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Indian Women's Health Intervention Policy Analysis Analyzing Interventions that Promote Cancer Screening

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Indian Women's Health Intervention Policy Analysis

Analyzing Interventions that Promote Cancer Screening

Final Report 9/30/92  
pursuant to the REVISED SCOPE OF WORK AND SCHEDULE  
for DHHS/PHS/ASC Purchase Order # 911AF36857301D

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EXECUTIVE SUMMARY

PURPOSE/DESIGN

This project was funded by the Office of Women's Health, Office of Assistant Secretary for Health, PHS, in collaboration with the Office of Planning, Evaluation, and Legislation to explore how the IHS-based outpatient planning methodology dubbed "Industrial Strength Triage" (hereinafter referred to as Outpatient Visit Planning/Industrial Strength Triage or OPVP/IST) and other health care management strategies promote women's health. In this report we review OPVP/IST and four programs funded under National Cancer Institute grants: a computerized pap tracking system for urban clinics, an after hours women's health research clinic, a community education program, and a KAB study.

This project supports the Public Health Service Goal 22, that is, to focus on health services for American Indian/Alaska Native women that will result in improved health status outcomes. It also evaluates Recommendation #5 of the IHS Women's Health Round Table, that is, to initiate OPVP/IST for Indian women as a means to increase Pap screening and improve early detection and treatment of cancer.

The project involved research of recent studies and IHS Provider articles, telephone conversations with participants and coordinators of various programs, as well as a written survey to 26 different sites. The majority of the survey instruments were sent to rural service units that have initiated OPVP/IST within the last two years. Each site received five surveys to be completed by mail. Respondents had the option of requesting an additional telephone interview. Four of the surveyed sites are urban programs that have very recently initiated a computerized pap tracking system. Only two participants were surveyed from each urban site. Copies of the survey instruments and tallies of the responses are available in the Appendices of this report. General descriptions of all the programs examined are contained within the main body of this report.

ISSUE DEFINED

Mortality rates for cancer in American Indian and Alaska Native women is alarmingly high. For many women, the cancer goes undetected until advanced stages. Recently published reports conclude that preventive screening tests should be given routinely to American Indian and Alaska Native women. Cervical cancer can be prevented with early detection using Pap smears or colposcopy. Use of breast examination, baseline mammogram, and self-examination can detect breast cancer at early stages.

It is important to eliminate barriers and improve access to women's health care because breast and cervical cancer can be treated and are preventable cancers. An IHS report describing a series of six studies on cancer in American Indian and Alaska Native women (with a particular emphasis on cancer of the breast and cervix) concluded that reductions of nearly 60% in mortality could be achieved through combinations of both screening and case management.

Different interventions have been implemented to ensure that proper screening takes place regularly. One intervention, effective for both breast and cervical cancer as well as other health problems, is the outpatient visit planning method nicknamed "Industrial Strength Triage" because of its thorough review of the medical record while a patient waits to be seen by a provider.
FINDINGS

Kauffman and Associates, Inc.'s survey to the sites that had Industrial Strength Triage training within the past two years indicates these responses (with an adjustment for those who did not know or did not answer):

• 85% of the respondents believe that since OPVP/IST was implemented preventive services are delivered more or much more;

• 67% of the respondents believe that more appointments are made for cervical or breast cancer screening;

• 79% think there is improved recognition of health problems beyond the chief complaint;

• 66.25% of the respondents think OPVP/IST helps them better identify patients who need services; and

• 76.25% think OPVP/IST improves client care.

Although OPVP/IST is comprehensive visit planning it does not overcome all the barriers to women's health care. It is recommended that multiple strategies be implemented when funding is available. Other strategies are being tested by various sites around the country including Eastern Cherokee, Alaska Natives, Native Hawaiians, and several urban Indian clinics. These groups have conducted Knowledge, Attitude and Behavior surveys and each has tried a different strategy to make health care more accessible to women.

Community education is stressed by the Native Hawaiian group. The Alaska Native community has extended the women's clinic at the IHS hospital into the evening hours and is bringing screening services to remote villages. The Eastern Cherokee have a mammogram on site and are working with a major university to identify barriers to care. The urban clinics are working with the American Indian Health Care Association to create a computerized network to track screening for cervical cancer. Any combination of these programs will ensure greater compliance with cancer screening for American Indian and Alaska Native women.

CONCLUSION

The future health status of thousands of American Indians and Alaska Natives demands new emphasis on comprehensive care. Various intervention strategies have been developed and are being tested throughout the country. OPVP/IST is a comprehensive health care tool that an effective intervention for women's health and cancer screening. It is not a separate program designated specifically for women's health or any other specialty. Rather, it is the foundation of a more complete means of addressing the health status of each individual who presents at an IHS or tribal clinic. The OPVP/IST methodology is very flexible and can adapt to the particular limitations of each clinic. It should be implemented across the board for IHS facilities including the larger regional hospitals. Implementation could be enhanced with the hiring of an OPVP/IST coordinator in each region perhaps beginning with the regions of greatest need.
Proper implementation requires the commitment of resources--trained staff, space, and respect. OPVP/IST takes more time, at least initially. There is the need for all computerized medical records to be up to date, requiring the hiring of adequate data entry and medical records technicians. A sufficient number of triagers is also needed, with a reminder of the additional paperwork and time needed to fully implement the program. It may be necessary to begin with some full-time positions that could later be reduced to part-time. OPVP/IST should be taught to all the providers (and support staff is possible) at each site. As there is a turn around in providers, refresher courses are needed. Adequate private space for triage is required to ensure candid responses from the patients. Although it is not the ideal, exam rooms can be used for triage as long as privacy is maintained. Respect is a key ingredient for the successful implementation of OPVP/IST. If the physicians undergo training along with the nurses they may be more apt to permit nurses to order screening tests. Without the understanding of each others' roles, it is easy for the OPVP/IST to fail. The program seems to benefit patients even when all the ideal conditions are not available. Its ability to be modified to fit the limitation at each site is what makes OPVP/IST a good intervention for IHS-wide implementation.
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SECTION ONE: PURPOSE

This project reviews the sites which have previously received training in either Outpatient Visit Planning/Industrial Strength Triage or interventions funded under the National Cancer Institute (NCI) Grant Program on Avoidable Mortality from Cancers in Native American Populations to:

• Analyze Visit Planning models and other health intervention methods of identifying American Indian women as candidates for breast and cervical cancer screening at preselected sites.

• Apply and demonstrate that these interventions promote Public Health Service (PHS) Goal # 22 of the PHS Women's Health Plan.¹

• Determine the health providers' satisfaction and perspective of these interventions for patient cancer screening.

• Develop a policy based on the experience of these models that could be implemented at health facilities with Indian populations.

• Provide a report to Indian Health Service on the findings and conclusions.

SECTION TWO: PROJECT DESIGN

KAI designed a survey instrument to be completed by five clinic employees at 22 different sites who have been trained in Outpatient Visit Planning/Industrial Strength Triage (OPVP/IST) within the last two years. Upon the suggestion of the IHS Office of Health Program Research and Development (OHRPD), the survey specifically targeted the Service Unit Director (SUD, or equivalent), Clinical Director (CD), a nurse, a physician, and a medical records technician. However, a packet of five surveys was delivered to a contact person at each site, that person had the discretion to distribute the surveys to the five designated positions or any other clinic staff familiar with OPVP/IST.

The survey instruments were delivered by mail. Each respondent also received an addressed and stamped return envelope and reply card to be returned by regular post.² The survey included three open ended questions and forty-seven multiple choice questions. The survey instrument was submitted to the IHS National Institutional Review Board on 6/4/92 and was subsequently approved.

Completed surveys were returned by 80 of 110 surveyed clinic employees. We also received 72 reply cards which noted the respondent's position and site location. Someone from each of the 22 sites responded. That is a total return of 73%. Since more surveys than reply cards were returned we can be sure that at least 6 sites returned all five questionnaires but it may be more. We received responses from at least 10 SUDs, 11 CDs, 22 nursing staff, 12 physicians,

¹ Goal 22: To focus on health services for AI/AN women that will result in improved health status outcomes. Action Plan for Women's Health. DHHS/PHS. September 1991, pg. 37. [hereinafter referred to as Action Plan.]

² Our apologizes to the handful who did not receive a stamped return envelope.
10 medical records technicians, 3 Physician Assistants, and one each -- Family Nurse Practitioner, Women's Health Coordinator, Patient Registration Technician, Clinical Coordinator, and Health Records Administrator. Information obtained from the surveys is reflected throughout this report, especially in Section Five. A copy of the OPVP/IST survey instrument with the final tally can be found in Appendix II. Answers to the open ended questions can be found in Appendix III.

The project also includes a supplemental telephone interview with any respondent who, on the reply card, supplied their telephone number and suggested an appropriate time to call. The telephone interview script was written based upon the comments provided in the open ended questions. The script was also approved by the IHS National Institutional Review Board. A total of 24 providers from 14 different sites requested a telephone interview. Only 20 were conducted due to vacation days, busy schedules and similar problems. Interviews were conducted with 3 Service Unit Directors, 2 Clinical Directors, 8 Nurses, 4 Physicians, 2 Physician Assistants, 1 Registration Records Administrator. A summary of the telephone interviews is found in Appendix V.

A similar survey was also sent to two providers at four urban Indian clinics that have instituted a computerized Pap Tracking system. The urban program is coordinated by the American Indian Health Care Association in Minnesota. Since this program was instituted at only four sites as recently as July 1992, only a few people are familiar enough with the system to be surveyed. Two people at each of the four intervention sites were surveyed; all but one responded. The small sample, despite its limitations, was included to bring in the perspective of the urban sector. This survey instrument differs from the one used at the IHS reservation sites because it eliminates questions about breast examination. Dr. Linda Burhansstipanov of the National Cancer Institute contributed to the revision of the survey instrument. The revised survey instrument has been approved by the AIHCA and the IHS National Institutional Review Board. A copy of the survey instrument for the AIHCA sites with the final tally can be found in Appendix VI along with a collection of the answers to the open ended questions.

SECTION THREE: LIMITATIONS OF THIS STUDY

This study was commissioned to follow-up on ideas generated at the Indian Women’s Health Care Task Force Round Table in January 1991. It was developed and implemented within a short-time frame with modest funding. All information obtained from the field is the opinion of the health providers and their support staff. No client satisfaction surveys were conducted, no patient records were reviewed to corroborate the information given. This study represents only the subjective view of clinic personnel.

The study focuses primarily on IHS and tribal clinics that have received training in the Industrial Strength Triage type of Outpatient Visit Planning (OPVP/IST). Some survey respondents had not received the training and several mentioned minimal use of IST at their facility.

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3 Of the 80 respondents, 11.25% did not answer questions #4, #5 and #6 five about when and where the respondent was trained. It is assumed that these nine individuals were not trained. We were not expecting to encounter this and did not give them an adequate choice on several of the survey questions. When indicated in the text of this report, adjustments have been made to exclude the "no answer" responses.

4 To better understand why OPVP/IST is not practiced to its fullest review Appendix IV.
The survey of the urban clinics is perhaps premature because the program just began in the summer of 1992. Only eight people were familiar with the program to be surveyed. Some had not yet fully implemented the program.

SECTION FOUR: BACKGROUND ON WOMEN'S HEALTH AND CANCER

A recent IHS report indicates that cancer in American Indian women, even though it is below the national average, is usually undetected until advanced stages. Also, cervical cancer rates for American Indian women are higher than the national average.\(^5\) Mortality rates for cervical cancer is highest in the Aberdeen, Billings, Alaska, and Southwest areas.\(^6\) DHHS has stated that American Indian and Alaska Native (AI/AN) women have unacceptably high mortality rates due to breast and cervical cancer and sets as a long term objective to reduce the rate of mortality due to cervical and breast cancer in AI/AN women.\(^7\)

Specific goals for a reduction of cancer mortality among the American Indian/Alaska Native population have been set.\(^8\) The Public Health Service set a goal to focus on health services for

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\(^6\) Indian Women's Health Care Consensus Statement, IHS/OPEL, IHS Round Table Meeting, January 1991, pg. 4. [hereinafter referred to as IHS Women's Health Round Table]

\(^7\) Action Plan, pg. 37, Goal 22.


- 16.3 Reduce breast cancer deaths to no more than 20.6 per 100,000 women. Note: adjusting as NCI does, to the 1970 rate, the equivalent target value for this objective would be 25.2 per 100,000.

- 16.4 Reduce deaths from cancer of the uterine cervix to no more than 1.3 per 100,000 women Note: adjusting as NCI does, to the 1970 rate, the equivalent target value for this objective would be 25.2 per 100,000.

See also under stated goal 16.12 Increase to at least 95 percent the proportion of women aged 18 and older with uterine cervix who have ever received a Pap test, and to at least 85 percent those who received a Pap test within the preceding 1 to 3 years.

Also see 1986 recommendations from the IHS Women's Health Task Force (as reported in IHS Women's Health Round Table, pg. 1): Objective I: Increase screening for cervical cancer of all AI/AN women 20 years and older by at least 20% within the next three year period.
AI/AN women that will result in improved health status outcomes. Specific tasks and completion rates were published.\(^9\)

Breast cancer mortality rates for Native American females have consistently remained much lower than the U.S. rates. However, the data also show that in recent years, breast cancer mortality appears to be increasing in some regions, especially in the Aberdeen and Nashville Areas.\(^10\)

Cervical cancer mortality rates, except for the Bemidji Area, have consistently been significantly higher than the U.S. rates. In the Aberdeen, cervical cancer mortality remains high despite much progress. Varying degrees of excess cervical cancer mortality was seen in all IHS regions.\(^11\)

IHS has been actively addressing barriers to care. Different ways to overcome barriers and improve access to care have been tried at different sites. This variety is necessary because of differences in population size, demographics, and customs. The IHS delivery system design does remove one of the most formidable barriers to cancer screening for its clients, that is, cost to the client. Other barriers do exist which keep clients from accessing care such as great distances to

\(^9\) *Action Plan*, pg. 37-8 Goal 22 stated action steps and mileposts:

1. Develop and implement a PAP Smear Registry (FY 1991) with a tracking system in every IHS service unit (FY 1992).

2. Develop an abnormal PAP smear follow-up program in every IHS service unit with supporting consultation and technical assistance programs in each area (FY 1991-1992).


4. Make diagnostic mammography services available to women in each IHS area (FY 1991-92).


\(^11\) Valway, et al., pg. 9
providers, long waits for care, inconvenient clinic routines, few female providers, and lack of motivation to screen for cervical cancer by both patients and providers.\textsuperscript{12}

It is important to eliminate barriers and improve access to women's health care because breast and cervical cancer can be treated and are preventable cancers.\textsuperscript{13} An IHS report describing a series of six studies on cancer in American Indian and Alaska Native women (with a particular emphasis on cancer of the breast and cervix) concluded that reductions of nearly 60% in mortality could be achieved through combinations of both screening and case management.\textsuperscript{14} IHS guidelines call for annual PAP smear screening because of the increased incidence of cervical cancer in the IHS population.\textsuperscript{15} PAP smear screening is considered an easy and inexpensive early detection intervention.\textsuperscript{16}

Multiple strategies may be needed to achieve substantial gains. The major drop-out point in the process of care appears to be after a visit has been made and the need for a follow-up appointment has been recognized. Research is needed in this area to examine the causes for avoidable morbidity and mortality with particular emphasis on developing information for intervention strategy development and implementation.\textsuperscript{17}

The future health status of thousands of AI/AN women demands new emphasis on comprehensive care.\textsuperscript{18} During the IHS Round Table on Women's Health it was recommended that OPVP/IST be initiated for Indian women as a means to increase Pap screening and improve early detection and treatment of cancer.\textsuperscript{19} In Appendix V we summarize the comments of respondents from different sites explaining the impact of OPVP/IST at that site and the local limitations.

\textbf{SECTION FIVE: OPVP/IST SITES EXPLORED}


\textsuperscript{13} Valway, et al., pg. 7.

\textsuperscript{14} Nutting, et al., pages 1 - 3.


\textsuperscript{16} Valway, et al., pg. 1

\textsuperscript{17} Nutting, et al., pg. 8.

\textsuperscript{18} Shorr, G., Dickey, E. \textit{Methods to Promote Comprehensive Care in the Indian Health Service.} IHS/OHPRD. No date., pg. 15.

\textsuperscript{19} IHS Women's Health Round Table, pg. 7 Recommendation #5.
**IST Generally**

OPVP/IST is formally defined as concurrent, comprehensive visit planning for clients who attend acute care clinics. The primary objective of OPVP/IST is to produce a brief, written set of instructions for the professional staff which are intended to expedite client care and improve recognition of health needs beyond the presenting complaint. OPVP/IST is a training course designed to improve outpatient clinic efficiency by teaching management strategies that work in IHS and tribal settings, and by defining the caregiver’s role as a manager and client advocate. The course promotes the delivery of comprehensive care by teaching the correct use of problem lists, health maintenance standards, protocols for triage of common complaints, and the construction of rational visit plans. Its goal is to promote comprehensive care and improve efficiency in IHS outpatient clinics.

OPVP/IST is designed to address all major known health problems addressed for every client who presents for care at an IHS or tribal facility. Health care staff will review the client’s medical record to identify major health problems, edit the problem list, recognize health maintenance needs (including such preventive services as immunizations, patient education, screening for cancer and elevated blood pressure), and devise a rational plan of care for the visit at hand based on the individual’s health needs and the overall workload. The visit plan includes assigning the client to a provider, ordering tests, vital signs, measurements, consent forms, state of undress, comfort measures, patient education and arranging for referrals and follow-up.

OPVP/IST works well with the move towards Continuous Quality Improvement (CQI) as recommended by the Joint Commission on Accreditation of Health Care Organizations’ (JCAHO). OPVP/IST can improve the clinic flow and ensure triage prior to screening which will likely lead to improved outcomes (e.g. more women receive annual pap smears and breast exams, increased detection of early pregnancy). OPVP/IST can be altered to accommodate local conditions, information obtained in a needs assessment, Quality Improvement data, and other available information or staff and client changes.

Although OPVP/IST is designed to address much more than women’s health, it is a good case management system for women’s health. OPVP/IST procedures ensure regular breast examinations, pap smears, and women’s health care. It also tracks clients who need follow-up care after an initial screening test.

**IST Survey Findings**

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20 Shorr, G., Daniels, S. Improving Outpatient Care with Concurrent Visit Planning: The Case for Industrial Strength Triage. IHS/Division of Health Systems Development. 4/17/87., pg. 3


23 Daniels, et al., pg. 23.

24 Whistler, pg. 2
In a 1987 study, IHS found that "clinic personnel had the subjective impression that IST increased staff productivity, decreased client waiting time, improved documentation of care, increased screening for unrecognized disease, increased delivery of preventive service, and improved recognition of health problems beyond the chief complaint." The KAI survey conducted five years later confirms the earlier assertions.

- **Staff productivity**

The KAI survey did not directly ask about staff productivity but it asked if respondents think OPVP/IST actually improves provider satisfaction; 63.75% answered more or much more. However 72% respondents also think paperwork increased and 62.5% think time spent late on the job has also increased more or much more.

- **Decreased patient waiting time**

Respondents think the waiting time has decreased since IST was implemented; 40% think it is better or much better; 33.75% about the same. Some respondents would not know the answer to this question (due to their position at the clinic.) Adjusting this response to eliminate those who do not know, 52% think that decreased waiting time is better or much better and 44% think it is about the same. Current waiting time for breast exam or pap at the different sites was estimated by 15% of the respondents to be less than 30 minutes; 43.75% responded 30-60 minutes, 8.75% think it's over an hour, and 27.5% think it varies.

- **Improved documentation of care**

Unlike the 1987 study, our survey did not address this issue. The best indicator regarding a change in the documentation of care is that 72.5% of the respondents think there an increase in paperwork is attributable to IST.

- **Increased screening for unrecognized disease**

25 Daniels, et al., pg. 2.

26 KAI survey of OPVP/IST sites prepared for this project, [hereinafter referred to as KAI IST Survey], question #44. Respondents answered: Much more 27.5%, More 36.25%, About the same 26.25%.

27 KAI IST Survey # 42.

28 KAI IST Survey # 41.

29 KAI IST Survey # 31.

30 KAI IST Survey # 30.

31 KAI IST Survey # 42.
58.75% of the respondents think that there is more or much more screening for unrecognized disease, 22.5% about the same. 18.75% don’t know or did not answer. Adjusting this response to eliminate those who do not know, 72% of the respondents who do know think there is more or much more screening and 28% think it's about the same.

- **Increased delivery of preventive service**

71.25% of the respondents believe that preventive services are delivered more or much more. Again, adjusting for those who do not know or who did not answer, the percentage of respondents increases to 85%. And 45% of the respondents think that more appointments are made for cervical or breast screening with OPVP/IST; adjusting for those who do not know or did not answer, the percentage increases to 67%. Of the total respondents 40% think the rate of keeping appointments is about the same; 35% see improvement. Of all the respondents 15% think that same day appointments for pap and breast happen always and another 21.25% think they usually happen. According to 31.25% of the respondents future appointments are always scheduled, and 50% think future appointments are usually scheduled. Respondents think appointments usually happen within 3 weeks (44.75%).

- **Improved recognition of health problems beyond the chief complaint**

Respondents think that health problems beyond the chief complaint are recognized 58.75% more or much more, 22.5% about the same. Adjusting for those who do not know or did not answer, 79% think other health problems are recognized. 66.25% of the respondents think IST helps them better identify patients who need

32 KAI IST Survey # 38.
33 KAI IST Survey # 37.
36 KAI IST Survey # 33.
35 KAI IST Survey # 34.
36 KAI IST Survey # 21.
37 KAI IST Survey # 22.
38 KAI IST Survey # 29.
39 KAI IST Survey # 39.
43.75% think detection of early pregnancy happens more or much more. And 47.5% think family planning happens more or much more. 42
Other Findings

Overall 76.25% of the survey respondents think the OPVP/IST improves client care.\textsuperscript{43} And 73.75% believe IST should be replicated and reproduced elsewhere.\textsuperscript{44}

OPVP/IST seems to be an effective women’s health intervention: Major risk factors for breast cancer are noted on the client’s problem list or otherwise prominently in their medical record most of the time. (22.5% always, 33.75% usually, 16.25% often).\textsuperscript{45} Respondents think they commonly check on: the date of the last menstrual period (42.5% always, 42.5% usually)\textsuperscript{46}, Pap smear (40% always, 42.5% usually)\textsuperscript{47}, breast examination (31.25% always, 40% usually, 13.75% often)\textsuperscript{48}, and breast mammography (28.75% always, 35% usually, 13.75% often).\textsuperscript{49}

A brief analysis of our respondents\textsuperscript{50} show a large number of “old timers”, that is, 42.5% have worked in the IHS system for more than 5 years, with 36.25% working where they work now for more than 5 years. Also, 31.25% described themselves as members of the local tribe; 20% as Indians from elsewhere; and 25% as long-time residents and 25% relatively new to the community. Most were trained in IST at their present site (67.5%), though 22.5% were trained elsewhere. Many (48.75%) of the respondents were trained over a year ago with 38.75% trained within the past year. Most respondents (57.5%) agree or strongly agree that they were adequately trained to implement OPVP/IST; adjusting for non-answers, 65% feel adequately trained.

The PCC system is prevalent at OPVP/IST sites, 92.5% always use it.\textsuperscript{51} Of the total respondents 81.25% are using problem lists always or usually.\textsuperscript{52} Health maintenance standards

\begin{itemize}
\item \textsuperscript{43} KAI IST Survey \# 43. Responses are: Strongly agree 36.25% Agree 40%
\item \textsuperscript{44} KAI IST Survey \# 45.
\item \textsuperscript{45} KAI IST Survey \# 16.
\item \textsuperscript{46} KAI IST Survey \# 17.
\item \textsuperscript{47} KAI IST Survey \# 18.
\item \textsuperscript{48} KAI IST Survey \# 19.
\item \textsuperscript{49} KAI IST Survey \# 20.
\item \textsuperscript{50} KAI IST Survey \# 1 - 6.
\item \textsuperscript{51} KAI IST Survey \# 12. The one telephone interview site where PCC is not in place is particularly burdened because the PCC form was introduced in preparation for obtaining the hardware but staff must also report under the current system.
\item \textsuperscript{52} KAI IST Survey \# 13.
\end{itemize}
are used by 76.25% always or usually, and triage protocols for common complaints prior to screening are 68.75% always or usually, and 13.75% often.  

**Personal Comments About IST**  

OPVP/IST, of course, is not perfect. Some sites find they are not able to implement it all the time due to client overload and/or staffing shortages. Others are inhibited by space limitations. At least initially OPVP/IST takes more time and work for the providers and support staff. The results are not always immediately apparent despite the additional effort. The amount of paperwork has increased.  

Some providers, when asked about client feedback to OPVP/IST, say the patients complain that the providers are gathering "unnecessary information". They find themselves in a bind when it takes long longer to explain the process than to complete the process. Though other providers commented that once explained, patients seem to appreciate that all their health care needs are being assessed. Perhaps more community education could nip any client dissatisfaction at the onset. For example, clients could learn about OPVP/IST and the types of questions that will be asked through a health center newsletter or posting, the local paper or radio PSAs.

**SECTION SIX: NCI GRANT SITES DISCUSSED**

The Division of Cancer Prevention and Control has formulated an intervention research program within the Special Populations Studies Branch to identify and test, in community settings, interventions to reduce the rate differentials noted between minorities and whites. The projects discussed below are from the Avoidable Mortality from Cancers in Native American Populations program. It's goal is to identify and remedy key factors that contribute to avoidable mortality from specific cancer sites. The NCI Grant Sites are summarized in the following chart:

53 KAI IST Survey # 14.

54 KAI IST Survey # 15.

55 See also Appendices III and V.

56 KAI IST Survey # 42, 72.5% say they do more or much more paperwork now that IST is in place.
<table>
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<td>Elizabeth Dickey, M.P.H. 602 670 6182</td>
<td>Doris Segal Matsumaga, M.P.H. 808 696 1599</td>
<td>Dr. Mark Digham 919 748 4565</td>
<td>Carol Marquez-Baines, M.P.H.612 293 0733</td>
<td>Dr. James Berner or Dr. Ann Lanier 907 257 1393</td>
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<td>Community education. Computerized Pap tracking system</td>
<td>KAB survey and evening clinic to overcome barriers</td>
</tr>
<tr>
<td>STAFF</td>
<td>No new staff</td>
<td>&quot;Navigator&quot; coordinates groups. Lay persons conduct the groups</td>
<td>Committees of lay-people and professionals. Educator &amp; Assistant at project site</td>
<td>Public health nurse educator staff on site Case Management Site Coordinator</td>
<td>Hired Native Corp. to run separate women's clinics.</td>
</tr>
<tr>
<td>TRAINING</td>
<td>23 sites across Indian country over the past two years</td>
<td>Kokua groups (family and friends) meet to learn about cancer. Attendees receive vouchers for them-selves and friends or relatives to obtain a free pap smear or mammography.</td>
<td>Monthly meetings of intervention teams</td>
<td>Clinical staff training (at all sites) in Pap &amp; breast exam procedures. For pilot sites, comm health workers also trained. Training at urban sites. Video.</td>
<td>Midlevel providers trained to do colposcopy and biopsy.</td>
</tr>
<tr>
<td>ACTION</td>
<td>Intake includes a review of the medical record to determine all (not just immediate) medical needs (to be addressed by referral or later appointment if necessary.)</td>
<td>Community analysis, Focus groups to develop concepts. Critique by Advisory committees. pretesting, implementation.</td>
<td>Review patient records (phone contact/home visit), educational outreach, clinic units, training for Indian nurse educators and non-Indian community health organizations, case management</td>
<td>Set up urban demonstration women's clinic with child care, evening hours, and female providers. Conduct screening at remote location</td>
<td></td>
</tr>
<tr>
<td>INDICATORS</td>
<td>Less after 4 p.m. traffic. Review of patients charts prior to IST for 9 indicators of quality care and efficient patient flow</td>
<td>Baseline telephone survey with mid and final followup. Pre and post-tests with the Kokua groups. Voucher follow up.</td>
<td>Increased number of Pap smear tests. Baseline interviews Focus Groups Pretests</td>
<td>Increase in the # of women seen and # receiving followup services (Data monitoring system)</td>
<td>Utilization rates, kept appts.</td>
</tr>
<tr>
<td>SITES</td>
<td>23 so far</td>
<td>Offices in tribal facilities for Eastern Cherokee and Lumbee</td>
<td>Tulsa/OKC Salt Lake City Seattle/Minneapolis Detroit/Milwaukee</td>
<td>Anchorage Aleutian Prifolof Islands</td>
<td></td>
</tr>
<tr>
<td>NEW MATERIALS</td>
<td>Training Manual Video is planned</td>
<td>Vouchers, KAB</td>
<td>Initial material and then booster material quarterly. Graphic booklet</td>
<td>Survey forms, educational materials (brochures, posters, video) Standardized protocol for data gathering.</td>
<td>KAB</td>
</tr>
</tbody>
</table>
Alaska Native Medical Center Prevention of Cervical Cancer Project

Mortality rates from cancer, in general, and cervical cancer, in particular, among Alaska Natives exceed those of the general U.S. population. There is evidence of increasing rates of cervical cancer and severe dysplasia in this population. Risk factors associated with increased risk of cervical cancer, sexually transmitted diseases, and smoking occur at high rates.

The IHS Alaska Area received a grant from the National Cancer Institute to address these problems. The IHS Alaska Area contracted with the Aleutian/Pribilof Islands Association (APIA) to fulfill the NCI grant. The contracting mechanism is a cooperative agreement rather than a self-determination contract.

The long term objectives of the project are to reduce morbidity and mortality from invasive cervical cancer in Alaska Native women. Specific goals are to promote knowledge and awareness of this disease, its risk factors and appropriate screening programs; to enhance the existing cervical screening program and follow-up care of precancerous lesions and to reduce risk factors.

The project has two major components. First, is the survey of knowledge, attitudes, and beliefs (KAB) regarding cancer and cancer screening in general, including cervical cancer, of a randomly selected sample of Alaska Native women residing in Anchorage, stratified by five years of age starting at age 20. Second, is the operation and management of one large urban women's health clinic at the Alaska Native Medical Center in urban Anchorage and conducting a women's clinic quarterly at the rural facility operated by the APIA.

Effectiveness indicators for the project are increases in PAP screening rates, increased knowledge, attitudes, and beliefs as measured by the KAB scores, reduction of the barriers to care, and increase in utilization rates and kept appointments as noted in chart audits.

About 1100 women were selected for the KAB survey. Criteria for selection is Alaska Native women, residing in Anchorage who are 20 years old by 1/1/92 and who had a physical encounter with ANMC within the last 3 years. Interviews for baseline KAB data began in June 1992 and are scheduled for completion by Dec. 31, 1992. There are two interviewers (one FTE, one half-time.) The full-time interviewer sees 20 women per week to meet the year-end goal.

The interviewers are flexible and try their best to accommodate the women to be surveyed. They have visited places of business and homes (at interviewer's discretion) and are available in two locations (midtown Anchorage at the APIA Office and at the Alaska Native Medical Center.) The interviewers find that there is about a 50% no-show rate on first appointments but when they are persistent, the woman will show for a second scheduled appointment. The interviewers try to coordinate with the ANMC and particularly the women's clinic. For example, if a women is scheduled for a mammogram or other service offered at ANMC, then the interviewer will ask her to meet for an interview one hour before or after the services are delivered.

The survey respondents are asked to participate in the complete project, that is, to commit to a follow-up KAB survey in three years and to consent to tracking of their medical history for the next three years using the IHS computer system or by releasing records from their non-IHS providers. If they agree to participate in the project, they receive a goodie package which includes a health tip calendar with stickers to mark date of last menstrual period and date of last breast self-exam; a write on/wipe off magnetic board with (on back) guidelines for early detection of cancer and seven warning signals; a quiz regarding risk factors; a shower guide with info for breast self-exam and for men's testicular exam; and a pen with a reminder about annual exams. If the women decides to only participate in the initial interview she receives the calendar and pen.
Baseline data is obtained by reviewing medical charts for the random sample over (at least) the past five years. The medical chart is reviewed for Pap smear history, reproductive history, use of hormonal replacement therapy, hysterectomy, and sexually transmitted diseases. The original focus of the chart review included several more indicators but expediency and efficiency required a restricted focus. (E.g. breast exams are not recorded.) The major focus is the Pap history. About 100 chart reviews from ANMC were completed as of the beginning of August. Another 50 charts from the rural clinic on St Paul Island were also reviewed.

Unfortunately, there has been no data entry for the interviews or chart reviews yet due to lack of staff. The project staff anticipate that a student will be available for this task during the next school semester.

At this time community education is provided through IHS brochures available in the clinic and the emergency room. As the data from the KAB is compiled, the results will be used to formulate appropriate community educational materials.

The APIA designed a women's clinic at the ANMC intended to reduce the barriers to access women's health care. The design is flexible to accommodate new findings; it incorporates the barrier reductions determined by a preliminary community assessment, that is 1) evening hours, 2) child care, and 3) female providers.

The APIA coordinates with two other native organizations who contract to provide women's health services at ANMC. One organization provides family planning and daytime ambulatory women's health care. The other provides pregnancy screening and initial prenatal examinations during the daytime hours. All three organizations use the ANMC facilities at no charge. ANMC provides all clinic supplies, covers the utility costs, and provides the necessary equipment. ANMC also provides pharmaceutical services until 7 p.m. nightly and ANMC provides Yupik and Inupiat translators as needed.

APIA conducts three evening clinics for women's health and one half-day clinic. Evening services are provided from 5 to 9 p.m. on Tuesdays, and from 5 to 7 p.m. on Wednesdays and Thursdays. One night mammography is available; another night colposcopy is available. The clinic also provides pregnancy screening but does not see prenatal appointments routinely.

ANMC owns the mammogram machine; the machine is used during the day by the other women's health contractor providers. The APIA project pays for the mammogram technician who is provided at a subsidized rate through the Shared Resources Program of a local private hospital. (The technician must be approved by ANMC.)

The women's clinic no longer has a separate child care component. Originally the evening clinics were located where child care was available. Moving the equipment around for the evening clinics proved too difficult to continue. The clinic now accommodates children by allowing them into the large exam rooms (with cribs and children's toys available in the rooms.) Hiring a child care professional is a future goal.

The women's clinic health care providers utilize the Outpatient Visit Planning/Industrial Strength Triage. One mentioned that she reviews the health summaries with the patient during intake to note any upcoming diagnostics and immunizations.

APIA administers the KAB Survey and provides clinical services for the native population on the Pribilof Islands. It is estimated that 150 of the 500 native Aleuts on the islands are women within the age targeted range. APAI is working on a census now. Staff spent five days on St. Paul Island to interview patients and conduct the chart review for baseline data. Apparently the
information is "sketchy" and not as easy to compile as at the urban site. About 18-20% of the female population showed up for interviews. At this same time, a physician conducted pap smears and colposcopy. APIA announced the visit ahead of time using the local radio.

The project budget includes funds for a colposcopy machine and nitrogen tank for the St. Paul site. Staff would also like to get a mammogram but may not have the population to support that expense. The APIA operates out of the small clinic on St. Paul staffed by a Physicians Assistant who is on call at all times. The clinic does experience some trauma incidents related to the fishing industry accidents which are evacuated to the ANMC. The project staff intends to visit the island to perform these services quarterly but is difficult to travel to the islands.57

APIA is very ambitious and has already planned to expand its program. APIA hopes, within three to six months to hire a counselor to implement a smoking cessation program. Another program in the brew is a weight loss/nutrition program for women.

APIA would like to produce public service announcements to be aired on the Rural Alaska TV Network. APIA would also like, for its women’s clinic, to produce a video or to use those available at ANMC or Planned Parenthood. APIA would also like to conduct a town meeting just for women on St. Paul Island.

The project will likely soon add four case control groups to the KAB. This would require an additional $30,000 to hire chart reviewers, KAB interviewers, more data entry and part-time statisticians.

There are two interviewers (1 FTE, 1/2) for KABs; a Nurse Practitioner; Intake Nurse; Chart Reviewer; Doctor - part time; and a Mammogram technician (funded in part by project and in part by private facility as its community contribution.)

Although planes are available daily in summer (two carriers) it costs about $1070 per person to fly to St. Paul. It is an additional cost to fly to St. George. In the winter time only one carrier is available and usually only three times per week in winter.
American Indian Health Care Association in Minnesota

The American Indian Health Care Association in St. Paul, Minnesota received an NCI grant to study cervical cancer prevention and treatment among Native American women living in seven metropolitan areas. The Native American Women and Wellness Project (NAWW) is designed to access cancer prevention knowledge, attitudes, and behaviors; develop a computer-based pap tracking system, and evaluate the effectiveness and efficiency of the system.

Preliminary work was conducted. AIHCA filtered out variances in collection techniques, changes in threshold of acceptance by different laboratories, and other variables affecting data collection. AIHCA developed a computer-based pap tracking system and training manual. AIHCA, as the central location for compilation and analysis of the Urban Common Reporting requirements (UCRR) computer statistics, matched three urban clinics to implement the computer-based pap tracking system with three comparison sites. Clinics have been matched based on population size of the urban area, Indian population size within the urban area, and level of sophistication of the health program, level of penetration in the urbanized Indian community and the geography of the area as follows:

<table>
<thead>
<tr>
<th>Intervention Site</th>
<th>Comparison Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seattle</td>
<td>Minneapolis</td>
</tr>
<tr>
<td>Detroit</td>
<td>Milwaukee</td>
</tr>
<tr>
<td>Tulsa</td>
<td>Oklahoma City</td>
</tr>
<tr>
<td>Salt Lake City</td>
<td>[comparison site eliminated due to loss of clinic funding]</td>
</tr>
</tbody>
</table>

The target population is 9,333 Native American women age 18 and over from the seven urban areas. The community education expected to reach 14,023 urban Native American women in four intervention communities. All seven sites will measure the number of participants who are screened for cervical cancer as well as those with abnormal Pap smears who receive follow-up treatment. Five of the seven clinics are Title V Indian clinics. The Central Oklahoma American Health Council in Oklahoma City and the Indian Health Care Resource Center of Tulsa are IHS demonstration sites. The clinics are not direct IHS facilities but are independently incorporated with their own Board of Directors. The clinics do not regularly employ staff gynecologists.

AIHCA conducted training at the intervention sites. Each test site has received a computer to be dedicated to the pap tracking system. The computers are not physically linked but the software has a special feature which allows the clinic to save its information to a floppy disk without revealing any of the client identifier information. AIHCA collects this data for evaluation purposes.

Training in Case Management was conducted by AIHCA at the end of June 1992 and began operating at some sites as early as August. Once fully implemented the computerized system will collect the following data: the Chart Number, Survey Respondent (whether or not they did participate in the NAWW survey), Clinic Number, Tribe I.D., Entry Date, Active or Inactive, Date of Birth, Date of Last Pap, Smoker, how many cigarettes per day, Comment (up to 60 characters), Memo (allows lengthy comments to be added to the records, hidden from view unless prompt is

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58 The Pap Tracking System is based on the Bethesda Pap Classification System of results.
Follow-up Data (listing of attempts to contact the client), and Results/Procedures. Each time a Pap or colposcopy result comes back from the lab it should be entered onto the Pap Tracking System. More information will be collected on the Pap Result: Is the specimen adequate, within normal limits? Are STDs infections or viruses present? Inflammation or cervicitis? Keratosis? Abnormal squamous cells? Abnormal glandular cells? More information is collected on the procedures: Pap Procedure, Colposcopy Result, Colposcopy Procedure, and Surgery Procedure. The computer software also has the following Print Functions and Reports: Result Letters and Mailing Labels, Results/Procedure Count, Missing Lab Results, Patient Report, and Priority List (top priority patients for social support and intervention.)

AIHCA will review patient records to determine the proportion of eligible women who receive annual Pap exams. Field workers will contact eligible non-screened clients. AIHCA expects this project will result in an increase in knowledge and cancer screening behavior. AIHCA will measure the frequency of cancer screening. AIHCA's hypothesis for cancer screening is an increase of 20% at intervention sites. AIHCA will also measure the percentage of Native American women in the urban community who receive regular cancer screening, especially women over 40 (new clinic users presenting for Pap and clinical breast screening.) The AIHCA hypothesis for reaching these women is an increase of 10% at intervention sites. AIHCA will measure increase in the percentage of Native American women who receive appropriate follow-up services of abnormal Pap exams within 6 months. AIHCA's hypothesis is an increase over 3 years, from 70% to at least 90%, that is, 155 more women at intervention sites.

Of the seven respondents to the survey, 71% think that the pap tracking system has helped better identify patients who need services. About half agree that paperwork has increased but no one thinks that they are working late more often. All the respondents agree or strongly agree that pap tracking improves patient care. Of the respondents, 85% think that the pap tracking program should be replicated and reproduced at other sites. For more results from the survey, see Appendix VI, Part I.

AIHCA has created a network for independent urban clinics by providing the computer equipment, dedicated link, and pap tracking system as well as training, baseline data, a reference manual, and program evaluation. The individual clinics do not have the resources to independently produce such a system. The networking of the different clinics provides a larger data base which is necessary for statistical purposes. The network is a sophisticated pap tracking system and a planning tool. The information gained will enable each site to use previous years' data to set goals for their own programs. By aggregating their data with other sites they will have a better perspective of the program's effectiveness. This is a good model for IHS to note. As IHS facilities are contracted by tribes and tribal organizations, it will be more important to develop networks between these otherwise autonomous clinics.

- North Carolina Bowman Gray School of Medicine

The Wake Forest University Bowman Gray School Medicine was awarded a grant for its Native American Cervical Cancer Prevention Project to be implemented with the Eastern Band of Cherokee and the Lumbee Indians (not affiliated with IHS). The project will use the Solomon Four Group Design: 250 women receive a pretest interview; 250 receive pretest interview and...
intervention; 250 receive intervention; and 250 will receive nothing. All 1000 women interviewed after study.

The study will be a KAB Assessment to aid in identification of barriers to obtaining Pap smears and follow-up care, the PRECEDE (Predisposing, Reinforcing and Enabling Causes in Educational Diagnosis and Evaluation) model will be used.

At Eastern Cherokee the first year was spent planning and doing a community assessment without interviews. Interviews began approximately Jan. 92 for Cherokee and Oct. 91 for Lumbee.

The project includes an educational component. The intervention will be presented to women by trained Native American lay health educators and reinforced by mail and telephone. The Minority Health Communication Model (MHCM) will be used. Initial education will be ongoing. Booster material will be available quarterly or more frequently if requested. A graphic booklet will be developed. The goal is to provide the initial program to 17 new women per month (booster contact with at least 5).

The project should generate the following data: Baseline population, Target population (N = 1000 from each Cherokee and Lumbee). Effectiveness indicators will be measurable changes in knowledge, attitudes and behaviors and an increase in Pap smear screening levels.

The project includes the use of Advisory Committees to review project plans for ways to facilitate implementation by lay advisors (business managers, workers, homemakers, and the elderly.) Health care issues will be reviewed by professionals (physicians, nurses, health educators, etc.) Focus groups will be used to collect impressions about Pap smears and follow-up care, the educational materials and barriers to behavior in each program site. The programs require tribal cooperation. Both operate out of the tribal council offices.

The Eastern Cherokee medical center has had a mammogram machine since mid-April 1992. It justified the need for the machine by showing that the target population makes 7 visits per year (that is 7 chances to provide screening each year.) The mammogram technicians play an important role. Prior to using the machine they explain to clients how to prepare for the x-ray and the schedule the appointment. A video plays while women wait for the mammogram.

At Cherokee the health workers have been doing IST-like prompts since the facility was computerized in 1987. Recent IST training did not dramatically change the way they approached individual patients. The medical center maintains a computer registry for those with abnormal mammogram (on the RPMS system.)

The community is very isolated and very rural. Researcher find it difficult to define the community because many reservation roads are uncharted.

- Hawaii Wai'anae Coast Comprehensive Health Center

The Hawaii Wai'anae Coast Comprehensive Health Center received a NCI grant for its Wai'anae Coast Cancer Control Project. The project is also coordinated with the University of Hawaii Cancer Research Center (CRC) and committed Wai'anae residents. Although the Native Hawaiian population is not served by IHS, this brief project description is included because of its culturally sensitive design.

The need for the project is apparent. Native Hawaiian women have the highest age-adjusted breast cancer rate for women over the age of 40 of any ethnic group in the U.S., and cervical cancer rates 1.6 times the rate for U.S. whites.
The focus of the project is patient and community education. It provides a culturally sensitive health education program that recognizes and builds upon the strength of Native Hawaiian social and family networks and their sense of "Kokua", that is, a Hawaiian social concept that encourages mutual support of community members as an integral part of life. A Community Advisory Committee assists in the project components. The project seeks to identify gaps and problems in the delivery of screening and related health services to women.

The project began summer 1992. Its target population is 1400 Native Hawaiian women. Baseline KAP data is being collected by telephone surveys at the start to be measured against follow-up telephone surveys collected at the midpoint and end of the program (recalling those initially interviewed.) Community diffusion will be assessed by telephone surveys of 600 randomly selected community members. KAP changes among this telephone survey sample will be compared to a telephone survey of native Hawaiian women outside the intervention area. An additional group of 600 women in both populations will be surveyed to control for the "learning" effect of participating in telephone surveys.

A designated "Navigator" identifies peer leaders who can form a Kokua group; the Kokua groups provide the link between health workers and Native Hawaiian women. The groups meet in casual settings, such as some one's home, to discuss women health issues, barriers to care, and prevention techniques. During the meeting, a "Documentor" will record the process through audio recording and note-taking. Participants receive vouchers for themselves as well as for friends or relatives to cover the costs of a pap smear, breast exam, or mammogram. Vouchers can be redeemed at the clinic or doctor of their choice. Women who receive abnormal results will receive follow-up services from the "Navigator", such as referral to the project nurse who can provide case management services, counseling, and referral to other agencies or organizations.

The effectiveness of the project will be measured primarily by tracking the redemption of screening vouchers, through the KAP studies as well as measuring changes in mammography and PAP screening rates. At the end of five years a report will be written based on the KAP surveys, Documentor's notes, staff feedback, voucher tracking, and other project records.
SECTION SEVEN: POLICY RECOMMENDATIONS

BE MORE SUPPORTIVE OF OPVP/IST

Convince the Administrators

OPVP/IST involves resources. It cannot be successfully implemented without sufficient training, staff, and clinic space. The only way to address these central issues is with IHS management behind the idea. Area Directors and SUDs should be supportive of OPVP/IST. Any request for IST training or refresher training should come from the SUD. The executive team at each clinic should be involved in assuring that it be implemented fully and should be involved in negotiations for the appropriate space, personnel, and training. Without an administrative-clinical partnership OPVP/IST will not be effective.

Implement OPVP/IST at all sites

Implement OPVP/IST at all IHS sites including the large tertiary centers (e.g. PIMC). This follows the Women's Health Round Table Recommendations Related to Cancer and Indian Women suggesting that OPVP/IST be initiated for Indian women as a means to increase Pap screening and improve early detection and treatment of cancer. Effective implementation requires administrative and supplemental support. Ideally, a certified teacher and coordinator should be appointed for each Area or region with few duties unrelated to OPVP/IST. A hot-line should be established specifically for troubleshooting OPVP/IST. A training video tape should be produced and given to each trained site.

Appropriate Training

First of all, the sites that are already using OPVP/IST need some additional training. Many sites are having difficulty maintaining the problem lists or are not properly using the health summaries. There should be a refresher course for any site that has not had one in the past year. An annual refresher course should be offered by video or in person each year. When high level personnel, (e.g. clinical director, outpatient supervisor, ambulatory care director, director of nursing) come on board at an OPVP/IST site without previous OPVP/IST training they should be sent to the next available training session.

Training should begin in those Areas where the need is greatest. The first regional coordinator position could be established in Alaska or Aberdeen Areas. All training should prepare sites for overload of unmet needs that may suddenly surface. Examples from other sites, such as setting up priority systems or changing staffing patterns, should be shared so that a newly trained site can be ready for the consequences of increased workload and increased fiscal support.

Appropriate Staffing

At many sites a shortage of triage staff was noted. Respondents said that with additional staff the facility would be able to implement OPVP/IST on a more consistent basis not only at the walk-in clinic but also with appointments and specialty clinics. IHS should recognize that

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62 IHS Women's Health Round Table, pg. 6.
OPVP/IST is time consuming and creates more paperwork.\textsuperscript{63} It was recommended that more OPVP/IST-trained nurses be placed in the outpatient department.

Staff must be capable. Nurses performing IST must have good interview skills, be able to handle and resolve conflict, work under pressure, and have enough management skill to pace the clinic and expedite the care of patients who clearly need special attention.\textsuperscript{64} Other staff positions that must be capably filled to ensure full benefit from OPVP/IST are the data entry and medical records technicians. Without this basic infrastructure, the computer system will be back logged; problem lists and health summaries will never be current.

**Adequate Space**

Triage involves many personal matters especially in regards to women’s health issues such as family planning, birth control, and sexually transmitted diseases. Many respondents complained that adequate private space was hard to find at their facility. Some places hold triage in an open room, others have rooms separated only by a curtain, thin plywood, or walls that do not extend to the ceiling. Candid answers to sensitive questions may be not be forthcoming under these situations.

We recommend that IHS design its new outpatient clinics to be compatible with the principles of OPVP/IST. Ideally, IHS could design model outpatient clinics for small, medium and large facilities that could be adapted to individual sites. A prospective design that incorporates the triage function will improve clinic flow.

**MORE SUPPORTIVE OF WOMEN’S HEALTH**

Of the total respondents 65% agree or strongly agree that IHS policy does support IST and other efforts to improve women’s health.\textsuperscript{65} In it’s *Action Plan for Women’s Health* PHS has stated a goal to focus on health services for AI/AN women that will result in improved health status outcomes.\textsuperscript{66} Specifically addressed were screening mammograms, on-site colposcopy, greater emphasis on women’s health education and preventive health, and separate women’s clinics.

1. **Mammogram for screening.**

IHS long term objectives include increases to at least 80 percent the proportion of women age 40 and older who have ever received a clinical breast examination and mammogram; and to at least 60 percent the proportion of women age 50 and older who received a clinical breast examination and a mammogram within a preceding year.\textsuperscript{67} Many providers mentioned the need

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\textsuperscript{63} KAI IST Survey #41; 62.5 % said that stay late more than the did before IST was implemented. KAI IST Survey #42 72.5% sais the amount of paperwork is more or much more.

\textsuperscript{64} Shorr, Dickey, pg. 19.

\textsuperscript{65} KAI IST Survey #47

\textsuperscript{66} *Action Plan*, pg. 37, Goal 22

\textsuperscript{67} *Healthy People 2000* The IHS Primary Care Provider, Vol. 16. No. 7, July 1991, pg. 109 - 123. FN 3, pg. 123. See also, IHS Women’s Health Round Table, pg. 6 Round Table
for IHS to support screening (and not solely diagnostic) mammograms. It has also been published that a substantial number of AI/AN women were found to have discovered a breast lump, but delayed examination by a physician for up to 18 months.68

The Women's Health Round Table recommended that mammography capability be available in every Service Unit.69 In our survey, 21.25% of the respondents say there is on-site mammogram and 22.5% say it is nearby (less than 15 miles).70 At several surveyed sites a mobile mammogram van comes to the site and IHS staff make appointments for their clients. A mobile mammogram machine can be the best solution because it saves the expense of buying and maintaining the machine, and the technicians and nurses are usually part of the service contract.

2. On-site colposcopy.

Reducing the significant rate of cervical cancer in Native American women is a high priority for the IHS. AI/AN women manifest a higher incidence of cancer of the cervix than do women of other ethnic groups in the U.S despite the fact that cervical cancer is a potentially preventable disease because its precursor lesions can be identified by Pap smears and colposcopy, are easily identified and can be eradicated. 71

Several telephone respondents mentioned the high “no-show” rates for Pap smear appointments. However, most OPVP/IST sites track who has missed appointments and work with the women to eventually come in for the screening tests. When colposcopy appointment is scheduled weeks or months later the no-show rate is apt to increase. This is especially true when the appointment site is further from the women’s home than the IHS site.72 OPVP/IST is helpful here, 73.75% of the respondents say that they always or usually track if appointments are kept or missed, 77.5% always or usually track if appointments for follow-up procedures are scheduled, and 76.25% always or usually track if follow-up appointments are kept or missed.73

IHS recognizes that on-site colposcopy is beneficial and has begun a training program at the PIMC. Resources need to be better coordinated. In the telephone interviews we learned of sites with equipment but no trained providers and vice versa. From the total respondents, 35%

Recommendations Related to Cancer and Indian Women: 1. Develop a program and standards of care related to Mammography Screening, Diagnostic Mammography, and Breast Cancer Prevention to assure that: a. Diagnostic Mammography and Mammography Screening for high risk women is considered Priority One for Contract Health Service (CHS) care in all areas of IHS delivery.

68 Nutting, pg. 3.

69 IHS Women's Health Round Table, pg. 6 Round Table

70 KAI IST Survey #28


72 Waxman, pg. 43

73 KAI IST Survey #s 23, 24, 25 respectively.
say that colposcopy is available on-site and 6.25% say it is available nearby; however, 28.75% say that the client has to travel more than 45 miles.  

3. Greater emphasis on women's health education and preventive health.

Cultural factors may be a barrier to screening; 61.25% respondents agree or strongly that cultural factors inhibit a women from obtaining a Pap smear or breast exam. This indicates a need for a monitoring program because this screening is likely not part of the client's lifestyle. Creating brochures and education materials locally to address specific needs of the local service population would also address this barrier. Some locally developed materials are available but at many sites the respondents stated that there is not enough time or other resources for this activity. The Women's Health Round Table recommended that community education and prevention efforts be undertaken by IHS and Indian communities which include "cancer survivors", are culturally sensitive, cognizant, and sensitive to poverty and its impact on prevention strategies, and are linked to the IHS delivery system. One site was inspired by OPVP/IST to include in each client's cart an Outpatient Department Health Care Maintenance Checklist. It includes seven screening tests and nine different topics to be reviewed with the patients each year. A space is provided for the provider or triager to note the date that each topic was discussed with the patient.

Many telephone respondents stated that women's health would also benefit if there were child day care services available on or near the medical facility. There were complaints that a room designed for day care was so unsuitable that it became a supply closet instead. Of the total respondents 21.25% say that regular day care is available but 67.5% say it is never available. One site mentioned that it has large exam rooms and each has a child's corner. One site mentioned that is leery about providing free care because parents might "dump" their children at the medical facility.

4. Provide women's clinic or special time set aside for women's clinic.

The IHS Women’s Health Round Table recommended, in relation to cancer in Indian women, that Special Women's Clinics should be initiated to provided for aggressive prevention, screening, and early detection of cervical cancer. PHS has set as a goal to establish at least one major regional Indian women's health clinic in each IHS area (by FY 1991.). These goals are all

74 KAI IST Survey #27
75 IHS Women's Health Round Table, pg. 6.
76 Tuba City Indian Medical Center Form 1-6/90. Tests include Breast Exam/Pelvic Exam/Pap smear; Rectal Exam/Fecal Occult Blood Test; EKG; Cholesterol; Random Blood Sugar; Visual Acuity; Tonometry or ophthalmoscopy. Counseling topics cover Seat belts; Tobacco use; Breast self exam; Alcohol/drug use; Exercise; Weight control; "Safe Sex"; Testicular self-exam; Contraception.
77 KAI IST Survey #10
78 IHS Women’s Health Round Table, pg. 6 Recommendations Related to Cancer and Indian Women #4.
79 Action Plan. pg. 37 Goal 21
consistent with another PHS goal to raise the health status of AI/AN women to the highest level possible and to deliver comprehensive high-quality health services. 80

Each of these goals is aiming at eliminating barriers to health care and safety for Indian women in Indian communities. While it does seem important to provide a separate women’s clinic or special time set aside for women’s clinic; on a few occasions providers stated that the separate clinics did not work at their facilities because it created a different set a barriers. Primarily, it did not work where it was dependent on the appointment system.

However, providers at other facilities favored the separate clinic and talked about how helpful it was for them. At surveyed sites 35% held women’s clinic regularly, 10% 2 -4 times a week, 17.5% about once a week, 6.25% about once a month, and 28.75% never. 81

Whether there is a separate clinic or not, the common thread to these two perspectives on women’s clinics is the importance of female providers. IHS has recognized the need for female providers, 75% of the respondents noted that they regularly have female providers. 82 The need for female providers was mentioned most often on the telephone. The term “women’s providers” has been explicitly defined to include female physicians, nurse practitioners, midwives, physician assistants, and mental health therapists. 83

At some sites it was the older people who did not like to see male providers when at other sites the older women are used to the male providers and did not mind. So the lesson to be learned is that it just depends on the population to know what will work in a particular site.

More frequently, providers stated that evening hours did not work as a means of bringing in more women. Some sites had tried it at one time on another but only 2.5% of the respondents noted they have regular evening hours. 84 It seemed to work best in the urban environment. The Alaska Native Medical Center Prevention of Cervical Cancer Project (at ANMC) women’s clinic is primarily operational in the evening and 85% of the AIHCA urban respondents indicated that they hold evening clinics at least once a week.

80 Action Plan, pg. 36 Goal 20
81 KAI IST Survey #7
82 KAI IST Survey #9
83 Action Plan, pg. 36 Goal 20: Long-term objective: Female providers. See also IHS Women’s Health Round Table Recommendations Related to Cancer and Indian Women #4, pg. 6.
84 KAI IST Survey #7
SECTION EIGHT: CONCLUSION

The overload of unmet needs in Indian women's cancer screening is being recognized at sites across the country. Aggressive methods of dealing with this problem are being developed methods as simple as overbooking screening appointments or as complex as instituting an elaborate computer pap tracking system. One method that is used at over twenty IHS and tribal facilities is the Outpatient Visit Planning methodology nicknamed "Industrial Strength Triage".

Although OPVP/IST was designed to address all clients' ongoing health needs but it seems to be an effective tool to meet all the goals and objectives set for cancer screening in women. The system is fairly new; its "bugs" can be expected to be worked out soon because OHPRD is currently conducting a study for that purpose.

Of our respondents, 73.75% felt that OPVP/IST should be replicated and reproduced elsewhere. Respondents are fairly comfortable with the implementation of OPVP/IST; 7.5% say it is similar to the previous system and an additional 32.5% think is makes a lot of sense.

We suggest that IHS adopt a policy to implement OPVP/IST at all sites including large tertiary centers. The emphasis should begin where cancer rates are highest. Implementation should include necessary additional resources for trained staff, adequate space, ongoing training and troubleshooting. A position should be established in each Area or region to coordinate IST programs. At each site staffing considerations should include a sufficient number of data entry and medical records technicians because more paperwork will be generated and OPVP/IST will like require more time from most staff members.

And OPVP/IST should be implemented with other accountability controls. IHS should conduct a reliability assessment for OPVP/IST by reviewing client records and asking the clients what questions are asked during triage. IHS has suggested that Pap tests meet quality standards by monitoring and certifying all cytology laboratories and it ensure that mammograms meet quality standards by monitoring and certifying at least 80 percent of mammography facilities. The Women's Health Round Table recommended that Standards of Care for women's cancer screening be developed by a national panel and adopted and enforced at the Service Unit level. The Round Table also recommended that IHS should develop and maintain a Tumor Registry for Indians.

---

85 KAI IST Survey #46, of the remaining 26.25%; 20% were not sure and 6.25% did not answer this question.

86 Healthy People 2000 The IHS Primary Care Provider, Vol. 16. No. 7, July 1991, pg. 109 - 123. pg. 123, 16.15 Ensure that Pap tests meet quality standards by monitoring and certifying all cytology laboratories. 16.16 Ensure that mammograms meet quality standards by monitoring and certifying at least 80 percent of mammography facilities.

87 IHS Women's Health Round Table, pg. 6. There are [no] tumor registries throughout the country that adequately represent Native Americans. National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) population-based tumor registry information about cancer incidence among Native Americans includes only limited Native American populations. Seventy-five percent of their data on Native Americans comes from the New Mexico Tumor Registry which includes Native Americans in Arizona and New Mexico. Valway, et al, pg. 10
IST/OPVP is an effective intervention is easily complemented by additional women's health intervention programs when funding is available. We suggest that multiple strategies be used whenever possible. We suggest more emphasis on community based education and working with Community Health Representatives to bring in clients in need of screening.

SECTION NINE: REFERENCES


7. Shorr, G., Dickey, E. Methods to Promote Comprehensive Care in the Indian Health Service. IHS/OHPRD. No date.


SECTION TEN: APPENDICES

I. List of Sites
II. Survey Instrument for IST Sites with Percentages
III. Answers to the Open Ended Questions for IST Sites
IV. Questions Asked in Telephone Interviews for IST Sites
V. Summary of Telephone Interviews
VI. Survey Instrument for AIHCA Sites with Percentages and Answers to the Open Ended Questions for AIHCA Sites
PROCEDURE--want to receive study

1. Dr. Stanley Griffith and Elizabeth Dickey

2. Vivian Pinn -- Office of Research on Women's Health

pg. 24 of Washington Post Magazine article

$ for including women in clinical trials

also supplemental grants us up to $50,000 each for trials already in progress or just beginning. Real good for urban settings.

3. Carol Marquez
4. Linda B.
5. Ann Lanier
6. Donna Click, Schurz (638)
7. & 8. Ellen
9. & 10. JoAnn
11. Luanna
12. Dr. Donahue
INTERVENTIONS FOR INDIAN WOMEN'S HEALTH CARE
POLICY ANALYSIS SURVEY

Outpatient visit planning/Industrial Strength Triage

SURVEY DATA 80 out of 115 surveys returned -- Note: Six questions have more than one response so responses to those questions total more than 100% -- questions # 3, 4, 5, 26, 27, and 28. There were some questions that received no answer, primarily because the respondent did not receive OPVP/IST training.

1. How long have you worked at this Service Unit?

< 1 year 1 to 2 years 3 to 5 years 5 to 15 years > 15 years no answer
10% 32.5% 21.25% 26.25% 10% 0%

2. How long have you worked with IHS?

< 1 year 1 to 2 years 3 to 5 years 5 to 15 years > 15 years no answer
10% 21.25% 21.25% 25% 17.5% 5%

3. How do you describe yourself as a member of the community?:

member of married Indian long-time new to community no local tribe to member from elsewhere resident or short-term resident answer
31.25% 2.5% 20% 25% 25% 1.25%

4. Where were you trained in OPVP/IST?

This site Another site No answer
67.5% 22.5% 11.25%

5. When were you trained in OPVP/IST?

more than in the past year a year ago not sure no answer
38.75% 48.75% 1.25% 11.25%

6. Would you say you were adequately trained to implement OPVP/IST?

Strongly agree Agree Not sure Disagree Strongly disagree No answer
18.75% 38.75% 16.25% 11.25% 3.75% 11.25%

Background Questions about the Health Facility

Does your facility have, specifically for women's health care:

- Evening hours? 2.5% 0% 2.5% 7.5% 81.25% 6.25%
- A separate women's clinic? 35% 10% 17.5% 6.25% 28.75% 2.5%
- Female providers? 75% 12.5% 1.25% 3.75% 6.25% 1.25%
- Child care? 21.25% 1.25% 2.5% 3.75% 67.5% 3.75%
- Women's support groups? 6.25% 2.5% 3.75% 10% 68.75% 8.75%
### Procedure Questions

**Do you use:**

<table>
<thead>
<tr>
<th>Question</th>
<th>Always</th>
<th>Usually</th>
<th>Often</th>
<th>Seldom</th>
<th>Never</th>
<th>No Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. • PCC system?</td>
<td>92.5%</td>
<td>3.75%</td>
<td>0%</td>
<td>0%</td>
<td>1.25%</td>
<td>2.5%</td>
</tr>
<tr>
<td>13. • Problem lists?</td>
<td>57.5%</td>
<td>23.75%</td>
<td>5%</td>
<td>6.25%</td>
<td>6.25%</td>
<td>1.25%</td>
</tr>
<tr>
<td>14. • Health maintenance standards?</td>
<td>53.75%</td>
<td>22.5%</td>
<td>7.5%</td>
<td>10%</td>
<td>2.5%</td>
<td>3.75%</td>
</tr>
<tr>
<td>15. • Triage protocols for common complaints prior to screening?</td>
<td>43.75%</td>
<td>25%</td>
<td>13.75%</td>
<td>7.5%</td>
<td>5%</td>
<td>5%</td>
</tr>
</tbody>
</table>

**16. Are major risk factors for breast cancer noted on the patient’s problem list or otherwise prominently in their medical record?**

<table>
<thead>
<tr>
<th>Always</th>
<th>Usually</th>
<th>Often</th>
<th>Seldom</th>
<th>Never</th>
<th>No Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>22.5%</td>
<td>33.75%</td>
<td>16.25%</td>
<td>16.25%</td>
<td>3.75%</td>
<td>7.5%</td>
</tr>
</tbody>
</table>

**Do you check:**

<table>
<thead>
<tr>
<th>Question</th>
<th>Always</th>
<th>Usually</th>
<th>Often</th>
<th>Seldom</th>
<th>Never</th>
<th>No Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. • Date of last menstrual periods?</td>
<td>42.5%</td>
<td>42.5%</td>
<td>6.25%</td>
<td>1.25%</td>
<td>6.25%</td>
<td>1.25%</td>
</tr>
<tr>
<td>18. • Date of last Pap smear?</td>
<td>40%</td>
<td>42.5%</td>
<td>7.5%</td>
<td>2.5%</td>
<td>6.25%</td>
<td>1.25%</td>
</tr>
<tr>
<td>19. • Date of last breast examination?</td>
<td>31.25%</td>
<td>40%</td>
<td>13.75%</td>
<td>7.5%</td>
<td>6.25%</td>
<td>1.25%</td>
</tr>
<tr>
<td>20. • Date of last breast mammography?</td>
<td>28.75%</td>
<td>35%</td>
<td>13.75%</td>
<td>7.5%</td>
<td>7.5%</td>
<td>1.25%</td>
</tr>
</tbody>
</table>

**Do you schedule:**

<table>
<thead>
<tr>
<th>Question</th>
<th>Always</th>
<th>Usually</th>
<th>Often</th>
<th>Seldom</th>
<th>Never</th>
<th>No Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>21. • Same day appointments for Pap smear and breast exam?</td>
<td>15%</td>
<td>21.25%</td>
<td>6.25%</td>
<td>38.75%</td>
<td>16.25%</td>
<td>2.5%</td>
</tr>
<tr>
<td>22. • Future appointments for Pap smear and breast exam?</td>
<td>31.25%</td>
<td>50%</td>
<td>8.75%</td>
<td>5%</td>
<td>2.5%</td>
<td>2.5%</td>
</tr>
</tbody>
</table>

**Do you track:**

<table>
<thead>
<tr>
<th>Question</th>
<th>Always</th>
<th>Usually</th>
<th>Often</th>
<th>Seldom</th>
<th>Never</th>
<th>No Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>23. • If appointments are kept or missed?</td>
<td>43.75%</td>
<td>30%</td>
<td>6.25%</td>
<td>16.25%</td>
<td>2.5%</td>
<td>1.25%</td>
</tr>
<tr>
<td>24. • If appts for followup procedures are scheduled?</td>
<td>33.75%</td>
<td>43.75%</td>
<td>5%</td>
<td>10%</td>
<td>6.25%</td>
<td>1.25%</td>
</tr>
<tr>
<td>25. • If the follow up appts are kept or missed?</td>
<td>37.5%</td>
<td>38.75%</td>
<td>7.5%</td>
<td>10%</td>
<td>5%</td>
<td>1.25%</td>
</tr>
</tbody>
</table>

**26. Who performs the Pap smears?**

<table>
<thead>
<tr>
<th>Designated On-site Provider</th>
<th>Any Provider On-Site</th>
<th>Women's Clinic</th>
<th>Designated Off-Site Provider</th>
<th>Don't know</th>
<th>No Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>23.75%</td>
<td>63.75%</td>
<td>8.75%</td>
<td>2.5%</td>
<td>0%</td>
<td>6.25%</td>
</tr>
</tbody>
</table>

**27. How many miles must the patient travel to the primary referral site for a colposcopy?**

<table>
<thead>
<tr>
<th>On site</th>
<th>&lt; 15 miles</th>
<th>15 - 45 mi.</th>
<th>45 - 90 mi.</th>
<th>over 90 mi.</th>
<th>No Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>35%</td>
<td>6.25%</td>
<td>30%</td>
<td>26.25%</td>
<td>6.25%</td>
<td>0%</td>
</tr>
</tbody>
</table>

**28. How many miles must the patient travel to the primary referral site for a mammogram?**

<table>
<thead>
<tr>
<th>On site</th>
<th>&lt; 15 miles</th>
<th>15 - 45 mi.</th>
<th>45 - 90 mi.</th>
<th>over 90 mi.</th>
<th>No Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>21.25%</td>
<td>22.5%</td>
<td>31.25%</td>
<td>25%</td>
<td>3.75%</td>
<td>1.25%</td>
</tr>
</tbody>
</table>
Questions about the Effectiveness of OPVP/IST

29. If it's noted that a patient needs a Pap and a breast exam, when will she get an appointment?

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same Day</td>
<td>7.25%</td>
</tr>
<tr>
<td>1 week</td>
<td>3.75%</td>
</tr>
<tr>
<td>2 - 3 weeks</td>
<td>33.75%</td>
</tr>
<tr>
<td>&lt; 2 months</td>
<td>26.25%</td>
</tr>
<tr>
<td>&gt; 2 months</td>
<td>25%</td>
</tr>
<tr>
<td>No Answer</td>
<td>3.75%</td>
</tr>
</tbody>
</table>

30. When a patient comes for a breast exam or Pap smear appointment, how long must she wait?

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 30 mins</td>
<td>15%</td>
</tr>
<tr>
<td>30 - 60 mins</td>
<td>43.75%</td>
</tr>
<tr>
<td>over an hour</td>
<td>8.75%</td>
</tr>
<tr>
<td>it varies</td>
<td>27.5%</td>
</tr>
<tr>
<td>Don't know</td>
<td>3.75%</td>
</tr>
<tr>
<td>No Answer</td>
<td>1.25%</td>
</tr>
</tbody>
</table>

31. Has the waiting period been decreased since OPVP/IST was implemented?

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Much Better</td>
<td>12.5%</td>
</tr>
<tr>
<td>Better</td>
<td>27.5%</td>
</tr>
<tr>
<td>About the same</td>
<td>33.75%</td>
</tr>
<tr>
<td>Worse</td>
<td>2.5%</td>
</tr>
<tr>
<td>Don't know</td>
<td>18.75%</td>
</tr>
<tr>
<td>No Answer</td>
<td>5%</td>
</tr>
</tbody>
</table>

32. Has OPVP/IST helped you better identify patients who need services?

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Much Better</td>
<td>30%</td>
</tr>
<tr>
<td>Better</td>
<td>36.25%</td>
</tr>
<tr>
<td>About the same</td>
<td>15%</td>
</tr>
<tr>
<td>Worse</td>
<td>1.25%</td>
</tr>
<tr>
<td>Don't know</td>
<td>13.75%</td>
</tr>
<tr>
<td>No Answer</td>
<td>3.75%</td>
</tr>
</tbody>
</table>

33. Do you think more appointments are made for cervical or breast screening since OPVP/IST?

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Much Better</td>
<td>27.5%</td>
</tr>
<tr>
<td>Better</td>
<td>27.5%</td>
</tr>
<tr>
<td>About the same</td>
<td>27.5%</td>
</tr>
<tr>
<td>Worse</td>
<td>1.25%</td>
</tr>
<tr>
<td>Don't know</td>
<td>12.5%</td>
</tr>
<tr>
<td>No Answer</td>
<td>3.75%</td>
</tr>
</tbody>
</table>

34. Do you think more appointments for cervical or breast screening are being kept?

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Much Better</td>
<td>11.25%</td>
</tr>
<tr>
<td>Better</td>
<td>23.75%</td>
</tr>
<tr>
<td>About the same</td>
<td>40%</td>
</tr>
<tr>
<td>Worse</td>
<td>0%</td>
</tr>
<tr>
<td>Don't know</td>
<td>21.25%</td>
</tr>
<tr>
<td>No Answer</td>
<td>3.75%</td>
</tr>
</tbody>
</table>

35. Do you feel cultural factors inhibit a women from obtaining a Pap smear or breast exam?

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>17.5%</td>
</tr>
<tr>
<td>Agree</td>
<td>43.75%</td>
</tr>
<tr>
<td>Not sure</td>
<td>15%</td>
</tr>
<tr>
<td>Disagree</td>
<td>16.25%</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>6.25%</td>
</tr>
<tr>
<td>No answer</td>
<td>1.25%</td>
</tr>
</tbody>
</table>

Now that OPVP/IST is in place:

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Much More</td>
<td></td>
</tr>
<tr>
<td>More</td>
<td></td>
</tr>
<tr>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Less</td>
<td></td>
</tr>
<tr>
<td>Don't know</td>
<td></td>
</tr>
<tr>
<td>No Answer</td>
<td></td>
</tr>
</tbody>
</table>

36. Detection of early pregnancy happens:

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>28.75%</td>
<td></td>
</tr>
<tr>
<td>38.75%</td>
<td></td>
</tr>
<tr>
<td>0%</td>
<td>11.25%</td>
</tr>
<tr>
<td>6.25%</td>
<td></td>
</tr>
</tbody>
</table>

37. Preventive services are delivered:

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>21.25%</td>
<td></td>
</tr>
<tr>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>12.5%</td>
<td></td>
</tr>
<tr>
<td>0%</td>
<td>10%</td>
</tr>
<tr>
<td>6.25%</td>
<td></td>
</tr>
</tbody>
</table>

38. Screening for unrecognized diseases happens:

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>43.75%</td>
<td></td>
</tr>
<tr>
<td>22.5%</td>
<td></td>
</tr>
<tr>
<td>0%</td>
<td>11.25%</td>
</tr>
<tr>
<td>7.5%</td>
<td></td>
</tr>
</tbody>
</table>

39. Recognition of health problems beyond the chief complaint happens:

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>21.25%</td>
<td></td>
</tr>
<tr>
<td>43.75%</td>
<td></td>
</tr>
<tr>
<td>17.5%</td>
<td></td>
</tr>
<tr>
<td>0%</td>
<td>11.25%</td>
</tr>
<tr>
<td>6.25%</td>
<td></td>
</tr>
</tbody>
</table>

40. Family planning happens:

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>18.75%</td>
<td></td>
</tr>
<tr>
<td>28.75%</td>
<td></td>
</tr>
<tr>
<td>35%</td>
<td></td>
</tr>
<tr>
<td>1.25%</td>
<td>10%</td>
</tr>
<tr>
<td>6.25%</td>
<td></td>
</tr>
</tbody>
</table>
Staff Satisfaction

Now that OPVP/IST is in place:

41. Do you stay late as often as before?  
   - Much More About Less Don't know No Answer  
   - 7.5% 55% 12.5% 2.5% 13.75% 8.75%

42. The amount of paperwork is:
   - 35% 37.5% 6.25% 2.5% 10% 8.75%

43. Would you say that the OPVP/IST actually improves patient care?  
   - Strongly agree Agree Not sure Disagree Strongly disagree No Answer  
   - 36.25% 40% 16.25% 1.25% 0% 6.25%

44. Would you say that the OPVP/IST actually improves provider satisfaction?  
   - 27.5% 36.25% 26.25% 2.5% 1.25% 6.25%

45. Do you think it was difficult to implement OPVP/IST?  
   - Yes, it is very different from what we were doing  
   - Yes, it takes a lot of thought  
   - No, it makes a lot of sense  
   - No, it is similar to what we were doing  
   - Not sure  
   - No Answer  
   - 16.25% 22.5% 32.5% 7.5% 12.5% 8.75%

46. Do you think this program should be replicated and reproduced elsewhere?  
   - Strongly agree Agree Not sure Disagree Strongly disagree No Answer  
   - 38.75% 35% 20% 0% 0% 6.25%

Policy Questions

47. Would you say IHS policy supports OPVP/IST and other efforts to improve women's health?  
   - Strongly agree Agree Not sure Disagree Strongly disagree No Answer  
   - 17.5% 47.5% 17.5% 10% 3.75% 3.75%

*48. How could IHS policy be more supportive to OPVP/IST?  

*49. How could IHS policy be more supportive to women's health generally?  

*50. What are the negative impacts of OPVP/IST?  

* See Appendix III
COMMENTS FROM SURVEYS GROUPED BY CATEGORY

48. How could IHS policy be more supportive to OPVP/IST?

+ PROVIDE TRAINING
  - Need better informed providers and nurses need to be updated regarding changing policies.
  - Train medical records staff to utilize system.
  + It is imperative that IST training courses be offered every six months — it is absurd to offer training every 3 years when average staff turnover is every 1-2 years! Few providers here know what IST is.
    - absurd to offer every 3 years when average staff turnover is 1-2 years.
  - Ongoing training for new and current staff.
  - Continue to give seminars/classes on its appropriate use. I was here for nearly 2 years before I really learned how to appropriately use the PCC form.
  - Funding for training, refresher course.
  - Provide adequate training for screeners.
  - Appoint a certified teacher and coordinator for each area who does little else.
  - Provide training money so that not just the providers get training but that support gets better PCC training which would help implement OPVP/IST.
  - More training.
  - Offer annual updates and remain open to suggestions.
  - Provide OPVP/IST Regional trainers.
  - Have CIM & Hastings [sic] implement and train staff in OPVP/IST.
  - Need training for new staff, especially nursing.
  - Be part of new employee orientation and provide continuous training.

+ PROVIDE ADDITIONAL STAFF
  - More staffing and adequate spacing.
  - We can only do IST 1/4 of the time due to inadequate nursing staff.
  - I hate to say the L word. “Line item” but OPVP/IST in addition to training requires additional RNs at each site. Executive members, who control number and types of positions, do not fully understand IST. Turnover within administrative staff, lack of full understanding by them leads to lack of support for the required additional RN staff to fully implement. As a result, those trained do not have time to implement, get frustrated, lose the skill, or turnover before having opportunity to fully utilize. We are lucky if we are able to do it 25% of the time. Marked improvement in problem lists have occurred, however, even with only 25% application.
  - When staff/facility limitations interfere with optimal implementation, remedy this; but it’s generally not policy that governs availability of the funds needed for such things.
  - Provide reasonable salaries for providers so we wouldn’t constantly be understaffed.
  - Staff increase.
  - More staff.
  - Unable to get sufficient support staff throughout facility to implement. We are working with one nurse to 3-4 providers; 1-3 of whom are temporary. We are unable to generate health summaries due to long lag in data entry and insufficient medical records staff to
print and place in chart. Unable to get medical staff trained to leave health summary in chart, not continuing to make attempt due to legion of other problems. We have only 1 room/provider which makes a bottleneck. Due to lack of staff, almost impossible to get all necessary personnel together to change policies and trouble shoot.

- By providing more physicians.

+ BROADEN SERVICES

- Implement it IHS-wide or at least in large tertiary centers (e.g. PIMC).
- Implement in all facilitites.
- By providing more screening clinics.
- Implement in the PHS Hospitals -- for faster patient flow.
- On-site mobile mammography available annually.

+ OTHER

- One main individual, sharing office space in San Xavier is frankly overextended. IST is fast becoming CQI tool and that person/other instructors are looked upon as outpatient consultants on a “site visit” which is actually good. More people, time, resources needed.
- First, all clinics should implement in a similar manner. Second, notification of public of policies so patients don’t feel you are ignoring their primary concern.
- Quit fighting with tribal administration and get your mind on work.
- Direct administration to refine IST process in a timely fashion.
- Is strongly supportive at this time.
- More IHS participation
- Less paperwork so we have more time for services.
- Policies have little to do with the actual implementation of a system; it takes the commitment and hard work by the local staff.
- Provide for implementation of PCC at all sites then teach OPVP/IST.
- I feel IHS is in agreement with OPVP/IST.
- Wish we were set up for basically by appointment care -- majority of patients use drop in or urgent care system. Screening takes time. They’re receiving more thorough excellent care but angry regarding waiting or having to be scheduled to return by appointment so needs can be met adequately.
- Our triage nurses are on the phone constantly and basically triage our pediatrics charts. Adult triage is not happening.
- Observe the plan in action and implementing it in all the clinics.
- Share computer information with rural clinics.
- Establish as a goal for the coming year.
- Initiate accountability controls to make sure its actually done.

49. How could IHS policy be more supportive to women’s health generally?

+ IMPROVE SERVICES

- Implement more services for women’s health clinic.
- Make more accessible -- long waits not consistent in care
- More staffing and adequate spacing
- On site mobile MGM annually available.
- Pay for mammograms routinely—not just high risk. Need more mobile units -- also need
  colposcopy available at every site if possible. Need colposcopes!! Need IHS sponsored
  training!
- By having more funding for mammograms -- and more personnel for Pap smears.
- Fund mammograms/colposcopy programs (if not already); IHS bulletins include changes
  in ACOG, ACS recommendations.
- Fund screening mammograms as recommended to ACS & ACOG.
- Get more colposcopy equipment and training
- Fund colposcopes.
- Fund colposcopy equipment/training for all sites.
- When they say the will make appointments and send them to patients—they should.
- Provide the service when women are referred to IHS.
- Provide services referred by clinics.
- Educate more on preventive health.
- Greater emphasis on women health education.
- Provide women clinic or special time set aside for women’s clinic.
- One day provide better method of mammography instead of the now painful method.

+ PROVIDE TRAINING AND STAFF
- Recruitment emphasis on female providers (MD’s, FNP’s PA’s) to do women’s health
  care.
- Put more nurses in the OPD and train the nurses (all of them) to do IST.
- By making screening, support groups for available. [sic]
- Hire staff who are trained specifically for women’s health.
- More staff.
- Provide reasonable salaries for providers so we wouldn’t constantly be understaffed.
- Provides more providers and nurses to do the job.
- Support a certified teacher and coordinator for each area.
- Support staffing needs.
- Better staff support.
- Improve staffing so health care maintenance is not seen as a “luxury”.
- Our screening improved once a specific provider was hired—this should be policy.
- Provide female women’s health practitioners (PAs/NPs). Promote a gynecologist.
  Provide supportive staffing. Provide women’s health counselors, educators. Private a
  department for services. Provide well-trained [???ters ] for mammography, i.e. techs,
  doctors/x-ray. Provide well-trained colosopists, [??ists].

+ OTHER
- Who are we kidding? Get IHS per capita up to rest of this country and improve women’s
  health.
- Adding information in PCC system to health factor screen (i.e. 1 degree relative with
  breast cancer or family history of heart disease.
- Allow development of staff generated brochures, education materials that address specific
  needs of our clientele.
- Professional staff get involved in establishing policy with support of management.
- Recognition, training, proper facilities, education.
- Staff people in IHS should be familiar with the needs of clinics and work with clinic staff to help develop and implement programs.
- IHS has done much to ensure compliance of QA implementation, i.e. tickler files, tracking.
- When there are women’s health conferences, there should be no discrimination on the part of Indian Service Unit for employee to get funded to attend conferences that do not come from their tribe.
- Providing more support to the people who do the women’s health.
- Our particular clinic is very supportive. If woman comes as drop in with WHC problems try to see through urgent care and women’s health care Nurse Practitioner will see, if available. However, think it’s vital not to give double messages — WHC takes time and needs to be scheduled by appointment and not drop in basis.
- It would help this woman’s health not to have to work at getting classes, travel orders, and vehicles (which are currently being denied).
- Give the issue regional emphasis.
- Develop a recall system.
- Service Unit Ex. Term; Safety and Inf. Control Committee and Medical Staff Committee
- Offer and promote educational programs (by Native Americans).
- Provide privacy.
- All [IHS facilities] should have specific women’s health care program.

50. What are the negative impacts of OPVP/IST?

+ PATIENT DISSATISFACTION
- Patients wait too long!
- Patients do feel that you are gathering “unnecessary information” sometimes it takes longer to explain what you’re doing than assessing the patients.
- Sometimes our agenda is different from the patient’s agenda; they object to being put through the ringer when they thought they could get quick disposition of a simple problem.
- One more line to stand in for the patient. Our only RN in clinic is doing this function and the nursing care is given by aides, volunteers, or LPN’s.
- Not dealing with the chief complaint.
- The patient is shuffled around in the triage process.

+ MEDICAL RECORDS ISSUES
- Larger charts — take up more room.
- Increase of paperwork!!
- The IST was constructed based on false beliefs.
- More paperwork.
- Limited amount of space for documentation.
- Too much paperwork with too little help.
- Paperwork, computer data recording delays.
- Not enough room to write summary if there is multiple problems or complaints.
- Not able to really access all the patients complete history at each visit, because of patient load.
- Time factor -- there is not enough time to see all patients in clinic and complete chart review.
- More paper on charts due to separate PCC’s with every visit.

+ HIGH LEARNING CURVE
- It takes a lot more time and work on everybody's part and the results are not always immediately apparent.
- It's hard to get the ball rolling.
- It takes a little more time to learn in the beginning to be sure you don’t miss anything.

+ STAFF RELATED ISSUES
- Family planner at our facility is seen by patients to be judgmental and harsh so they resist seeing her.
- Other departments and physicians get mad when nurses order diagnostic tests.
- Middle management frustration. Expectations by upper management without full support of staffing requirements. I would not offer training until additional staff hired first. Waste of limited training staff’s time.
- Doesn’t make the doctor work any faster here! -- our own little “bottleneck”. Info. well implemented by all other staff.
- Who is going to do it! We barely have the staff to keep the clinics open.
- Puts transcriptionists our of work.
- Getting providers and co-workers to comply.
- More stress on nurses to make medical decisions -- need continuing training and support.
- It is great for the nursing staff. More emphasis should be with data entry.
- Human factor and training are factors and the support of the SUD when it comes to implementation.
- Inadequate staffing levels.
- Unable to fully implement--lack of a visit planner.
- Not enough providers and too many patients for time allotted.

+ TIME CONSUMING
- It takes time to be thorough ... We are working very hard to pre-triage appointments the day before so they can get through the system in a timely manner. And then perhaps the appointment triager can then assist the urgent care (or drop in) triager more through some of their load. Everyone done the line must assist in triaging the chart and looking for lost or missed concerns.
- Takes more time (but that’s because we’re doing more [than] we should be doing.)
- Takes a lot of time!

+ OTHER
- We have screened so well that we have outstripped out abilities to do pap smears! So we have devised a priority system for not-so-delinquent (<3 yr.) and very delinquent ≥3 yr.) paps. When you have a program that improves screening, an organization has to be ready for the consequences of increased workload and increased fiscal support. Most IHS facilities do not couple clinical and fiscal management well.
- Frustration at having trained staff not able to do IST due to inadequate numbers of nurses
- We started using the system in our women's clinic but discontinued it when medical records said that only a physician could update problem list.
- Failure of refinement in IST with ongoing health problems.
- Thicker charts, see more to do but no extra staff to do it.
- It's a good system, not that much different from what we were doing, however.
- Additionally, all components of the PCC are not implemented which hinders triage. We are getting there.
- Does not seem consistently applied here.
- No method of follow-up, tracking patient.
- Have to start it and continue it on a daily basis- not just once in a while.

ADDITIONAL NOTES OFFERED BY RESPONDENTS

- When it comes to women's health, (along with other issues such as immunizations) we have been routinely screening for Pap status at every visit. A woman can get a Pap/breast exam as a walk-in without appointment in any general clinic, or at the ObGyn special clinic; or those who decline same-day Pap can make an appointment (rarely later than a week after, unless they so desire.) We are presently obtaining FNP training for one nurse so we can offer paps by a female. We now can obtain on-site mammography from a traveling mammographer. For several years our rate of current pap smears has been leading the Billings Area. This is without full-fledged IST, but is essentially an IST-type approach to this one issue.

- Tried prenatal classes — in past, attendance very poor.

- With recent addition of health educator for community and clinic newsletters done quarter plus new family or women's health care nurse practitioner— we've seen steadily increasing improvement in health issues.

- Increased paperwork is more lab work and more follow-up letters.
APPENDIX IV  Follow up questions for telephone interviews

**topic: IMPLEMENTATION**

- Would you say that IST is being implemented in the time
  - walk-in clinic
  - appt. clinics
  + women's clinics?
    - If not, why not?
  - What differences are apparent when IST is implemented?

- How thorough is the implementation?
  - 100%
  - 50%?
  - 25%?

- Did you experience an overload of unmet needs (e.g. in paps needed)?
  - What types of overloads?
  - How did you handle it?

- How did the (female) client population learn of IST?
  - When they first encountered it?
  - Notified in advance?
    - It was explained in the local newspaper or a clinic newsletter.
    - Notices in the clinic itself?
    - Health providers explained it prior to implementation?
    - Other?

- Do you have any ideas how to decrease the client waiting time (at the facility)?

- What kind of feedback do you get from the clients?
  - Do they complain that they only have a simple problem and are being asked too many questions?
  - Do they seem to understand the purpose of IST?

- Is there adequate space in the facility/women's clinic to conduct IST?
  - Where does IST take place?
    - Describe the room, degree of privacy, client comfort, etc.

- Do you have experience with IST another site?
  - If yes, does implementation differ at the sites?
    - How?

**topic: TRAINING**

- Would you be available for refresher training on IST (e.g. a video)?
  - How often?  Every 6 months?  Every year?
- Were the women's clinic staff trained?
- Is there a need for additional training on women's health issues at your facility?

+ **topic: STAFFING**

  + How many additional staff do you think are needed to implement IST 100% of the time?
    - What positions are needed in outpatient?
    - What positions are needed in the women's clinic?

+ **topic: BARRIERS FOR WOMEN'S HEALTH**

  + Does your facility have child care for clients?
    - If no, do you think it should?
    - Why or why not?

  + Does your facility have evening for women clients?
    - If no, do you think it should?
    - Why or why not?

  + Does a mobile mammogapher come to your facility?
    + If so, how many days does it stay on site?
      - How many women are tested in one day?
      - How much notice to you have?
      - Additional information?
    - If not, do you think one should?

  + Is colposcopy provided on site?
    - If no, do you think it should be available on site?

  + Are educational materials available on women's health issues?
    - Any materials produced by the staff or specific for the facility's clients?

+ **topic: Other**

  + Do you have a
    - Pap Smear Registry
    - Pap smear follow-up program
    - major regional Indian women's health clinic in your area?
Description of Sites Using IST Based on Telephone Interviews

1. Carl Albert Clinic, Ada, Oklahoma
   IST is not practiced formally at this facility. Basic triage is used in the walk-in clinic and that may include some elements of IST. There is no triage in pediatrics. The respondent felt that the staff are already overloaded with training and new initiatives and therefore does not see a need for pushing IST.
   The facility does have a separate women's clinic. The respondent spoke highly of its success and of very positive feedback from clients. It is housed in a separate wing of the building next to the postpartum ward. Clients report directly to the women's clinic (bypassing the central registery.) A nearby university provides specialty clinics for women such as stress test for pregnancy. The facility is expecting to hire its fifth midwife in order to provide around-the-clock access to a midwife. Currently mammogram is not available on site but is expected in the future. There are three colposcopy units on site.
   There is a shortage of doctors at this facility, another nurse is badly needed. No child care. At one time the clinic was open in the evenings but it was not successful. Would like to generate local education materials; “we want to but there's not enough time.”

2. Crow Agency, Crow Nation
   Use IST for walk-ins about 75% of the time depending on how many charts are waiting. They will usually take the first 20 charts in without the IST and then use IST on the next 40-60 within a four-hour period.
   Can receive a Pap or Breast exam in walk-in sometimes (depends on load and the doctor available.) Women’s clinic in the evening once or twice a month (from 5:30 p.m. to 7:30 p.m.). Otherwise women’s health services are usually provided by appointment.
   There is a need for more female providers. Seems that there is a perfect show rate for the women’s clinics when a female provider is available. Positive feedback from clients. They seem to understand the purpose of IST.

3. Fort Defiance, Navajo Nation (two people interviewed)
   IST is being used in the general walk-in clinic, pediatric and family walk-in clinics. The well child care clinic uses the old system (which is consistent with IST.) The ObGyn clinic uses IST; respondent views this is the biggest need for improvement.
   The hospital identified those individuals with chronic health care needs and put them on a continuity provider program. Women needing a pap smears were also sought out. Respondent says there was an 80% need for pap smears and the facility has achieved 95% compliance in less than 3 months.
   The hospital is antiquated and slated for replacement. In the meantime, the facility is overloaded so other facilities are being used such as: a women’s health mobile van (mammogram), schools, and other places where nurses and rooms are available. E.g. the mobile mammogram is provided under contract and it provides its own nurses. (Underfunded, understaffed, and under spaced.) Have only .66 nurses per provider. About half the providers are women.
   The new hospital will include a 20-bed unit for adolescent psychiatric care.
   This hospital has not been limiting access to walk-ins, (available 8 hours every weekday.) Women's clinic is available the same. It is attempting to increase the amount of appointment time and defer services if necessary. Now there is a 50% no-show rate for appointments.
   Are conducting their own inservice on IST once a week for eight weeks. Plan to do this every year or year and a half.
Have their own ongoing inservice for many topics. Staff from other Navajo facilities come to Fort Defiance for these programs (e.g. Advanced Life Support). They have initiated a Master’s program in Public Health Administration with the Central Michigan University. Providers take weekend courses from university-supplied teachers and can earn up to 3 credit hour per course. The courses are held at the Fort Defiance hospital.

Videos in the waiting room to quiet down the kids. Videos are about safety or are Disney videos with health announcements in between.

Have women’s clinic until 7 p.m. one night a week. Also have evening classes for childbirth and breast feeding. They have a Pap registry. Have mobile mammogram 3 half days per month conducted on appointment schedule for all women over 40. About 20% of the women are up to date. Diagnostic mammograms are 30 miles away. Colposcopy is on site. Gallup is the nearest major women’s health center.

Use local education materials when they can, especially Navajo health videos. Community Day Care is available.

Make recommendation that any request for IST come from the SUD, that the executive team be involved. IST requires negotiations about space, personnel, and training. This use of ambulatory care personnel needs the attention of the SUD. An administrative-clinical partnership is needed to ensure effectiveness.

The hospital has been emphasizing using PHNs (and to some extent, CHRs) to reach out to the community, especially to the younger populations. They bring in the young pregnant mothers to get prenatal care early on. Teens are targeted with other health programs and there are special clinic hours for them. The tribe runs a family planning program out of the hospital near the ObGyn clinic area. Other programs include working with obese children.

Focused on a Wellness Center approach. Combine western and traditional medicine. Will pay a consultancy fee for a medicine man.

4. Fort Yates, Standing Rock Sioux

IST is used about 60-65% of the time. The major limitation is the shortage of available triage rooms and the lack of privacy. Respondent thinks a training video would be helpful for new nurses and that refresher courses should be given yearly.

When IST was first initiated it did result in extra hours, there is virtually no overtime now. Unmet need overload was met with harder work on the part of the staff. Clients seem to understand the purpose of IST.

No child care for clients’ children, but respondent would like to see it. The facility is usually open until 9 p.m.

A mobile mammogram comes one day a month, it may also go to a field clinic. Usually sees between 12 - 24 women at Fort Yates. Letters are sent to women a head of time to alert them. Colposcopy was provided on site every Monday but is now offered every other Monday. An ObGyn comes down from Bismarck to perform this service. Educational materials have been created regarding pregnancy, immunization, safety for kids and common diseases. The facility has some instructional videos also.

5. Jay Clinic, Oklahoma (interview cut short)

Jay Clinic, Oklahoma (interview cut short)

Use IST 100% at all their clinics, all the time. Clients sometimes understand the purpose of IST but it depends on the individual.
6. Hoopa Clinic

IST is used informally by the nurses but they do not have the staff or space to use it regularly. They've been able to handle the unmet needs because an adequate number of providers are on staff. Their limitation is the shortage of space. They are planning to move to a larger facility in two years. There is no separate women's clinic.

IST questions seem to be well accepted by the community. Waiting time for a Pap smear has been reduced to two weeks.

Mammograms are now available 20 minutes away (Used to be an hour and fifteen minutes away.) There is a colposcope on site but it has never been used. They are hoping to send some staff for training soon. They do have one trained provider now but she is with the clinic for only two months. There is no major regional Indian women’s clinic in the area. A Pap smear registry is kept. A designated nurse has the task of tracking those who need further testing. Would favor a refresher course after they have the space and hire a triager.

No child care, think it would be very helpful. No evening hours. Educational materials have been produced on hepatitis, for mothers with new babies, and AIDS. The clinic also has a column in the local weekly newspaper.

7. Hu-Hu-Kam Memorial Hospital, Sacaton, Arizona

IST is used at the about 75% of the time in all the clinics (walk-ins, appointment clinics, and the women’s clinic.) The major limitation is times of client overload. IST is not used at the satellite clinics. There are two private triage rooms but two other rooms used for triage are have no door, only a curtain.

Unmet needs that surfaced included paps, breast exams, and mammography. The staff is getting better at doing Pap smears as walk-ins. There is a bad no-show rate so they try to handle everything the day the client presents. Respondent feels waiting time has improved, and that clients seem to understand and appreciate IST.

This clinic did something unique that might be worth repeating elsewhere. This facility conducted its own training courses. They closed down their outpatient clinic for a week to train their staff in IST (retreat style). The Outpatient Nursing Director wrote a letter to two local newspapers, flyers were used, to inform the public of the major change happening at the clinic. They had another two-day retreat this past spring and called Liz Dickey from OHPRD to come up to help out.

The women’s clinic utilizes a tribal mid-wife (tribal employee who works at the IHS facility.) There is no day care for patients' children, thinks it would really be nice. No evening hours. No mammogram on site. They have two doctors trained for colposcopy and want to get a machine. They may rent one until they can raise the money to purchase one. Colposcopy are currently scheduled at PIMC. There is a 45 - 90 day wait for an appointment and they lose a lot to no-shows. Would like to see colposcopy and mammogram on site to avoid losing folks through the no-shows due to making the appointments so far in advance. They simply forget (which may be akin to denial but transportation is also a problem.)

They have a Pap smear registry but it is not up to date. They are soon hiring an ObGyn NP who will take charge of the registry.

Respondent feels IST is great, it does help address health maintenance needs for females. Makes the patients more aware of family planning.
8. Not-Tso Gah-Nee Indian Health Center, Fort Hall (two people interviewed)

Used 100% in walk-in clinic, weekday afternoons, used less when there is a shortage of doctors (due to vacations, as there seems to be during the summer.) Started using it in the new women’s clinic mid-August. Could use more space for triage. There’s a special room for it now, only one at a time. Doctor does triage first 2 hours, then nurse for 1.5 hours.

Notes an unmet need of Pap smear screening. Gave the women 2 months to make an appointment (there’s only one female doctor available) and followed up on them.

IST was first discussed with patients when triage began; discussed the screening program as a means to keep track of health maintenance needs. Patients are 75% receptive. Most complaints when patient comes in with cold or flu, i.e. they are not feeling well, and they do not want to deal with all the questions.

A staff member (Dr. Applegate) can train or provide a refresher course. Feels only need refresher course every year to year and a half for those familiar with triaging. Favors video and training for all the nurses, LPNs, and doctors at each site.

No day care for client’s children. No evening hours — tried it, unsuccessful. No mammogram or colposcopy on site.

Thinks IST works well with women’s health. At Fort Hall, the PHN or CHR will track down a woman with an abnormal Pap if she doesn’t respond to the mailed notice.

In preparation for the upcoming women’s clinic, the staff held a conference on women’s health for the community women. Discussed, among other things, menopause, cancer. Are planning to have another conference.

9. Nowata Clinic, Oklahoma (two people interviewed) (638)

Use IST 100% of the time, very favorable. A women’s Gyn. clinic is conducted Thurs. a.m. and OB clinic Thurs. p.m. There is only one room for triage, one room for screening, and only two nurses on staff. Respondent feels it is enough room for now, but cautioned that this is a new clinic which experienced a doubling of its workload in the last 16 months. The overload of unmet needs was met with aggressive scheduling including overbooking. Lab Techs keep list of women who had an abnormal Pap smear.

Favors a training video for new employees. Favors annual refresher course. (Every couple of years.)

No child care. Tried evening hours but not enough takers. Mammogram and colposcopy at Claremore — 32 miles away. The mammogram machine is mobile (comes from Tulsa to Claremore.) Claremore is the major regional Indian women’s health clinic in the area.

Lots of local community education. Clinic supports this with 2 AIDS counselors and certified child sexual abuse examiner. Have created materials on mammogram, breast exam, STDs, AIDS, and teen pregnancy (and probably more.) Clients seem to be impressed with thoroughness of IST but some are inconvenienced.

New hardware and software seems to have improved the computer system but the computer person just quit to be replaced by an insurance clerk. (Potential problem noted.)

10. Rosebud Hospital, Sioux Nation (three people interviewed)

Very seldom implement IST. Several people were trained but staffing problems interfered with implementation. Priority is to get a stable staff. Their basic infrastructure is missing. They do not have the data entry staff to put information into the computer record. They Medical Records staff are not able to print out the reports regularly. They often experience backlog.

Space is also a problem. The Service Unit outgrew the new hospital immediately.
Have 10 doctors, 3 midwives, 1 P.A. and 2 N.P.s. With the new specialty people they've been able to increase services. They doubled their outpatient load. There are 15 exam rooms in outpatient and that many providers. Three exam rooms are being used for triage. The staff could use twice as many exam rooms as they have.

ObGyn clinic is threatened because the ObGyn left although another is expected. Have several female doctors and the midwives. Midwives are leaving with no replacements expected. They have had nurse midwives for the past eight years handling the clinic.

Have mammogram, ultrasound, as part of general clinic. Do sometimes receive clients from Pine Ridge and Wanblee. Surgeon or ObGyn can perform colposcopy. Nurses were sent to PMIC for surgery training but they lack other resources to do colposcopy consistently.

Have surgeon on board but are hampered with not having an anesthetic on board. A contract anesthetic comes in every 2 weeks for 2 days. When needed they will fly a patient out to Yankton (state hospital nearly across the state at a cost of $5,000 per trip, paid out of CHS funds). An ObGyn from Yankton comes to the Rosebud Hospital every two weeks.

Aberdeen Area Tribal Health Board recently awarded CDC grant to help with prenatal care and reduce infant mortality (by 50% in 5 years). They have satellite clinics in Antelope and St. Francis and are considering evening hours there. No child care but are contemplating making an area of the waiting room into a children's play area and trying to get volunteers to watch the children. There was a day care designed into the hospital but it was poorly placed among the mechanical equipment and has become and adjunct to the supply room instead.

No local educational materials but PHN conducts childbirth classes. LPNs are not comfortable using IST. Think the RNs would be enthusiastic.

Favors the video for training and refresher course at least once a year. Spent $7,000 on a teleconference satellite for training purposes. Not ready for any kind of update. Recommends waiting until the infrastructure problem is taken care of.

11. Sells Hospital, Tohono O'Odham Nation (three people interviewed)

This facility uses IST nearly 100% of the time at the walk-in clinic and less formally with appointments. Two nurses conduct the triage in a private room; additional triage is conducted in an open, not private, area. More space is needed to ensure privacy especially when dealing with family planning issues. Triage works very quickly and efficiently as long as there is no overload of waiting patients. The site has a shortage of physicians.

It was stated that the need for improvement in women's health was the impetus for initiating IST. There used to be a separate women's clinic but it was changed because things worked out better if women's health was integrated into the general clinic and eliminated the need to make a separate appointment for a Pap, etc. (Missed appointments are high.) There is a female physician in general clinic every day of the week.

Patients seem more aware of health care maintenance issues. They understand that IST is for their health needs and provides a more comprehensive approach to health care.

Currently there is some on-site colposcopy but when there's a complicated case or a shortage of physicians or no ObGyn on staff, then patients are sent to Phoenix or Tucson. Two physicians were recently trained in colposcopy at PIMC and three more will be trained soon. A mammogram machine has arrived but there is no one trained to use it. With the colposcopy and mammogram on site there is a need for a separate wing or area for women's health. Did have a computerized pap smear registry but they stopped using it about a year ago. Now each provider follows up and this has caused some problems. The closest major women's health clinic is at PIMC.
A refresher course is needed. Staff should discuss how to improve on triage system. Trouble with manipulating the problem list. A training video could be helpful. Used to rely on Dr. Shorr when he was in Tucson for troubleshooting.

Would like to see additional support to encourage women’s health. Sometimes the women’s health workload is overloaded and they must ask patients to come back another time. Doctor who was very focused on women’s health issues is gone. Need more support staff in women’s health so that the women’s health provider can work daily.

No local educational materials developed but the letters notifying patients of abnormal pap smear were written to be culturally appropriate. No child care, thinks it may help but probably not significantly. Nurses do help watch children. No evening hours.

12. Trinidad Clinic (two people interviewed)

This clinic is located on Yurok reservation and serves a number of tribes. IST is only used in the walk-in clinic at the two satellite clinics. The major issue here is that PCC is not up and running as early as expected. Providers are still filling out two sets of forms (one for PCC and one for the current procedures) without the benefit of PCC.

The clinic is small and even with two trailers there are no separate rooms for IST. Nurses conduct triage in the exam room before the doctor comes in. The triage nurse is overworked, she “wears lots of hats”. The triage nurse works mostly on the telephone separate from the clients. It was suggest that another triager be hired to work directly with the clients as they wait for to see a provider.

With 3 NPs and 3 physicians, the staff is able to track the patients and Pap smears. Paps are not provided for walk-in clients and there has been a 25% - 50% no-show rate for appointments so follow-up is important. Two part-time triagers share one FTE.

Favor a refresher course as soon as the computer system is operational. Need at least a one-day course on how to manipulate the problem list. One respondent said that even without the computerized system, he noticed during the end of day chart reviews that the staff had become more thorough.

Day care care is available for staff’s children but not for clients’ children. No evening hours. No mammogram on site, sent 12 miles to town. Colposcopy on-site. Some Gynecology surgery is also available on site.

No computerized pap registry but a pap tracking system. No major Indian women’s health center in area, rely on private sources.

The staff includes a health educator who is very motivated. She works on health education with community children a lot. Local educational materials have been created with help from local artist. The clients were informed about IST through a hospital newsletter (the Acorn Basket).

13. Tuba City Indian Medical Center, Navajo Nation

IST is practiced most of the time in the family medicine clinic (unless short-staffed). They include a written notation in the family practice clinic log whenever IST is not used due to short-staffing. LPNs are not comfortable using IST. Doctors don’t like the nurses ordering tests in advance. Hoping that the turn around of doctors (happening soon) will change that around also. Have 2 female providers, expecting 2 more soon. Have 4 board certified gynecologist, this clinic acts as the regional women’s clinic.

After using IST they found they had been losing people to follow-up. Put diabetes patients on routine care and got those with positive pap smears in for further tests. Clients seem to understand IST and are glad the providers are making sure they get all the care they need.

There is a separate triage room but it has only plywood walls and an open ceiling (but
this is an improvement to when triage was conducted right behind the receptionist.)

Right now the Outpatient Supervisor has not had IST and does not seem to understand the importance of it. Perhaps she should be included in the next training (wherever it is.) She is soon moving to the Ambulatory Care Director position and it is unknown if the next Outpatient Supervisor will be familiar with IST.

Mobile mammogram comes 2 days each month. Diagnostic mammogram is done in Flagstaff. X-ray staff schedule the patients for the mammograms. Colposcopy on-site. Paps are only by appointment, walk-in is reserved for acute care. Are trying to keep a pap smear registry. Have had trouble getting the records straight but they seem to have cleared up that problem by sending a copy of each pap result to a nurse midwife.

Do not have child care but really see a need for it. Have been discussing evening hours for two years but it is unlikely because it would either require rotation (which no one wants) or additional staff (and they are short on housing space.)

Have developed local pamphlets on UTI prevention and care, diarrhea, foot care. Other culturally specific materials are available from the tribe or the Navajo Nation Family Planning.

Overall the clinic does a better job for women’s health than in the general population. One thing they instituted on their own is to be sure to counsel clients on certain topics annually (to take advantage of their waiting time while they are in the clinic.) They created a routine health care maintenance checklist to cover: seat belt use/car seat use; breast exam; exercise and diet; safe sex; reduction in cigarette use; testicular self-exam; contraception; and cancer risks.

Have one CHR (Hopi) who reviews charts and seeks out those women who are behind in Pap or breast exams. Would be helpful if they had some Navajo CHRs who would screen the charts.

14. Walker River Tribal Clinic, Schurz, Nevada (638)

This site is the only one to mention that they video taped the original IST training. The respondent was in the process of learning IST because she was absent for the training sessions. The video is owned by the tribe because it is a tribally contracted site. This site will take initiative and view the videos on their own. Respondent favors training every couple of years.

IST is similar to the previous system. The triage takes place in a private room separated only by a curtain. Triagers move elsewhere when the information gets very personal.

No separate women’s clinic. Child care starts Sept. in a trailer behind the hospital. It’s geared for the children of community employees but is also available for client’s children. Would favor mobile mammogram, patients now travel 2 hours. On-site colposcope was moved to another site with greater need. Thinks it is okay elsewhere because then follow-up is by ObGyn. (Only one doctor at this site.) An ObGyn comes once a month from Reno. No computerized Pap Smear Registry but there is a follow-up program. Closest major regional Indian women’s health clinic is PIMC, outside of the area.
INTERVENTIONS FOR INDIAN WOMEN'S HEALTH CARE
POLICY ANALYSIS SURVEY TALLYED

1. How long have you worked at this urban health clinic?

<table>
<thead>
<tr>
<th>Duration</th>
<th>1 year</th>
<th>1 to 2 years</th>
<th>3 to 5 years</th>
<th>5 to 15 years</th>
<th>&gt; 15 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>43%</td>
<td>14%</td>
<td>29%</td>
<td>0%</td>
<td>14%</td>
</tr>
</tbody>
</table>

2. How long have you worked with a Native American population?

<table>
<thead>
<tr>
<th>Duration</th>
<th>1 year</th>
<th>1 to 2 years</th>
<th>3 to 5 years</th>
<th>5 to 15 years</th>
<th>&gt; 15 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>29%</td>
<td>14%</td>
<td>43%</td>
<td>0%</td>
<td>14%</td>
</tr>
</tbody>
</table>

3. How do you describe yourself as a member of the community?:

<table>
<thead>
<tr>
<th>Description</th>
<th>Member of Indian local tribe</th>
<th>Indian from elsewhere</th>
<th>Long-time resident or short-term resident</th>
<th>New to community</th>
<th>No answer</th>
<th>Other answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>43%</td>
<td>14%</td>
<td>14%</td>
<td>14%</td>
<td>14%</td>
<td>14%</td>
</tr>
</tbody>
</table>

4. Do you feel cultural factors influence a woman obtaining a Pap smear?

<table>
<thead>
<tr>
<th>Agreement Level</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>43%</td>
<td>43%</td>
<td>0%</td>
<td>14%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Background Questions about the Health Facility

Does your facility have, specifically for women's health care:

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Regularly</th>
<th>2-4x week</th>
<th>1x week</th>
<th>1x month</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evening hours</td>
<td>14%</td>
<td></td>
<td>71%</td>
<td></td>
<td>14%</td>
</tr>
<tr>
<td>A separate women's clinic</td>
<td>14%</td>
<td></td>
<td>14%</td>
<td></td>
<td>71%</td>
</tr>
<tr>
<td>Female providers?</td>
<td>86%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child care for patients?</td>
<td>14%</td>
<td></td>
<td>14%</td>
<td></td>
<td>71%</td>
</tr>
<tr>
<td>Women's support groups?</td>
<td>29%</td>
<td></td>
<td>14%</td>
<td></td>
<td>57%</td>
</tr>
</tbody>
</table>

Procedure Questions

Do you check:

<table>
<thead>
<tr>
<th>Question</th>
<th>Date of last menstrual periods</th>
<th>Date of last Pap smear</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>71%</td>
<td>71%</td>
</tr>
</tbody>
</table>

Do you schedule:

<table>
<thead>
<tr>
<th>Question</th>
<th>Same day appointments for Pap smear</th>
<th>Future appointments for Pap smear</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>57%</td>
<td>57%</td>
</tr>
</tbody>
</table>

POLICY ANALYSIS SURVEY TALLY FOR 78 RESPONSES
9/30/92 APPENDIX VI, Part 1 KAI Women's Health Intervention Policy Analysis
### Do you track:

<table>
<thead>
<tr>
<th>Event</th>
<th>Always</th>
<th>Usually</th>
<th>Often</th>
<th>Seldom</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>If appointments are kept or missed?</td>
<td>43%</td>
<td>43%</td>
<td>14%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If appts for follow up procedures are scheduled?</td>
<td>14%</td>
<td>71%</td>
<td>14%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If the follow up appointments are kept or missed?</td>
<td>29%</td>
<td>71%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

17. Who performs the Pap smears?

<table>
<thead>
<tr>
<th>Provider</th>
<th>Designated On-site Provider</th>
<th>Any Provider On-Site</th>
<th>Women's Clinic Off-Site Provider</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>43%</td>
<td>57%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

18. How many miles must the patient travel to the primary referral site for a colposcopy?

- On site: < 15 miles (57%) 15 - 45 mi. (43%)
- 15 - 45 mi.: 45 - 90 mi. (14%)
- 45 - 90 mi.: over 90 mi. (29%)

### Questions about the Effectiveness of Pap Tracking

19. If it's noted that a patient needs a Pap, when will she get an appointment?

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Same Day</th>
<th>1 week</th>
<th>2 - 3 weeks</th>
<th>&lt;2 months</th>
<th>&gt;2 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>14%</td>
<td>57%</td>
<td>43%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20. When a patient comes for a Pap smear appointment, how long must she wait?

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>&lt;30 mins.</th>
<th>30 - 60 mins.</th>
<th>over an hour</th>
<th>it varies</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>57%</td>
<td>14%</td>
<td></td>
<td>43%</td>
<td></td>
</tr>
</tbody>
</table>

21. Has the waiting period been decreased since pap tracking was implemented?

<table>
<thead>
<tr>
<th>Improvement</th>
<th>Much Better</th>
<th>Better</th>
<th>About the same</th>
<th>Worse</th>
<th>No Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>14%</td>
<td>57%</td>
<td></td>
<td></td>
<td>29%</td>
</tr>
</tbody>
</table>

22. Has pap tracking helped you better identify patients who need services?

<table>
<thead>
<tr>
<th>Improvement</th>
<th>Much Better</th>
<th>Better</th>
<th>About the same</th>
<th>Worse</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>57%</td>
<td>14%</td>
<td>14%</td>
<td></td>
<td>14%</td>
</tr>
</tbody>
</table>

### Staff Satisfaction

<table>
<thead>
<tr>
<th>Comparison</th>
<th>More</th>
<th>About the same</th>
<th>Less</th>
<th>Much less</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

23. Do you work late as often as before?

24. The amount of paperwork is:

<table>
<thead>
<tr>
<th>Quantity</th>
<th>43%</th>
<th>43%</th>
<th>14%</th>
</tr>
</thead>
</table>

POLICY ANALYSIS SURVEY TALLY FOR 78 RESPONSES
9/30/92 APPENDIX VI, Part 1 KAI Women's Health Intervention Policy Analysis Page VI-1.2
25. Would you say that pap tracking actually improves patient care?

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Not Sure</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>57%</td>
<td>43%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

26. Would you say that pap tracking actually improves provider satisfaction?

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>29%</td>
<td>43%</td>
<td></td>
<td>29%</td>
<td></td>
</tr>
</tbody>
</table>

27. Do you think it was difficult to implement pap tracking?

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, it is very different from what we were doing</td>
<td>Yes, it takes a lot of thought</td>
<td>No, it makes a lot of sense</td>
<td>No, it is similar to what we were doing</td>
<td>Not sure</td>
</tr>
<tr>
<td>43%</td>
<td>29%</td>
<td>29%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

28. Do you think this program should be replicated and reproduced elsewhere?

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Not Sure</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>71%</td>
<td>14%</td>
<td>14%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Policy Questions

29. Would you say IHS policy supports pap tracking and other efforts to improve women's health?

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Not Sure</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>14%</td>
<td>71%</td>
<td>14%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*30. How could IHS policy be more supportive to the pap tracking system? __________________________

*31. How could IHS policy be more supportive to women's health generally? __________________________

*32. What are the negative impacts of pap tracking? __________________________

* See Appendix VI, Part 2.
+ APPENDIX VI, PART 2: Comments From (AIHCA) Pap Tracking Respondents

+ 30. How could IHS policy be more supportive to OPVP/IST?
- Implementing it across the country on all IHS facilities!
- Assist urban programs with computer purchase and training.
- By making sure that all IHS clinics have pap tracking in their clinic.
- Will need financial support to maintain personnel to keep up the tracking after the project has ended.
- What are IHS' policies and procedures on pap tracking? Perhaps a standardized policy for all IHS units.
- Working together.

+ 31. How could IHS policy be more supportive to women's health generally?
- Provide more health education, in-services/conferences. Develop more health education patient materials and make them available at all IHS sites!!! 1) Video; 2) Pamphlets; 3) Posters; 4) TV ads.
- In this community women travel to rez often. There is unequal funding for rez clinics vs. urban. It is difficult to get colposcopies, mammograms, etc. for the Indian women because of having limited resources. Some choose to travel great distance back to rez to have follow-up because of lack of funding for individuals here in the urban setting. It is partly difference from state to state also.
- Can't do a good job by not having the reason [sic] things for our clinic, more money for doctors and money set aside for other tests for clients who don't have insurance or money.
- Support more organized women's events re conferences to increase education.
- IHS needs to develop a standardized cancer screening tool (form) for all IHS units. It is obvious patients in most IHS units are deficient.
- Have one day (women day) out of each week.

+ 32. What are the negative impacts of OPVP/IST?
- Developing and implementing program at less than full time. Once initial data input is done, then go to part time position if applicable.
- More time consuming.
- Time consuming.
- Cannot think of any at present. The hardest part of pap tracking here is the mobility of patients in this community. Future contacts are difficult due to frequent moves, without phones.
- As for Native Americans, it is keeping a current address in the computer. Native Americans are very mobile and one can lost contact. Some follow-ups are important but no current address limits interventions.