THE IHS PRIMARY CARE PROVIDER

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

September 2000 **Volume 25, Number 9**

Understanding Nursing Home Care in Indian Country

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Introduction

Most Indian health care facilities have developed some sort of a working relationship with extended care facilities (also referred to as skilled nursing facilities or nursing homes). In some situations, Indian health providers may simply write an order for the transfer of their patients to such a unit from time to time. At the other end of the spectrum, some Indian Health Service/tribal/urban (ITU) facilities have established intimate arrangements with specific extended care facilities (ECF); they may refer patients to one facility often, care for those ECF residents when they become acutely ill, and, in some cases, provide physician attending services to patients residing in that ECF. No matter what the relationship is, it is useful to know how to work with an extended care facility, so that our patients there receive the best care possible. This brief article will discuss some advice for those readers who have not had the opportunity to work in such an environment.

First Hand Experience

The following observations are based on my own personal and anecdotal experience. Until I began working in the nursing home ten years ago, I had little knowledge about what went on there. Many physicians, and many others in other health professions may have had little opportunity during training or prior work experiences to become familiar with life and health care in such facilities. To work there is an education in and of itself.

Staffing

It is not infrequent that when a patient is referred from an ECF to a hospital or clinic for a diagnostic procedure or for a consultation in a specialty clinic, there is a request that the ECF "send a nurse with the patient." While there are legitimate needs for assistance (translation for the elder who does not speak English, reassurance of the demented patient, or help with someone who may tend to wander off, for example), ECFs are generally staffed only to provide care in the facility. There is a certain ratio of licensed nursing staff (RNs and LPNs) and certified nursing assistants (CNA) to patients that varies from facility to facility in a fairly narrow range. In these times of Medicare cutbacks and reduced reimbursements to ECFs, staffing is "lean" and the nursing staff is *very* busy. Most often, there are no nurses or CNAs "free" to transport and attend to a patient

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while they are outside the facility. Family members are the best resource for this attendant activity; when tests or appointments are first scheduled, that is a good time to discuss whether or not a family member might assist.

There is a Physician at the Other End

Each patient at every facility is attended by a physician (or, in some instances, by a nurse practitioner or physician assistant), who visits that patient on a regular basis, depending on the status of the patient and the requirements of the facility. While those who are relatively healthy and stable may be seen only once a month, those who have an acute illness or who are complex or unstable may be seen several times a week. When patients are first admitted, they are seen by the physician within the first 48 hours, at which time they have a history and physical examination, and orders are written.

Those transferring a patient from, say, the inpatient setting, can optimize their care by making sure that they are accompanied by the appropriate information, such as the admitting history and physical, progress notes, consultations, diagnostic tests, immunization records, problem list, discharge orders, discharge summary, follow-up recommendations, and so on. When a patient is particularly ill or complicated, it may be beneficial for all involved to call the attending phyician who will be caring for the patient to discuss the case, much like when you transfer such a patient to another hospital.

When a patient is seen in the emergency department for an acute illness, or in a specialty clinic, it is important to be sure that a copy of the progress note accompanies the patient back to the ECF for the physician to follow up on.

Sometimes patients are admitted to the ECF from home or from another facility. In this case, the ECF physician may request health records from your facility as background information essential to patient care. It is important that such requests be handled in a timely manner.

Communication Needs to be Two Way

Just as good patient care requires the transfer of information *to* the ECF, it also depends on good communication *from* the ECF. Most miscommunication arises out of misunderstanding about what needs to be communicated, to whom, and by whom. If patients arrive in the emergency department without notice or without sufficient information, it is important to communicate that to the attending physician so that he or she can assure that procedures are established and followed to make sure that such communication always occurs. Just as hospital and clinic staff may have no concept about how nursing homes function, ECF nurses or clerks trying to schedule appointments or transfer patients may have little insight into how the hospital or clinic functions. It may be worthwhile to arrange reciprocal visits to promote better understanding and communication, and to be sure that proper procedures are in place.

While the patient's ECF attending physician may not have been present at the time of the transfer of a patient to the hospital (or, indeed, may not have been aware of it), it would often be useful to contact him or her to obtain additional information or to discuss care upon return to the facility.

A Broad Spectrum of Patients

Providers' experience with ECF patients in the hospital may lead to a distorted impression about specific patients or the ECF caseload in general. There is tremendous variation in the age, health status, and functional status of residents in the ECF. There are teenagers and octogenarians, there are young quadriplegics who are quite independent in their daily activities, and there are patients who are quite ill with complex and serious illnesses who, not too long ago, might be in the hospital. Some residents require frequent hospitalization at your facility; others may be seen there rarely, and then only for preventive services. It would be a mistake to base one's impression of the "typical" ECF patient on the sample one sees in the hospital suffering from acute illness.

Often when patients are sick enough to require hospitalization, they suffer a dramatic decline in function and mentation. Delirium may render unconscious a patient who was laughing and socializing the day before. It is important to remember that once this acute illness is resolved, this patient is likely to return to his or her premorbid, vital condition, with many more years of enjoyment to come. Much the same as it is true that the right time to establish advanced directives is when the patient is well and can participate, so it is also true that it may be the wrong time to do so when the patient is suffering from what may likely be a reversible illness. It may not be appropriate to change a patients "DNR" status when they are suffering from a urinary tract infection without the counsel of the attending physician.

Extended Care Facilities are often willing to and capable of caring for patients with complex and serious illnesses, including those with tracheostomies, central lines, and surgical wounds, and those on dialysis, intravenous antibiotics, and vacuum assisted closure (VAC) for deep pressure sores. If beds are often filled at your facility, it may be to your advantage to establish optimal relationships with the ECF so that they can care for some of your patients on a short term basis who are too ill to go home, but who do not need to be in the hospital.

They are, as the Name Says, *Skilled* Nursing Facilities

The nurses and CNAs that provide care at the ECF are extremely dedicated and hard working, and have a broad range of skills. When it comes to many conditions, such as swallowing disorders, pressure sores, or patients requiring total care, they can provide care unsurpassed by anyone.

A Need in Indian Country

With the rapid increase in our oldest old population in Indian Country, it is likely that we will see more of our patients going to long term facilities. Although the overall trend on a national basis (and the deliberate policy of many states) is toward

home- and community-based care, there will always be a small proportion of our patients for whom facility-based long term care (versus community-based long term care) is the best choice. As Indian health providers we need to be thinking about how we can continue to care for our patients, even those in nursing homes. This may mean designating one of our providers as the nursing home provider to visit those patients. Some sites have also used behavioral health technicians to visit nursing home patients to act as advocates for them. It is an unfortunate reality that many ECF facilities are quite far from the reservations. Many tribes have expressed an interest in developing extended care facilities on or nearer to reservations. We should see facility-based long term care as part of the spectrum of care that our elders may need and be sure that we do not abandon them when they move to that setting.

Conclusion

Providers who have not worked in an extended care facility often have misconceptions about what they are and how they function. They are mysterious places. It would be a valuable experience for all who interact with these facilities – emergency department nurses, primary care physicians, specialty physicians, unit clerks, and many others – to visit. Not only would they learn a great deal about what goes on there, but they would come to associate a real person with the voice on the other end of the phone. It would also be useful to invite personnel from the ECF — administrators, nurses, social workers — to the hospital or clinic to visit. Improved communication and working relationships, as well as better processes and procedures can only lead to better patient care, and it will make everyone's job, on both sides of the relationship, easier.

RPMS Laboratory Package Implementation: A Team Approach

Bert Tallant, MT (ASCP), Laboratory Supervisor, USPHS Indian Hospital, Santa Fe, New Mexico

Is your facility using the RPMS (Resource and Patient Management System) Laboratory Package? If so, you are among the 75 IHS, tribal, or urban facilities that have implemented the package since 1995. If not, you may find this article helpful if you decide to implement this laboratory software package.

A Team Approach

Implementation at the Santa Fe Indian Hospital (SFIH) began in August 1995. Thanks to the efforts of our "Implementation Team," the SFIH is now using all of the functionality of the Laboratory Package with the exception of the Blood Bank module, which is still under development. The SFIH Implementation Team consisted of the Site Manager, Medical Records Manager, Business Department Manager, Clinical Director, Nursing Director, Quality Assurance (QA) Manager, and Administrative Officer. Using a multidisciplinary approach, Angelina Albert, MT (ASCP), CLS, from the SFIH laboratory staff, worked with the various hospital departments to customize the package to each department's specific needs. Outlined below are the responsibilities of the members of the Implementation Team.

Administration

Before the package can be implemented, there must be a financial commitment from the facility administration to support the project. The initial costs of the printers, terminals, and interface will more than pay for themselves in increased billing collections. Furthermore, funds for training of the laboratory staff and time for installation and maintenance of the laboratory package must be available.

Site Manager

The site manager will be responsible for installing the package on the RPMS computer, running cables throughout the hospital, configuring connectors for the various devices, setting up the printers, terminals, and label printers, and assisting with the instrument interfacing. In addition, he or she will create menus for the laboratory and hospital staff and assign access to all users of the system. After the package is implemented, he or she will continue to update the package with new software patches.

Medical Records

The Medical Records department will assist with designing the new "laboratory cumulative reports." These reports, generated by the Laboratory Package, will replace the instrument reports that are currently used, and this will require training of the Medical Records staff with regard to how to file these new reports. Integral to the use of these reports is the concept of replacing the existing cumulative report with the updated report each time a patient has new laboratory data available.

Business Office

The business office will assist with determining CPT billing codes for each test and with matching ICD-9 codes from the PCC (Patient Care Component) encounter form to the appropriate CPT code. These CPT codes will be reviewed and updated each year by the Laboratory Information Officer in conjunction with the Billing Office. Medicare and Medicaid regulations require that each laboratory test is correctly coded and reviewed annually.

Medical/Nursing Staff

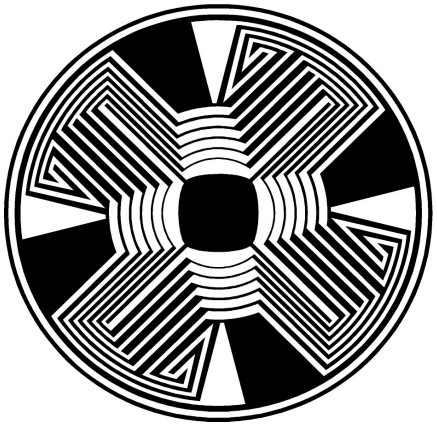
The Medical and Nursing staff will play a key role in determining where the terminals and printers are located for quick access. They will also help in formatting the cumulative reports that will appear on the medical charts. If the Medical Staff is to be responsible for ordering their laboratory tests in the computer and looking up the results, they must receive adequate training prior to using the package.

Laboratory

The Laboratory Manager will assign the responsibility of setting up the package to someone in the laboratory, or in many cases, assume that responsibility themselves. In smaller facilities it is an additional duty for the laboratory technologist, and in some of the larger facilities, this is a full time position. At SFIH, our "laboratory information officer" spends about 20-25% of her time maintaining the laboratory package. After attending the basic training course on implementing the package, the "laboratory information officer" will begin to modify the laboratory files, which generally takes several weeks of uninterrupted work. Alternately, the Division of Information Resources can assist with on-site support, as can private contractors. Once the laboratory package is up and running, there will be a need for ongoing support for adding new tests, modifying reference ranges, auditing the system, and other maintenance activities.

Benefits of Implementation

Is all of this work worth the effort? The staff at SFIH would answer with an emphatic YES! Authorized users can access laboratory results from any of the RPMS terminals in the Santa Fe Service Unit. When a patient presents at one of the field clinics, the staff have immediate access to laboratory results from the hospital, and vice versa. Also, the Medical Records Department is able to file laboratory reports in the patient record in a few hours, not days or weeks later, since the cumulative reports are printed in chart order. Finally, the laboratory data passes directly to the billing office, which has resulted in a tremendous increase in billing, and thus additional revenue for the service unit. For the laboratory itself, we are able to more easily generate statistical reports from the laboratory data, we can process laboratory results faster, and the phone has all but stopped ringing!



Video Strives to Increase Awareness of Breast Health Screening Methods Among American Indian Women in Arizona

Sallie Saltzman, Director, Education Section, and Agnes Attakai, Program Coordinator, both from the Minority Cancer Prevention Program, Arizona Cancer Center, Tucson, Arizona

Thanks to grants from the Susan G. Komen Breast Cancer Foundation and the Arizona Department of Health Services, an outreach video has been developed by the Minority Cancer Prevention Program at the Arizona Cancer Center to increase breast cancer awareness and highlight the importance of early detection for American Indian women.

Caring for Arizona's American Indian Women's Health is a culturally appropriate video designed to educate American Indian women in Arizona about breast cancer screening in the hopes that increased knowledge will improve survival rates from breast cancer among American Indian women. With the exception of Alaska Native women, American Indian women have a lower incidence of breast cancer (31.6 per 100,000) than US non-Hispanic white women (115.7 per 100,000).[1] However, American Indian women diagnosed with breast cancer have a lower 5-year survival rate (46%) than US white women (76%).[2] This lower survival rate appears to be, in part, a result of the detection of breast cancer at a later stage. To increase breast cancer survival, American Indian women need to learn and be encouraged to perform and receive routine breast cancer screening.

For more than five years the Minority Cancer Prevention Program at the Arizona Cancer Center has been working with community health representatives (CHRs) on reservations and in urban settings teaching breast cancer education. During our training sessions, our audiences were unable to identify with the current films on breast cancer screening methods. Most of these films targeted white women and included actors, dialogue, and scenes that were not culturally appropriate to our target audience. The Center made a commitment to our CHRs to develop a video that would focus on the dual role of CHRS: to teach women about the importance and mechanics of breast cancer screening and to help facilitate access to medical services. After consultation with key stakeholders and focus group testing, it became clear that the goals of this film also needed to include increasing awareness about the high breast cancer mortality rates for American Indian women, highlighting the importance of early detection in terms of survival, and increasing knowledge of breast cancer screening methods.

The video, presented in English, was narrated by Irene Bedard, who volunteered her services to this film because of the critical importance of its message. Featured "actresses" included Glenda Hernandez, Rose Kasey, and Arlita Fall (CHR), American Indian community members of the White Mountain Apache Tribe. Health professionals who had critical roles in the film included Joyce Stevenson, RN (White Earth Chippewa from Minnesota) and Catherine Midgette, Caryn Xavier and Dennise Tuthill, all Mobile On-Site Mammography staff.

This video comes with an interactive video guide and breast self-exam brochure using culturally appropriate illustrations. A set including the video, video guide, and BSE brochure will be sent free of charge to every Community Health Representative Office and to Indian Health Service and tribal clinics throughout Arizona in the hopes that they will deliver this very important message.

For others who would like to receive a copy of this video, please contact Sallie Saltzman at the Minority Cancer Prevention Program, Arizona Cancer Center, 2810 N. Alvernon Way, Suite 600, Tucson, AZ 85712; phone (520) 318-7065; e-mail *sallies@u.arizona.edu*.

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2. Samet JR, Key CR, Hunt WC, Goodwin JS. Survival of American Indian and Hispanic cancer patients in New Mexico and Arizona, 1969-1982. *Journal of the National Cancer Institutes* 1987;79:457-463.

Training for AI/AN Leaders of Cancer Support Groups Available

The IHS Cancer Program continues to sponsor training for American Indian and Alaska Native people interested in starting cancer support groups in their own communities. The next training will be October 2-6, 2000 in Albuquerque and Santo Domingo Pueblo, New Mexico.

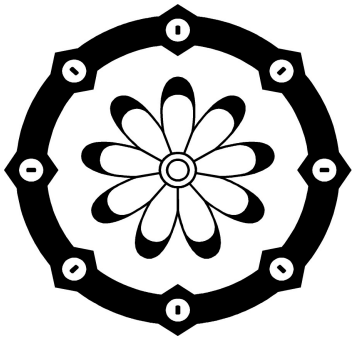
The training is being conducted in conjunction with the People Living Through Cancer organization (Albuquerque, NM) and A Gathering of Cancer Support (Santo Domingo Pueblo, NM). The 4½-day training format includes lecture/discussion sessions, simulations, and education materials. The ideal support group leader is a cancer survivor, a survivor's family member, or a close friend who has shared the cancer experience.

The IHS Cancer Program will provide reimbursement for travel, tuition, and expenses for a limited number of people interested in this training. For more information, please contact Roberta Paisano at the IHS Cancer Program, 5300 Homestead Road NE, Albuquerque, NM 87110; phone (505) 248-4132; or e-mail *Roberta.Paisano@mail.ihs.gov*.

Celebration of National American Indian and Alaska Native Heritage Month

Each year the President designates the month of November as National American Indian and Alaska Native Heritage Month. As a result of continual hard work and dedication of employee volunteers in the planning of events, we have been able to increase public awareness and appreciation for the significant contributions that American Indian and Alaska Native people have made to the history of our Nation.

The theme for this year's 2000 celebration is "Celebrating Our Strengths." Artwork and posters will be developed around this theme and shared with Indian Health Service Area Offices and the other organizations that will participate with us in this month of celebration.



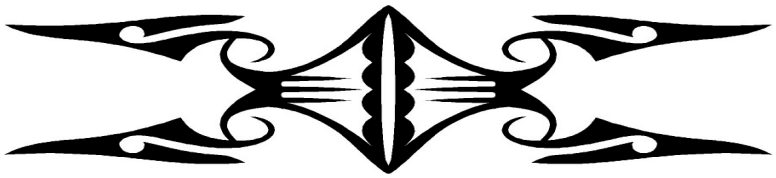
As part of the Headquarters Heritage Month events, a highlight of the November 1 opening ceremony at the Rockville Civic Center in Rockville, Maryland, will be the presentation of IHS awards to recipients from all IHS Areas. On November 2 the opening ceremony for the Department of Health and Human Services will take place in the Great Hall of the Hubert H. Humphrey Building. In addition, on November 9, November 16, and November 30, the IHS has planned heritage activities that will take place in the Parklawn Building in Rockville, Maryland.

The IHS Headquarters Heritage Committee 2000 website has been established at *http://www2.ihs.gov/heritage*, and information will be posted as it is developed. The website will provide a Heritage Calendar of Events highlighting IHS and other activities sponsored by other organizations and agencies of the Washington, D.C., metropolitan area.

As you begin to establish your committees we encourage the sharing of ideas and suggestions among IHS committees nationwide. We also encourage establishing Heritage Month partnership committees with tribal and urban Indian organizations in your area and with other Federal, state, and local government offices.

Smoking Cessation Specialist Training Program

In FY 2001, there will be a National Smoking Cessation Specialist Certificate Program offered in the Albuquerque Area. The session will train 40-60 pharmacists in a six-hour training cession (0.6 CEU) which will then be followed by two months of patient encounters necessary to obtain certification. If you are interested please contact Randy W. Burden, PharmD, CDE, PhC, Albuquerque Area IHS Clinical Pharmacy Consultant and Director, Native American Cardiovascular Risk Reduction Program, Santa Fe Indian Hospital, 1700 Cerrillos Road, Santa Fe, NM 87501; phone (505) 988-9821 ext 388; fax (505) 983-6243; e-mail *Randy.burden@mail.ihs.gov*; or pager (505) 995-5998.



Older Americans 2000: Key Indicators of Well-Being

Did you know that, in one study, one third (35%) of Americans over the age of 85 demonstrate moderate or severe memory impairment on objective testing? Or that the average health care expenditure (insurance and out-of-pocket expenses) among Medicare beneficiaries in 1996 was $5,864 for persons 65-69 years of age, and $16, 465 for persons 85 and older?

This information and much more is available in easy to follow tables and charts in *Older Americans 2000: Key Indicators of Well-Being*. This report, assembled by the Federal Interagency Forum on Aging Related Statistics, seeks to provide a unified picture, through a host of statistics, of the health and well-being of older Americans.

While there are precious few specific American Indian or Alaska Native (AI/AN) data included in this chartbook, it is a rich source of comparative data as we look at issues of aging in our population. And in areas where specific data on AI/AN elders just do not exist, it provides us with proxy data for planning or grant applications.

This report can be found online at *http://www.agingstats.gov/chartbook2000/default.htm* or can be requested by mail from the Federal Interagency Forum on Aging-Related Statistics, 6525 Belcrest Road, Room 790, Hyattsville, MD 20782.

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THE 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 February 1994 issue) can be found at the CSC home page, *www.csc.ihs.gov.*

Circulation: THE PROVIDER (ISSN 1063-4398) is distributed to more than 6000 health care providers working for the IHS and tribal health programs, to medical and nursing 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*

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