grade abnormality or a positive HPV test result.
- After treatment of AIS, when future fertility is desired and cervical conization margins are clear, conservative follow-up may be undertaken with cytology and endocervical sampling every six months.

- Women should not be treated with ablative therapy unless endocervical sampling test results are negative for abnormalities and the lesion seen and histologically evaluated explains the cytologic finding. In the absence of other indications for hysterectomy, excisional or ablative therapy for CIN 2 or CIN 3 is preferred.

Management of abnormal cervical cytology and histology. ACOG Practice Bulletin No. 66. American College of Obstetricians and Gynecologists. *Obstet Gynecol*. 2005;106:645–64.

Family Planning

Emergency contraception in adolescents: no compromise of family planning or increased sexual behavior.

Conclusion: Young adolescents with improved access to EC used the method more frequently when needed, but did not compromise their use of routine contraception nor increase their sexual risk behavior. Level of Evidence: I.

Harper CC, et al. The effect of increased access to emergency contraception among young adolescents. *Obstet Gynecol*. 2005 Sep;106(3):483-91.

OB/GYN CCC Editorial comment

These Level I data confirm other studies that the use of EC in adolescents is not associated with a compromise in the use of routine contraception, nor an increase in their sexual risk behavior. Our federal regulatory agencies should rely solely on scientific data to make decisions on medication availability.

Emergency contraception for adolescents, American Academy of Pediatrics

". . . Although adolescent birth rates have declined in the past ten years, unintended teen pregnancy and the associated negative consequences of adolescent pregnancy remain important public health concerns. Adolescent birth rates in the United States are much higher than rates in other developed countries. Emergency contraception has the potential to significantly reduce teen pregnancy rates and this will similarly reduce the abortion rate."

Medical Mystery Tour

J. D. is 25 year old gravida 4, para 1, 0, 2, 1 who presents to the outpatient clinic for follow up of pelvic pain and vaginal bleeding and to receive methotrexate. The patient initially presented to the emergency department (ED) six days ago and had followed up there again last Friday night. The patient had been told to follow up in outpatient clinic on Monday.

The patient had had some vaginal spotting 5 - 6 weeks prior, but it was not like her normal menses. Prior to that time the patient had a history of irregular menstrual cycles, so she was not sure of her exact previous cycles. The patient's obstetric history is significant for one term vaginal delivery of a 3,565 gram male, one ectopic pregnancy treated with laparoscopic salpingectomy, and one ectopic pregnancy treated successfully with single dose methotrexate. Those events occurred at another service unit and the records are in transit, as the patient had signed a release of information when her pregnancy test first became positive two weeks ago.

Other past history included a case of cervical *Chlymadia trachomatis* at 18 years of age treated with azithromycin; one case of presumed pelvic inflammatory disease treated as an outpatient with ceftriaxone 250 mg IM in a single dose, doxycycline 100 mg orally twice a day for 14 days, and metronidazole 500 mg orally twice a day for 14 days; and a new relationship with a partner who is interested in having a large family

Physical examination revealed BP 126/76, P 88, RR 16, weight 147 lbs., height 66 inches, body surface area 1.76 m^2. There was mild pelvic tenderness, right side greater than left, and a small amount of recent vaginal bleeding from a closed and long cervix.

Laboratory values were as follows: Blood type B positive, hemoglobin 11.2, urinalysis negative. Quantitative HCG results were:

	Value	Percent increase
6 days prior	850	-
4 days prior	1400	54% increase
2 day prior	2142	53% increase

Imaging studies were performed with the following results. The pelvic ultrasound performed two days prior revealed a 3 cm right adnexal structure thought to be a possible ovarian cystic structure with complex elements or a curved hydrosalpinx. The structure had the appearance of a donut. The radiologist's dictation stated that the study was consistent with a hydrosalpinx or corpus luteum cyst, but that ectopic pregnancy needed to be considered clinically. There were also indistinct intrauterine contents not unlike a gestational sac, but no distinct fetal pole or yolk sac. The radiologist could not rule out a pseudosac. The radiologist's *draft* report suggested appropriate medical/surgical intervention depending upon the patient's condition.

The patient's chart was not found due to her recent visits to the ED, hence the ED clinical notes were not available. The lab values had been pulled up on the RPMS system. The patient said the ED physician told her that her HCG levels were not increasing appropriately for a normal pregnancy.

The patient needed to get back to work to her new job at a large retail outlet nearby as soon as possible. She said that as this was another ectopic pregnancy, she would prefer repeating a course of single dose methotrexate, just like last time. This patient was the first of two overbooked patients at 1:00 PM as the clinic was trying to maintain its "third next available" statistics for improved patient access. Both overbooked patients were in rooms and the 1:15 PM was being checked for an evaluation of chronic pelvic pain and need for a narcotic refill.

The patient said that ED provider told her that you would know what dose of methotrexate to prescribe in this particular situation. She said she heard the ED physician was concerned that her HCG had not increased by 66% during the previous serial two-day intervals. She said the ED physician said that you might want to call a specialist to find out, because this was her third ectopic pregnancy.

What dose of methotrexate would you prescribe to this patient?

Oklahoma Perspective from Greggory Woitte, Hastings Indian Medical Center

Electronic Health Record for care of women and children.

As many of you are aware, technology is becoming very pervasive in our lives. Cell phones, pagers, PDAs, and laptops are all part of our daily existence. I can remember what it was like without these advances but can't imagine going back. The electronic health record (EHR) is one of those technologies. Here at Hastings Indian Medical Center, we began to implement a change from written documentation to EHR over a year ago. At that time, three physicians were chosen to begin training and utilization of the new system. I was the OB/GYN that was to begin using the system. Initially, I discovered, as did my pediatric counterpart, that this system was not designed for the OB or pediatric population. In fact, EHR is an older version of a system used in the VA hospitals (not many pediatric or OB patients there). So we had to adapt. I created various templates that we use for our daily visits, but we still had to continue to use the OB flow sheet to maintain continuity in the system. I understand that one of the future updates will include a flow sheet, but that it is a ways away.

Despite the pitfalls of the system and the setbacks that we have had in the past year, I have a difficult time reverting to the old pen and paper system. I find that the computer reminds me to ask things from my patients that I might have forgotten to ask in the 15 minute appointment. I am told that the documentation has improved drastically, not to mention the legibility. EHR is not a panacea, and it has had a rough start, but it has a lot of potential to become one of those necessary technologies.

OB/GYN CCC Editorial comment

The Office of Information Technology is working to develop standardized national pediatric and OB templates that will be available for use with the EHR as well as PCC+, optimistically by the end of 2005. Contact *theresa.cullen@ihs.gov* for questions.

Perinatology Picks, George Gilson, MD, Anchorage, Alaska

First trimester prenatal genetic screening: is it ready for 'prime time' at your facility?

A provider writes, "I have been reading a lot recently about first trimester nuchal translucency (NT) measurement as a screening tool for fetal Down syndrome. I already do all our OB ultrasounds and have been doing US for over seven years. I am excited to try NT. My question is, If I do this screening on women I am dating anyway, should I be offering this screening to all our patients? How about just the high-risk women? Do you have to do the biochemical screen as well?"

Dr. Gilson replies as follows: First trimester screening for fetal aneuploidy by means of measurement of the nuchal translucency (NT) combined with biochemical testing (PAPP-A and free beta HCG) is being requested more and more by our patients. There is a narrow window when this testing may be done (11 weeks, 0 days to 13 weeks, 6 days), so accurate dating is critical. The advantage of first trimester screening is an earlier and more accurate answer for our patients who are concerned about this issue. The detection rate (sensitivity) of the combined NT + PAPP-A (pregnancy associated plasma protein A) and "free beta" (not our usual bHCG pregnancy test) approaches 90%, with a low false positive rate (FPR) of about 3%, in the best studies.

"In the best studies" is a key phrase here. NT measurement is not an easy skill that can be casually acquired by any sonographer. The median normal value of the NT is just under 1 mm, so it must be obtained in a very well defined and strict fashion. A certification process and an ongoing quality assurance program are necessary to assure that we have the skills on which our clients can rely in order to make major decisions about their pregnancy. In order to become certified you must first take a one-day didactic course and pass a written exam (not too hard). You must then acquire a set of your own images which must be sent to the certifying body, followed by a video documenting how you obtained the images. This process may take up to a year. More images must then be submitted annually for quality assurance and renewal of certification. The images are judged strictly, and it requires quite a while for most applicants to accumulate a certifiable number of images. Most of our facilities will probably require referral to a quality center for this exam at this time.

The NT measurement alone only has a sensitivity of about 75%, with a FPR that approaches 20%, so it *must* be combined with the biochemical panel. Medicaid and most insurers pay for these tests, but our patients without a payment source must pay out of pocket, about $95. Nevertheless, it is probably the most cost-effective test, because the low rate of false positives allows us to avoid a lot of unnecessary referrals, invasive procedures, and parental anxiety.

Another issue is whether you are able to readily provide referral for chorionic villus sampling (CVS) if the screening results are positive. Are you able to counsel the parents appropriately about the details and the risks of this costly, invasive procedure? Or does the patient want to wait until 15 weeks and have amniocentesis? Since less than half of board-certified maternal-fetal medicine (MFM) specialists include CVS in their practice, do you have a qualified specialist in your area to whom you can refer? The ability to provide adequate

counseling, referral, and follow-up is critical before your practice embarks on this screening scheme (see the attached abstract detailing some of the ethical issues involved in referring or not referring).

Patients who have had first trimester screening probably should *not* go on to have second trimester screening (triple or quad screening) because it will result in many more false positives (the majority of the cases will already have been detected in the first trimester). There is a testing scheme called "integrated screening" which integrates the results of both the first and second trimester screening to give a final answer. This actually has the best detection and the lowest false positive rate, *but* the lab must correct the patient's second trimester risk with her new first trimester risk in order to give an accurate answer and avoid a high FPR. Unlike in the U.K., where this strategy has been extensively studied and developed, most labs in the U.S. are not set up to integrate results in this fashion at the present time.

That brings up the issue of second trimester testing for fetal open neural tube defects (ONTD). First trimester testing does not address that issue. While the maternal serum alpha fetoprotein (AFP), collected between 15 and 20 weeks, can detect 65% of fetal ONTD and abdominal wall defects, it is currently available only in a "package" as the "triple screen" or the "quad screen" where it is able to generate a software program-derived risk assessment. It is not available as a single test for ONTD, and "you don't want to know" the other values that may now give you a high false positive rate for Down syndrome. You can get around this problem by omitting second trimester serum screening and doing a second trimester anatomic scan (over 90% sensitivity for ONTD), but, for most of us, this may require another costly referral.

As you can see, "the in's and out's" of implementing first trimester screening at the present time are formidable. The laboratory logistics have not quite caught up with the studies or the patient demand. While first trimester screening is preferred by clients, and eventually will probably become the test of choice for women who present early enough, it currently entails multiple barriers for most of us, and is not yet "ready for prime-time." Unlike "Nike," you can't "just do it." This situation will certainly be evolving over time. ACOG originally called first trimester screening "investigational," but has now stated that it is "an option" if the following criteria can be met:

- Appropriate ultrasound training and ongoing quality monitoring programs are in place.
- Sufficient information and resources are available to provide comprehensive counseling to women regarding the different screening options and limitations of these tests.
- Access to an appropriate diagnostic test is available when screening test results are positive.

Our goal now should be to try to meet those standards in our practice settings. Yes, we've implemented this option in Anchorage, but it has been "a process." I hope that answers the questions you've raised and will help you make the best decision for your service unit. Please read the accompanying abstracts to further your understanding of some of these issues. Stay tuned for further developments!

Prospective first-trimester screening for trisomy 21 in 30,564 pregnancies.

Conclusion: The most effective method of screening for chromosomal defects is by first-trimester fetal NT and maternal serum biochemistry.

Avgidou K, et al. Prospective first-trimester screening for trisomy 21 in 30,564 pregnancies. *Am J Obstet Gynecol*. 2005 Jun;192(6):1761-7.

Implementation of first-trimester risk assessment for trisomy 21: ethical considerations.

We conclude that ethics is an essential dimension of implementation of first-trimester risk assessment for trisomy 21.

Chervenak FA, McCullough LB. Implementation of first-trimester risk assessment for trisomy 21: ethical considerations. *Am J Obstet Gynecol*. 2005 Jun;192(6):1777-81.

This is a page for sharing "what works" as seen in the published literature, as well as what is being done at sites that care for American Indian/Alaskan Native children. If you have any suggestions, comments, or questions, please contact Steve Holve, MD, Chief Clinical Consultant in Pediatrics at sholve@tcimc.ihs.gov.

IHS Child Health Notes

Quote of the month

"The time to read is anytime: no apparatus, no appointment of time or place is necessary."

John Aikin (1747-1822)

Article of Interest

Relationships between poverty and psychopathology: a natural experiment. *JAMA*. 2003 Oct 15;290(15):2023-9. *http://jama.ama-assn.org/cgi/content/full/290/15/2023?eaf*

Summary: Social causation (adversity and stress) versus social selection (downward mobility due to mental illness) are competing theories about the origins of mental illness. Halfway through an ongoing longitudinal psychiatric study, a casino opened on an Indian reservation that gave families an income supplement. A significant number of Indian families moved out of poverty while non-Indian families in the study had no change in economic status. There was a marked decrease in the number of Indian children diagnosed with conduct and oppositional defiant disorder but no change in anxiety or depression symptoms. The results suggest a social causation explanation for conduct and oppositional defiant disorder but not for anxiety or depression.

Editorial Comment

This article is two years old but raises lots of interesting questions. Many of us have strong feelings about gambling in general and Indian gaming in particular. This study takes the issue out of the moral arena and asks about health effects of Indian gaming with some surprising results. It touches on the larger question of the relationship between health and economic status.

Infectious Disease Updates

Rosalyn Singleton, MD, MPH

Menactra®: Addressing a rare but deadly killer.

Neisseria meningitides infects a small proportion of the general population (<1 - 5 per 100,000); however, despite its rarity, meningococcal disease is important because of its high mortality rate – 10 to 25%. A quadrivalent polysaccharide vaccine (A, C, Y, and W-135) has been available; however, polysaccharide vaccines are poorly immunogenic in children < 2 years and do not induce immunologic memory. Serogroup prevalence varies widely. In the U.S., serogroups C (28%), Y (34%), and B (33%) were the most prevalent serogroups during 1995 - 1998. The highest rate of meningococcal disease (5 per 100,000) occurs in infants; however, a peak also occurs in 15 - 19 year olds.

In January, the FDA licensed a new meningococcal quadrivalent (A, C, Y, and W-135) conjugate vaccine (Menactra®, Sanofi-Pasteur). Studies in children showed superior immunogenicity and similar side effects compared with the older polysaccharide vaccine (Menimmune®). In February 2005, the Advisory Committee on Immunization Practices (ACIP) voted to recommend routine vaccination with Menactra® at pre-adolescent (11 – 12-year olds) visits with catch-up before high school entry (15-year olds), and for college freshmen living in dorms, and other groups at highest risk (e.g.. asplenia, terminal complement deficiency, military recruits, travelers to or residents in countries with epidemic disease). Since boarding schools pose similar risks of transmissions as dormitories, individual Areas may want to extend vaccination recommendations to include students between 11 and 18 years entering boarding schools. The vaccine was added to the list of Vaccines For Children (VFC) eligible vaccines.

Recent literature on American Indian/Alaskan Native Health

Doug Esposito, MD

Confronting oral health disparities among American Indian/Alaska Native children: The pediatric oral health therapist. *Am J Public Health*. 2005;95(8):1225-29. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=16006412&query_hl=2*.

Summary: The authors outline the historical development and recent deployment of pediatric oral health therapists in rural Alaska as a means of addressing the disparities that exist with regard to dental health and access to dental services in isolated Native communities. American Indian/Alaska Native children suffer from the highest rates of tooth decay and the poorest dental health in the nation. For many, access to dental service is severely limited. In Alaska, geographic isolation serves as a significant barrier. Additionally, it has been extremely difficult to attract dentists to rural and isolated areas, (but not for want of trying). The authors make a cogent moral and public health argument in support of the dental health aide and the Pediatric Oral Health Therapist Program as it is currently being planned.

Editorial Comment

The interested reader will want to review the American Dental Association's (ADA) negative view of the Pediatric Oral Health Therapist Program as outlined in the May 2005 issue of the *American Journal of Public Health*, entitled "Improving the Oral Health of Alaska Natives." Also of interest is the Anchorage Daily News article "Dental Training Rouses Protest from Dentists," which appeared on June 1, 2005. The integrity of this rational and innovative approach to reduce dental health disparities by increasing access to quality care for isolated communities is jeopardized as a result of this ADA attack. Can valid programs serving the greater good ever succeed when pitted against the economic interests and controlling tendencies of relatively small professional groups in a democratic capitalist society (yikes!)? Efforts to develop oral health therapist programs have failed before in the United States at the hand of such attacks, despite documented efficacy and safety from other countries. Will this brave attempt also fail? Only time will tell.

Additional Reading

Improving the oral health of Alaska Natives. *Am J Public Health*. 2005 May;95(5):769-73. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15855450&query_hl=1*.

Dental training rouses protest from dentists. *Anchorage Daily News*. June 1, 2005. *http://www.adn.com/news/alaska/story/6556940p-6439704c.html*

Developing a pediatric oral health therapist to help address oral health disparities among children. *J Dent Educ*. 2004 Jan;68(1):8-20. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=14761168&query_hl=2*.

Article

Community-onset methicillin-resistant *Staphylococcus aureus* associated with antibiotic use and the cytotoxin Panton-Valentine leukocidin during a ferunculosis outbreak in rural Alaska. *J Infect Dis*. 2004;189(9):1565-73. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15116291&query_hl=1*.

Highlights

- Despite its cumbersome (and perhaps frightening) title, it's a wonderful, relevant, and timely paper, and well worth reading.
- The authors report their findings of risk factors associated with a particular community-onset MRSA (CO-MRSA) skin infection outbreak in a rural Alaska Native village.
- Though causality could not be definitively established due to study design, use of antibiotics in the twelve preceding months was strongly associated with MRSA skin infection.
- The Panton-Valentine leukocidin (PVL) genes were present in 97% of MRSA isolates, and in none of the methicillin-sensitive *S. aureus* (MSSA) isolates. PVL is a virulence factor that has been associated with skin and soft tissue infection, and appears to play a significant role in the development of skin infections in Alaska as well.
- "The emergence of MRSA strains that cause skin infections in rural Alaska appears attributable to the selective pressure of antibiotic use for drug-resistant strains expressing PVL." In other words, antibiotic use selected for more virulent PVL-containing strains of MRSA. The more exposure to antibiotics, the more likely a person was to have a MRSA skin infection. The judicious use of antibiotics issue yet again rears its ugly head in daily clinical practice!

Editorial Comment

Community-onset/community-acquired MRSA (CO-MRSA) is emerging as a significant health problem across the nation, and has been extensively reported in the literature. This paper, although not specifically related to child health, is relevant and timely. It serves as a reminder to all of us that antibiotics have real and measurable costs, both from an individual patient and a public health perspective. Although antibiotics are indispensable aides in the control of infections, more use results in more, and measurable, resistance.

CO-MRSA represents a problem of particular concern for Native communities. Given the prevalence of certain socioeconomic factors, many AI/AN populations experience a relatively high background rate of skin infections. Additionally, AI/AN populations tend to experience a greater burden of deep and invasive infections than the general population. These and other realities could serve to lower the threshold for antibiotic use among providers, and translate into additional selective pressure on microbes within Native communities.

As always, judicious use of antibiotics is warranted. Many of us who work in Native communities are well positioned to put into practice rational approaches to antibiotic use, given our inclination toward public health practice.

In Alaska, given the high prevalence of CO-MRSA, an effort was made on the part of the CDC Arctic Investigations Program to encourage appropriate antibiotic use when confronted with suspected staphylococcal infections. Efforts were designed to limit the development of inducible clindamycin resistance among MRSA strains, and to use vancomycin with the utmost caution. Cotrimoxazole became the first-line antibiotic, used only if local care of infection was unsuccessful or impracticable. Although the effect of this effort is unknown, the time is ripe for all of us to look critically at this issue and develop rational approaches to antibiotic use for suspected staphylococcal infections within our own clinical settings and communities, in an effort to further limit the development of microbial "super strains."

Additional Reading

Community-acquired methicillin-resistant *Staphylococcus aureus* in a rural American Indian community. *JAMA*. 2001;286(10); 1201-5. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=11559265&query_hl=5*

Community-acquired methicillin-resistant *Staphylococcus aureus* in southern New England children. *Pediatrics*. 2004;113(4):347-52. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15060266&query_hl=8*.

Community-associated methicillin-resistant *Staphylococcus aureus* in pediatric patients. *Emerg Infect Dis*. 2005 Jun;11(6):966-8. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15963299&query_hl=10*.

Pediatric Locums Service

The AAP Committee on Native American Child Health has developed a website to help IHS and 638 contract sites find pediatric *locum tenentes*. The website has an online form you can fill out describing your *locum tenens* needs and which will be posted for AAP members. Go to *www.aap.org/nach*. In addition, the AAP is interested in helping sites find pediatricians to fill permanent vacancies. Contact AAP staff member Sunnah Kim at (847) 434-4729.

Executive Leadership Development Program Announces 2006 Dates

VISION

The Executive Leadership Development Program is the preferred, premier leadership training program for Indian health care professionals.

PURPOSE

To educate current and future leaders to continually improve the health status of Indian people.

MISSION

The Executive Leadership Development Program will be the recognized leader in education and support services for Indian health care systems through collaboration, partnerships, and alliances.

Executive Leadership Development Program New Dates

ELDP collaborates with federal, tribal, and urban Indian health care systems to develop and increase leadership and management skills. In addition, participants develop new relationships and networks with other executives within the Indian health care systems.

SESSION DATES:

Session One– Aurora, CO
May 8- 12, 2006

Session Two– Aurora, CO
June 19- 23, 2006

Session Three – Aurora, CO
July 24 -28, 2006

The IHS Clinical Support Center is the accredited sponsor.

Contact:
Indian Health Service Clinical Support Center
Executive Leadership Development Coordinator
Wes Picciotti or Gigi Holmes
Indian Health Service, Clinical Support Center
Two Renaissance Square, Suite 780
40 N. Central Avenue, Phoenix, Arizona 85004-4424
Phone: (602) 364-7777 FAX: (602) 364-7788
Internet: ELDP@mail.ihsgov
Website: *www.ihs.gov/nonmedicalprograms/eldp*

Notes from the Elder Care Initiative

Conferences and Training Opportunities

The First Annual American Indian and Alaska Native Long Term Care Conference will be held November 16 - 17, 2005 at the Sheraton Old Town in Albuquerque, New Mexico. The theme will be *Honoring Our Elders: Best Practices in Long Term Care*. This conference is intended to support the development of long term care systems and services for elders throughout Indian Country. Participants will benefit from the experiences of successful program directors while learning from each other about how to create and develop sustainable programs, cultivate federal, state, and private resources, and respond to the unique long term care needs of their community. This two-day conference and site visit are brought to you by federal agency, tribal, Indian organization, and private nonprofit partners.

There is an abstract submission process for selection of promising practices in American Indian and Alaska Native (AI/AN) long term care, with scholarships based on need available for programs selected to present at the conference. For information about agenda, conference registration, and abstract submission, go to *www.aianlongtermcare.org*.

A Veteran's Administration (VA) palliative care course is available for Indian health system clinical staff. The VA Ann Arbor Geriatric Research, Education and Clinical Center (GRECC) and the University of Michigan Medical School invite Indian health clinical staff to attend *Critical Clinical Issues in the Care of the Older Adult: Pain Management and Palliative Care* October 6 - 7, 2005 in Ann Arbor, Michigan. The program is designed for primary care physicians and providers (nurse practitioners and physician assistants), geriatricians, oncologists, and hospice and palliative care providers (physicians, nurses, social workers, and chaplains). There are a limited number of slots reserved for Indian health at the special VA registration fee of $150.00.

The conference brochure can be found at *http://www.cme.med.umich.edu/events/pdf/U012215.pdf*. For registration information, contact Dr. Bruce Finke at *bruce.finke@ihs.gov*.

From the Literature

Walter LC, Covinsky KE. Cancer screening in elderly patients: a framework for individualized decision making. *JAMA*. 2001 Jun 6;285(21):2750-6.

Most cancers increase in incidence with age, while the benefit of screening for elders is diluted by competing mortality from age and chronic disease. How do we properly counsel elders about the benefits and risks of cancer screening in advanced age? In this article the authors suggest an interesting strategy for evaluating the value of screening for cancer in the elderly. They note that the likelihood of benefit from screening to detect cancer depends on several quantifiable factors, including the risk of death from the specific cancer, life expectancy, and screening factors (how well the screening test works). Based on these data, they calculate the number needed to screen (NNS) to prevent one cancer death at selected ages for the highest, middle, and lowest quartiles of life expectancy.

The results of this analysis can be quite striking. For women in the highest quartile of life expectancy at age 80 (vigorous, healthy octogenarians without chronic disease), 240 mammograms would be needed to prevent one death from breast cancer, comparing favorably to 226 mammograms needed to prevent a single death by breast cancer in women at age 50 in the lowest quartile of life expectancy. For men in the highest quartile of life expectancy at age 85 the benefits of colorectal cancer screening (NNS = 554) are greater than for men in the lowest quartile of life expectancy at age 50 (NNS = 630). Tables published in the paper outline these relationships in selected ages in very useful ways.

These findings match our clinical understanding that it is the overall health and vigor of the elder, not his or her age, that are important in these decisions, and the article provides tangible information to bolster and clarify that relationship. The authors take pains to point out that the decision to screen or not screen, at any age, should be driven by the individual's health goals, values, and preferences, informed by the best information we can offer.

It does no one any good (and can do significant harm) to urge cancer screening for frail elders who are unlikely to benefit. At the same time, we do a disservice to vigorous, healthy elders if we underestimate the possible benefit of screening based on age alone. The tables provided in this paper allow us to give our elders real and specific information about the possible benefit of cancer screening to help them make their decisions.

To receive this monthly e-mail newsletter, subscribe to the Eldercare listserve at *http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm?module=list&option=list&newquery=1*.

Change of Address or Request for New Subscription Form

Name _____ **Job Title** _____

Address _____

City/State/Zip _____

Worksite: ☐ IHS ☐ Tribal ☐ Urban Indian ☐ Other

Service Unit (if applicable) _____ **Social Security Number** _____

Check one: ☐ New Subscription ☐ Change of address

If change of address, please include old address, below, or attach address label.

Old Address _____

THE IHS PRIMARY CARE PROVIDER

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

THE IHS PROVIDER is published monthly by the Indian Health Service Clinical Support Center (CSC). Telephone: (602) 364-7777; fax: (602) 364-7788; e-mail: *the.provider@phx.ihs.gov.* Previous issues of THE PROVIDER (beginning with the December 1994 issue) can be found on the CSC Internet home page *(www.ihs.gov/PublicInfo/Publications/HealthProvider.asp).*

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.

Publication of articles: Manuscripts, comments, and letters to the editor are welcome. Items submitted for publication should be no longer than 3000 words in length, typed, double-spaced, and conform to manuscript standards. PC-compatible word processor files are preferred. Manuscripts may be received via e-mail.

Authors should submit at least one hard copy with each electronic copy. References should be included. All manuscripts are subject to editorial and peer review. Responsibility for obtaining permission from appropriate tribal authorities and Area Publications Committees to publish manuscripts rests with the author. For those who would like more information, a packet entitled "Information for Authors" is available by contacting the CSC at the address below or on our website at www.csc.ihs.gov.

Dept. of Health and Human Services
Indian Health Service
Clinical Support Center
Two Renaissance Square, Suite 780
40 North Central Avenue
Phoenix, Arizona 85004

PRESORTED STANDARD
POSTAGE AND FEES PAID
U.S. DEPT. OF HEALTH & HUMAN SERVICES
PHOENIX, AZ
PERMIT NO. 5691

CHANGE SERVICE REQUESTED

_____

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE $300