Nashville Area News

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Nashville Area News

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Medication Errors Kill More Americans Each Year Than Breast Cancer or HIV/AIDS

By Neill Dial, BS, R.PH, Nashville Area Pharmacy Contact

The November 1999 report of the Institute of Medicine (IOM), entitled "*To Err is Human: Building a Safer Health System*," estimated 44,000 to 98,000 people die in hospitals each year as the result of medical errors. Even using the lower estimate, this would make medical errors the eighth leading cause of death in this country—higher than motor vehicle accidents (43,458), breast cancer (42,297), or AIDS (16,516). About 7,000 people per year are estimated to die from medication errors alone, about 16 percent more deaths than the number attributable to work-related injuries.

- The Institute for Healthcare Improvement estimates 15 million instances of medical harm occur in America every year.
- Health Grades, a healthcare rating organization estimates 238,000 preventable deaths occurred between 2004 and 2006 due to medical mistakes.
- The California State Department of Public Health estimates 100 incidents of preventable medical harm occur every month.
- The VA counted almost 3,000 errors--some 700 deaths among them between June 1997 and December 1998.

Examples of Medical Errors

In 2006 three babies in Indiana died after receiving overdoses of heparin. Concentrated heparin was accidentally (10,000 units/mL) in storage locations in patient care areas designated for less concentrated heparin vials (10 units/mL). Vials (both from Baxter, according to the media) containing the different strengths of heparin looked similar. Thus, the nurses—who were accustomed to finding only the 10 units/mL concentration of heparin in stock—did not notice the error until after the wrong concentration had been used to flush the infants' access lines.

► **continued to page 4**

Newsletter Undergoes Name & Format Change

You may notice that this newsletter is called the ***Nashville Area Newsletter***. Formerly called the ***Office of Public Health (OPH) Newsletter***, the name change is the result of the growing contributions to this newsletter from throughout the Nashville Area. While the Office of Public Health still publishes the newsletter, programs throughout the Area have contributed to this issue, including the Office of Environmental Health and Engineering, the United South and Eastern Tribes, Inc., and several local health programs in the Area.

You may also notice the format change. The larger font size is designed for easier reading, and articles have been grouped by category. We hope that you will save this issue and refer to it throughout the next few months. To access previous issues of the newsletter, go to: http://home.nashville.ihs.gov/oph/.

A MESSAGE FROM THE AREA DIRECTOR

I am proud that that this newsletter has become recognized nationally for being informative and useful to our programs. It is part of the Nashville Area's continuing efforts to keep you informed of ongoing health issues and ways that we can better serve your needs.

I would especially like to take this opportunity to congratulate those programs in the Nashville Area who participated in both the $100,000 GPRA Initiative and the $50,000 Childhood Obesity Initiative. You can read more about these two innovative programs on pages 13 and 17, respectively. Our Area Office continues to look for unique ways to address health disparities in Native Americans, focusing on the Director's Three Initiatives of health promotion/disease prevention, behavioral health, and chronic disease management, and the underlying issues of diabetes, tobacco use, and obesity. The initiatives begun this year will hopefully help Area health programs continue to prioritize these conditions and initiatives in the future.

I would also like to welcome the arrival of IHS services at both the Tuscarora Nation (NY) and Mashpee (MA). While both programs are linked to the IHS currently as CHS programs, we hope to help these programs in the future with direct health care services.

We remain committed to providing you with competent and quality technical assistance in the management of your health programs, and we look forward to your feedback on our services as well as your suggestions for improvement.

From the Desk of the Chief Medical Officer

Nine months ago I became the Nashville Area Chief Medical Officer. The past months have been interesting, and I appreciate all of your help as I tailor my services to your needs.

I am proud of the day-to-day effort that all of our programs have made to improving the quality of health care provided to Native Americans in the Nashville Area. Several of our programs are moving forward to becoming accredited, a step designed to formally recognize the high quality of care you provide. I continue to encourage all programs to consider accreditation in the future.

Please let me know how we can help you over the coming year, and I look forward to yet another year as your Chief Medical Officer.

From the Desk of the OPH Director

As we have just concluded our 3rd Annual Health Summit, where over 120 attended for the 2nd straight year, the Nashville Area Office of Public Health is now focused on developing our FY 2009 Work Plan to better serve you over the coming year.

In the past year, OPH health professional consultants conducted 63 site visits to Area health programs, up from 36 the year before. We believe that the program reviews we conduct are one of the best ways we can provide assistance to programs.

Now is when we need your help. If you have ideas on how we can best serve you, please don't hesitate to let us know. We look forward to another successful year in FY '09.

LETTERS TO THE EDITOR

Dear Editor:

I was reviewing the last OPH newsletter to re-read the chronic care initiative article. I re-read the breastfeeding article and found it very informative. However, I was surprised by the image at the bottom of the page, which was of a baby bottle. This seems to be a conflicting message. A quick Google search shows that there is breastfeeding clip art available, and I feel that we public health people should 'walk the walk, and talk the talk,' and be cognizant of the messages (extrinsic and intrinsic) we send. In any case, I am sure this was just an oversight. Overall, great newsletter!

Editor's Response:

Indeed there is clip art available on breastfeeding. As readers may remember, the article entitled "Got Milk?" discussed the benefits of breast feeding—improving a baby's immune system and decreasing such problems as diabetes, obesity, high cholesterol, certain cancers, and asthma. These benefits are enormous, and putting art that didn't match the article (the clip art included a baby bottle) could mislead the reader that the article was discussing formula rather than breast milk. Thank you for the keen eyes!

Dear Editor:

I enjoyed the last newsletter, but I have lost the e-mail where you sent it out. Is there a copy available somewhere, and what about other newsletters that have been sent out?

Editor's Response:

Great question! All previous issues of the OPH Newsletter (now the Nashville Area News) are available at http://home.nashville.ihs.gov/oph/. The newsletters are available electronically only to those Area sites that are behind the IHS firewall, however. For others who would like copies of previous issues (there have been 5 previous issues), e-mail the Editor, Dr. Tim Ricks, OPH Director, at Tim.Ricks@ihs.gov.

Dear Editor:

Thank all of you for an outstanding Health Summit this year! I really learned a lot about integrated care, and the speakers were really good. You mentioned at the Health Summit that presentations would be available online after the Health Summit. Where do I find them? I would like to see some of those!

Editor's Response:

The Health Summit presentations, along with other information on the Office of Public Health, can be found on the OPH webpage at http://home.nashville.ihs.gov/oph/. Again, this information is available to those behind the firewall. Other information on the Office of Public Health is available at www.nashville.ihs.gov.

Do you have questions you would like answered? Corrections to make to the newsletter? General comments about the newsletter? If so, contact Dr. Tim Ricks, Editor, at Tim.Ricks@ihs.gov. The next newsletter will be sent out electronically early in 2009, so send your questions, corrections, and comments to the Editor by January 1, 2009. Thank you for your interest and contributions to this newsletter!

Medication Errors Kill….

♦ continued from page 1

Another example of medication errors recently made national headlines. Three infants, including the newborn twins of Hollywood celebrities Dennis and Kimberly Quaid, received 1,000 times more heparin than intended when vials containing 10,000 units/mL instead of 10 units/mL were used in error to flush the infants' vascular access lines. Fortunately, none of the affected infants suffered lasting adverse effects from the error.

A final example: Two months after a double bypass heart operation that was supposed to save his life, comedian and former Saturday Night Live cast member Dana Carvey got some disheartening news: the cardiac surgeon had bypassed the wrong artery. The surgeon said he had made an honest mistake because Carvey's artery was unusually situated in his heart. It took another emergency operation to clear the blockage that was threatening to kill the comedian.

People in hospitals are just a small proportion of those at risk. Doctors' offices, clinics, and outpatient surgical centers treat thousands of patients each day; retail pharmacies fill countless prescriptions; and nursing homes and other institutional settings serve vulnerable patient populations. The Massachusetts State Board of Registration in Pharmacy estimated that 2.4 million prescriptions are filled improperly each year.

The four most common ways medical care goes awry

(1) Medication Errors—Incomplete patient information (not knowing about patients' allergies, other medicines they are taking, previous diagnoses, and lab results, for example); Unavailable drug information (such as lack of up-to-date warnings; Miscommunication of drug orders, which can involve poor handwriting, confusion between drugs with similar names, misuse of zeroes and decimal points, confusion of metric and other dosing units, and inappropriate abbreviations; Lack of appropriate labeling as a drug is prepared and repackaged into smaller units; and Environmental factors, such as lighting, heat, noise, and interruptions, which can distract health professionals from their medical tasks.

(2) Poor Doctor-Patient Communication—Lack of face time with the doctor (average patient visit is only 15 minutes); Feelings of intimidation on the patient's part; Patient's lack of comfort with the subject matter; Failure to inform the patient of test results; and Failure to coordinate/communicate patient care among providers.

(3) Hospital Errors—Bed sores; Falls; Hospital-acquired infections; and Failure to aid patients in distress.

(4) Surgical Errors—36 percent of mistaken surgeries were performed yearly are on the incorrect patient; and 2,700 wrong-site surgeries are performed each year.

Cost of Medical Errors

Medical errors cost the Nation approximately $37.6 billion each year. $17 billion of the $37.6 billion are associated with preventable errors. 50% of the expenditures for preventable medical errors are for direct health care costs.

Preventing Medication Errors

Read the article on page 6 that discusses medication errors and steps health programs can take to minimize such errors.

October is National Pharmacy Month

By Neill Dial, B.S., RPH, Area Clinical Applications Coordinator, Pharmacy Contact

- Idea introduced by Robert J. Ruth of Asheville, NC @ the 1924 APha Annual Meeting
- First celebration was held on October 11-17, 1925
- In 2004 National Pharmacy Week evolved into American Pharmacists Month each "OCTOBER"
- Goal: Highlight the important role of pharmacy professionals play in the lives of Americans

William Procter, Jr., a founding member of the then-American Pharmaceutical Association (APhA) observed in 1867, that "public opinion is in America a forceful agent of reforms, and has been the main source of progress in pharmacy." Robert J. Ruth, a pharmacist from Asheville, NC unveiled his plan of "A National Pharmaceutical Week" at the 1924 APhA annual meeting, and with that the first National Pharmacy Week was born. The first celebration was held on October 11-17, 1925. During this inaugural effort, radio stations across the country broadcast special programs which emphasized the professional side of pharmacy.

A 1959 National Pharmacy Week press kit highlighted many of the same issues we talk about today: pharmacy careers, medication costs, and standards for training. Practicing pharmacists were also offered displays, posters, radio and television material, newspaper articles and even speeches (a complete kit cost $2.00) to 'promote' the profession.

After celebrating National Pharmacy Week for nearly eight decades, 2004 marked the launch of American Pharmacists Month. The expansion to a month responded to APhA member comments that a week was not enough time to fully promote the expanding role of the pharmacist. And while the length of time was changed, the goal of the event has remained the same: to highlight the importance of the pharmacists' value to the healthcare system and their role as medication experts. Since then, American Pharmacists Month has continued to grow. ***Celebrate your pharmacy/pharmacist during the month of October for providing quality health care.***

National Hospital and Health-System Pharmacy Week:

October 19-25, 2008

National Hospital & Health-System Pharmacy Week acknowledges the invaluable contributions that pharmacists and technicians make to patient care in our nation's health care institutions. It is an ideal time for pharmacy departments to acknowledge and celebrate their achievements in ensuring safe and effective medication use in their institutions and to share those accomplishments with patients, other health professionals, and the community.

What is the difference between a pharmacist and a pharmacy technician? What are the differences in degrees and education requirements with pharmacists? See page 6 for more information……..

Pharmacists and Pharmacist Technicians

By Neill Dial, B.S., RPH, Area Clinical Applications Coordinator, Pharmacy Contact

The Doctor of Pharmacy, or PharmD, degree

The PharmD is neither an undergraduate degree (such as a BS or BA) nor a graduate degree (such as an MS, MBA, or PhD). The doctor of pharmacy is a professional degree for pharmacists similar to the doctor of medicine (MD) for physicians or a doctor of dental surgery (DDS) for dentists. Individuals with this training have a total of six years—two years of pre-pharmacy pre-requisites and four years of pharmacy coursework and training.

Bachelor of Pharmacy, or B.S. Pharmacy, degree

It is the basic prerequisite for registration to practice as a pharmacist, and requires a total of five years of training—two years of pre-pharmacy pre-requisites and three years of pharmacy coursework and training.

Pharmacist Licensure

Licensure requires (1) passage of a state licensure exam administered by a state board of pharmacy; (2) passage of the North American Pharmacist Licensure Examination (NAPLEX®); and (3) experience requirements (for example, the State of North Carolina requires 1500 hours of practical pharmacy experience under the supervision of a licensed pharmacist after the satisfactory completion of two years of college work, with at least 1000 hours of community or hospital pharmacy experience and a maximum of 500 hours allowed for “non-traditional” experience).

Pharmacy Technician Education

Pharmacy technician training programs are offered by the military, some hospitals, proprietary schools, vocational or technical colleges, and community colleges. Training is also often offered as part of employment with many pharmacies. Training often includes labs and an "externship."

Pharmacy Technician Certification

Institute for the Certification of Pharmacy Technicians (ICPT) and the Pharmacy Technician Certification Board (PTCB) offer exams for certification. The ICPT Exam is called the Exam for the Certification of Pharmacy Technicians (ExCPT). Completing one of these exams earns the technician the credentials "CPhT", corresponding to the professional title of Certified Pharmacy Technician.

Pharmacy Technician Registration

Most states require registration/licensure, and passage of a state examination administered by the board of pharmacy

National Pharmacy Technician Day

October 23, 2007

Pharmacy technicians play a vital role in providing pharmaceutical care.
National Pharmacy Technician Day has been designed to recognize their contributions.

The Essential Role of Pharmacists In Medication Safety

By Neill Dial, B.S., RPH, Area Clinical Applications Coordinator, Pharmacy Contact

Two out of every three patients who visit a doctor leave with at least one prescription for medication, leading to a record volume of nearly 3.4 billion prescriptions dispensed in 2005, an increase of nearly 60% since 1995. In the U.S., 81% of adults take at least one medication during a given week while 27% take at least five. Medications contribute to better health and to a longer and greater quality of life when used safely. However, a vast number of Americans take prescription medications without being fully informed about the associated risks, contraindications, and adverse effects. Misuse of medications can interfere with desired treatment and cause harmful reactions. The annual costs of drug-related illness and death in ambulatory care settings alone were estimated at more than $177 billion in the year 2000.

The most common types of medication misuse are:

- Taking the incorrect dose
- Taking a dose at the wrong time
- Forgetting to take a dose
- Stopping medicine too soon

According to research published by the California Board of Pharmacy and others:

- 50% of prescriptions taken each year in the United States are used improperly
- 96% of patients fail to ask questions about "How to use their Medications"

Failure to take medications as prescribed results in:

- Unnecessary disease progression
- Disease complications
- Reduced functional abilities
- A lower quality of life
- Death

A 2007 Survey by the National Council on Patient Information and Education (NCPIE) found the following factors contribute to the failure of patient medication adherence:

- Lack of clinician awareness about basic medication management principles
- Poor communication between patients and clinicians
- Operational aspects of pharmacy and medical practice
- Professional barriers

What can be done locally to minimize medication errors?

Collaboration by all members of the healthcare team also needs to be enhanced in order to ensure optimal medication use education and monitoring. Pharmacists can impact the management of patients' chronic disease and contribute substantially to improved outcomes and lowered healthcare costs. Engaging and supporting the pharmacist as a resource for safe medication use, early detection & management of adverse drug reactions is an important step toward improving the health of the nation. However, <u>the staffing levels of pharmacies must be sufficient to support the ability of the pharmacist to play this critical role</u>. Most experts agree that a single pharmacist dispensing more than 125 prescriptions per day (an average of 1 prescription every 3-4 minutes) compromises patient safety and increase the likelihood of mistakes and or patient harm.

"a vast number of Americans take prescription medications without being fully informed about the associated risks, contraindications, and adverse effects."

Keeping an Eye on Silent Dangers: Playground Safety is in Your Hands

By LT Jessica L. Schwarz, REHS, Environmental Health Specialist

As childhood obesity rates increase, and we as health advocates push for increased child activity levels it seems appropriate to guide our children back to an old standby, the playground. However, there can be several silent dangers lurking in and around your local playground. Keeping an eye on these dangers, notifying maintenance, maintaining facilities, and proper child supervision are key factors in maintaining a safe environment for our children to play. As a playground safety inspector I thought I would share some helpful hints with you on maintaining safe playgrounds. This article is aimed at informing you of the possible hidden dangers so that you can be better equipped to identify them, and prevent serious injuries from occurring.

First and foremost surfacing of a playground helps prevent injury. The number one cause of serious injuries on the playground occurs from falls (79% of playground injuries are caused by falls according to the National Playground Safety Institute). A large percentage of these injuries can be prevented by providing an adequate amount of protective surfacing. Maintaining appropriate depths of mulch, gravel, sand and other surfacing materials is key to preventing injuries children can obtain from falls during the normal course of play. There is a chart available from the Consumer Product Safety Commission (CPSC) which will help calculate the appropriate amount of material needed to prevent serious injuries from occurring (below). If you have any questions about how to perform this calculation please contact me directly.

Table 2. Minimum compressed loose-fill surfacing depths

Inches	Of	(Loose-Fill Material)	Protects to	Fall Height (feet)
9		Shredded/recycled rubber		10
9		Sand		4
9		Pea Gravel		5
9		Wood mulch (non-CCA)		7
9		Wood chips		10

Another item to be aware of is heat dangers. When you or I touch a hot surface we quickly pull away, but small children often don't yet posses the thought process to remove themselves from the hot surface and will sit and scream until an adult can remove them. This can cause serious burns. In a recent article in the New York Daily News highlighted these dangers (see picture below, courtesy of the Daily News). A five year old was highlighted in this article who received serious burn injuries to the bottoms of his feet when playing barefoot on dark-colored rubberized surfacing. In the heat of the day metals, plastics and rubberized surfacing can become very hot from sun exposure. Temperatures over 120°F can cause scald burns. Playground surfacing and equipment can easily reach this temperature and has been recorded as high at 170°F. Keeping playground surfaces light colored and providing adequate shade structures can help prevent scald and burn injuries. It may also be necessary to prevent children from playing on the equipment during certain times of the day.

Keeping an Eye on Silent Dangers: Playground Safety is in Your Hands

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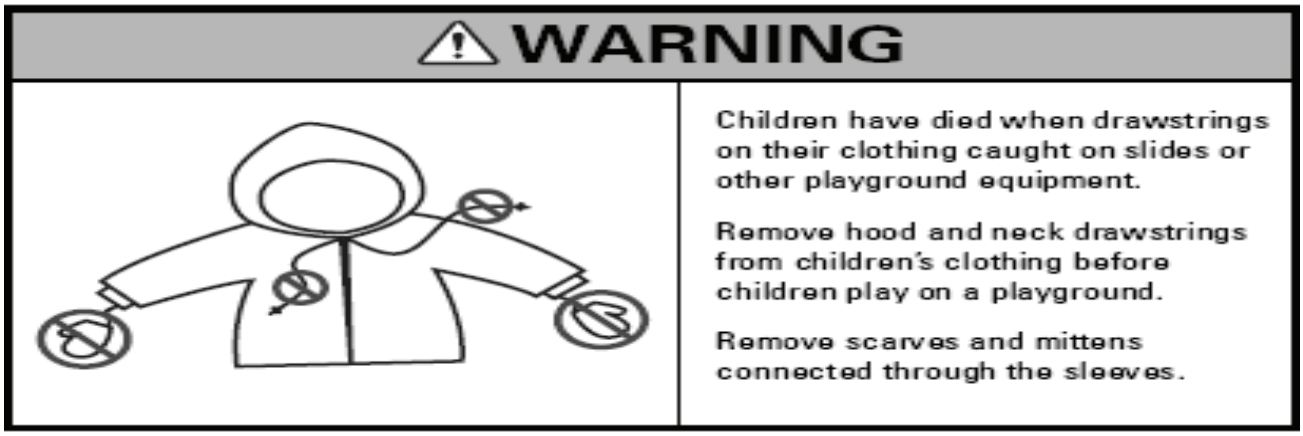
Several other playground dangers can easily be identified if you know what to look for. Entanglement hazards (hazards which can entangle clothing and cause strangulation) are the number one cause of playground fatalities. Looking for properly closed "s" hooks on swings and making sure nuts are properly equipment, tightened and bolts to not stick out more than two threads past the nut can help prevent entanglement. It is also important to make sure children's clothing does not have dangling or loose items which can become entangled (see CPSC warning below). Children should also not be allowed to wear bicycle helmets when using playground equipment as this can cause head entrapment and strangulation.

Look for insect and foreign material hazards. Bees, ants, and glass can cause serious injuries. Playgrounds should be checked daily before use for these hazards. Keep an eye out for the silent dangers and let someone know when something isn't safe. Keep children away from unsafe equipment until it is fixed. Properly supervise children and prevent misuse of equipment. Make sure equipment is appropriate for the age that will be using it. Follow all directions on posted signage and equipment warnings. With your help playgrounds can be a safe, fun and effective way to keep our children healthy and active. The Environmental Health Services Branch can provide playground safety services including playground safety inspection, new playground plan review, and help developing inspection check lists and safety documentation. Visit the CPSC Public Playground Safety Handbook for more information at http://www.cpsc.gov/CPSCPUB/PUBS/325.pdf or email me at Jessica.schwarz@ihs.gov for more information on playground safety.

Kian Mehran-Lodge, 5, with photo of his feet, which were burned in a Brooklyn playground. (Daily News)



What is epidemiology?

By CAPT John Mosely Hayes, Tribal Epidemiology Center, United South and Eastern Tribes, Inc.

Epidemiology is the study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to the control of health problems. There are other definitions, but this is one we like.

Three Greek word roots make up the word epidemiology – epi, demos, and logos. "Epi" means upon, on or over. "Demos" means people or populace. And "logos" can mean study, word, discourse, count, tell, say, or speak. Therefore epidemiology is also "the study of what is 'upon' the people," "discourse about what is 'upon' the people,", or "counting what is 'upon' the people."

The practice of epidemiology can also be viewed as a community health problem solving process. The epidemiological process parallels the steps in processes familiar to health professions, like "the diagnostic process", "the nursing process", "the scientific process" and "the quality improvement process", especially if one sees the target process outcome as improving the health of "specified populations" vs. an individual. Consider these cyclical processes (albeit oversimplified) with different names but similar steps.

The Problem Solving Process:

1. Identify the problem and possible contributing factors.
2. Make a list of solutions and choose one.
3. Implement the solution.
4. See if it worked.

The Diagnostic Process:

1. List the symptoms.
2. Perform a physical examination; order tests.
3. Identify possible diagnoses and choose one (sometimes more than one).
4. Implement a treatment.
5. See if it worked.

The Nursing Process:

1. Assess
2. Diagnose
3. Evaluate
4. Plan
5. Implement

The Scientific Process:

1. Identify a question that needs an answer.
2. Pose a hypothesis; a guess (with some thought behind it) about why or how something occurs.
3. Design a study method; collect data/information.
4. Analyze the data; test the hypothesis.
5. See if it will work again.

The Quality Improvement Cycle:

1. Identify a problem/issue.
2. Collect data/information; analyze the data.
3. Determine a desired outcome or result (benchmark).
4. Design interventions to achieve the result.
5. Collect data again.
6. See if it worked.

What is epidemiology? - continued

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Public Health Intervention:

1. Identify a condition (with possible positive or negative consequences) that you want to either change or reinforce.
2. Collect data and analyze data.
3. Determine a desired outcome or result.
4. List appropriate interventions; make a selection.
5. Implement the program.
6. Collect data again.
7. See if it worked.

Surveillance:

1. Identify what and who you want to watch and/or monitor.
2. Determine where and how to collect data.
3. Analyze the data.
4. Create a report and disseminate the information.

Thinking through the similarities of the steps outlined in the processes above and how epidemiology is a combination of both Public Health Intervention and Surveillance, it also makes sense to define epidemiology as a community health problem solving process. The USET Tribal Epidemiology Center is here to assist the Nashville Area AI/AN communities cycle through their community health problem solving processes.

- Adapted from Great Lakes Inter-Tribal Epidemiology Center News, Vol.9, No.2.

Questions and Answers about the Nashville Area Tribal Epidemiology Center (TEC)

Editor: Who are the team members of the Tribal Epidemiology Center, and what are their major roles/projects?

Chris Compher, TEC Epidemiologist: John Mosely Hayes is the senior epidemiologist; Chris Compher is the community health epidemiologist; Christy Duke is the tobacco/cancer/women's health epidemiologist; Nichole Blackfox is the project assistant; and Wes Cornelius is the programmer/statistician. Together, the team writes reports, does data analysis, and carries out specific projects such as the Maternal and Child Health Project. They also collaborate with the USET Tribal Health Program Support (THPS) departments on data analysis and report-writing.

Editor: How can/does the TEC assist Nashville Area Tribes/Nations?

CC: The TEC provides public health surveillance data and analysis to the individual tribes and provides the Nashville Area Indian Health Office and Area tribes aggregate Area data. The TEC also can handle special requests such as grant consultation, looking into potential health concerns, providing data and risk factor information for a specific health concern, as well as providing any technical assistance around most public health concerns. The TEC is also happy to refer Tribes to other resources, if needed.

Editor: How can the TEC be reached?

CC: Call 615-872-7900 and ask for epi staff, e-mail the TEC team at usetepi@usetinc.org, or visit the TEC web page by going to www.usetinc.org and clicking on the Tribal Epidemiology Center.

Prepare for Influenza—Copy this information from the CDC for your patients

Flu is a serious disease

Each year in the United States, on average:

- **5% to 20% of the population gets the flu;**
- **More than 200,000 people are hospitalized from flu complications, and;**
- **About 36,000 people die from flu.**

Take action to protect yourself and your loved ones from the flu.

CDC Says "Take 3" This Flu Season

1 Take time to get a vaccine.

- A flu vaccine is the best way to protect against the flu.
- The flu vaccine protects against three different flu viruses.
- Getting a vaccine is very important for people at high risk for serious flu complications and their close contacts. People at high risk include infants, pregnant women, people with chronic health conditions like asthma, diabetes, or heart disease, and people 65 and older.
- This year, an all-time high supply of vaccine is available so more people than ever can seek protection from the flu.

2 Take everyday preventive actions.

- Cover your nose and mouth with a tissue when you cough or sneeze--throw the tissue away after you use it.
- Wash your hands often with soap and water, especially after you cough or sneeze. If you are not near water, use an alcohol-based hand cleaner.
- Stay away as much as you can from people who are sick.
- If you get the flu, stay home from work or school. If you are sick, do not go near other people so that you don't make them sick.
- Try not to touch your eyes, nose, or mouth. Germs often spread this way.

3 Take antiviral drugs if your doctor says to.

- There are flu antiviral drugs that can treat the flu or prevent infection with flu viruses.
- For treatment, antiviral drugs should be started within 48 hours of getting sick.
- For prevention, antiviral drugs are 70% to 90% effective in preventing infection.
- These drugs must be prescribed by a health care provider.
- If you develop flu-like symptoms (usually high fever, headache, extreme tiredness, dry cough, sore throat, runny or stuffy nose and muscle aches), or are exposed to the flu before you get a flu vaccine, your health care professional will decide whether you should take antiviral drugs.

For more information, visit www.cdc.gov/flu or call 800-CDC-INFO.

Nashville Area Announces Winners of $100,000 GPRA Challenge

By Kristina Rogers, Area GPRA Coordinator, and Dr. Tim Ricks, OPH Director

The Nashville Area Director, RADM Richie Grinnell recently announced the program award recipients of the **2008 $100,000 GPRA Challenge:** "***Excellence Taken to A New Height.***"

This initiative provided an opportunity for sites to improve their current practices in order to receive a program award based on performance and improvement regarding the 22 nationally reportable GPRA (Government Performance and Results Act) measures. GPRA is based upon the Health People 2010 Objectives, and the measures are designed to serve as benchmarks for quality in the health care setting.

We would like congratulate and thank all of the Nashville Area programs who participated in this initiative for your efforts in demonstrating excellence and quality in aspects of GPRA. The program award recipients for GY2008 are:

Best Performance:

(1) Chitimacha Tribe of Louisiana
(2) Micmac Service Unit
(3) Oneida Nation of New York

Most Improved:

(1) Houlton Band of Maliseet Indians
(2) St. Regis Mohawk Tribe
(3) Seminole Tribe of Florida

The Area Director recently notified tribal leadership of the awards. These sites will receive program awards in the amount of $25,000 (1st), $15,000 (2nd), or $10,000 (3rd) in the coming weeks to support GPRA projects over the coming year.

The GPRA Year runs from July 1st to June 30th. As has been the process the last few years, the Office of Public Health will continue to send programs quarterly "GPRA Report Cards" to show progress on the measures.

Interested in improving GPRA Performance? *Customized Recommendations May Help*

By Dr. Tim Ricks, OPH Director

Several health programs have recently inquired about how they can improve performance on the Government Performance and Results Act (GPRA). As you may know, many programs across the IHS use GPRA as a standard in measuring the quality of care provided in health care settings.

The Nashville Area Office of Public Health has recently helped a few programs by identifying ways to clinically improve GPRA performance, and these recommendations are customized to the requesting health clinic.

If your facility is interested in improving GPRA performance and you would like the assistance of various health care professionals in developing a customized "action plan," please contact either Dr. Tim Ricks, OPH Director, at tim.ricks@ihs.gov, or Kristina Rogers, Area GPRA Coordinator, at Kristina.rogers@ihs.gov.

Issues on User Population and Workload

By Kristina Rogers, BS, Nashville Area Statistician

The quality and integrity of data ensure that the information housed at the National Data Warehouse (NDW) is accurate and complete. Since the NDW has become the primary system used by the agency to report User Population and Workload, it is important to understand the requirements for successful data processing at the NDW. The NDW produces specific reports to help troubleshoot and monitor data problems at specific sites. Throughout the year Nashville Area sites have received updates and suggestions for improvement that have come from information established from the Data Marts at the NDW. The User Population/ Workload Data Marts are used to produce reports for reporting requirements and a new Data Mart, known as the Data Quality Mart, gives insight as to why certain visit or patient records were unable to be processed. There are specific required fields that are needed in order for registration and encounter records to be properly loaded into the NDW.

Patient registration affects both Workload and User Population. In order for patient registration data to be successfully loaded into the NDW, the records must (at a minimum) contain the following elements:

- Last Name
- First or Middle Name
- Chart Number
- Community of Residence (IHS Standard Code Book*)
- Tribe of Membership (IHS Standard Code Book*)
- Beneficiary/Classification (IHS Standard Code Book*)
- Blood Quantum Code (IHS Standard Code Book*)

* To reference acceptable codes, the IHS Standard Code Book can be located at http://www.ihs.gov/CIO/scb/index.cfm.

While not necessarily required, To help with the un-duplication process and ensure that all patients get loaded into the Data Warehouse, it is important that patient records list a Date of Birth, a Gender and if possible, a Social Security Number (SSN).

There are also required elements for encounter records that must be met in order for the visits to pass the data quality checks established by IHS. There are four types of visits (Ambulatory, Contract, Dental and Inpatient) that are reported at the NDW and each has their own specific required elements:

Ambulatory Visit requirements

- Service Type (IHS Standard Code Book*)
- Service Category (IHS Standard Code Book*)
- Provider Code (IHS Standard Code Book*)
- Clinic Code (IHS Standard Code Book*)
- Diagnosis Code (IHS Standard Code Book*)

Contract Visit requirements

- Provider Type (IHS Standard Code Book*)
- Service Date
- Discharge Date (for Inpatient services, must not be before the Service Date)
- Visit Type (CHS outpatient or CHS inpatient)

Dental Visit requirements

- ADA Code
- Visit Type (Direct or CHS)
- Service Date

Inpatient Visit requirements

- Primary Diagnosis
- Admission Date
- Discharge Date (for Inpatient services, must not be before the Service Date)

* To reference acceptable codes, the IHS Standard Code Book can be located at http://www.ihs.gov/CIO/scb/index.cfm.

Nashville Area Sponsors 2-Week "Coding Boot Camp"

By Neill Dial, B.S., RPH, Area Managed Care Assistant

- Eleven people participate in Certified Professional Coder Course

The Nashville Area Indian Health Service sponsored a Coding Boot Camp July 14th – 25th at Nashville Area Office. This is the first Nashville Area sponsored coding boot camp in four years. Mary D. Gregory, RHIT, CCS, CPC, and CCS-P from MAS Coding Solutions of Charlotte, NC lead the boot camp. The following tribes and or nations were represented: Alabama-Coushatta, Cherokee, Choctaw, Oneida, Passamaquoddy, and Seneca.

The two week training prepared the students for the Certified Professional Coding (CPC) exam. Participants with a coding background of at least two years were eligible for CPC certification while novice (less than 2 years) coders were eligible for the CPC apprentice certification.

Participants stated the training impact on their job:

- "Capture more revenue for the clinic since I double as the clerk"
- "Improve job qualifications"
- "Capture more revenue for the clinic"
- "The coding class has retrained my mind regarding coding. This will allow me to capture revenue for the clinic. The coding class has made me more aware of the rules and regulations; as well as the steps I need to take"
- "A better understanding of coding guidelines will enable more confident communication with providers and possibly increase billing revenue that had previously been unknown"
- "I know more about coding than I did"
- "Hopefully we can get more money for the clinic"

Most participants felt the Coding Boot Camp prepared them quite well for the CPC exam.

The CPC exam is composed of three sections with one hundred fifty questions and participants have five hours to complete the exam. A score of 70% in each section is required to pass the exam. Mary Gregory stated: "Although it is a hardship for students to be away from family for two weeks it's an essential component of the training because it allows the student to focus on preparing for the exam". Participants stated the instructor was well organized, knowledgeable and always made time to answer questions and explore typical coding challenges.

The success of the Coding Boot Camp is attributable to the support of the Nashville Area Health Center Directors, the Nashville Area Office of Public Health and the sacrifice of individual participants. The Nashville Area Office of Public Health will sponsor additional Coding Workshops based upon demand and or needs.

Stay tuned to future opportunities for Certified Professional Coder trainings offered by the Office of Public Health.

Preventing Childhood Obesity

By Michelle Ruslavage, BSN, RN, CDE, Nashville Area HP/DP Coordinator and Chief Nursing Officer

There were 3 sessions at July's Health Summit related to Childhood Overweight. It's an issue that all sites are struggling with and as research starts to catch up to practice, any best and promising practices are the most useful.

What puts kids at risk for overweight? Research is validating what many have noticed in the field. There are some common factors that are linked to a higher incidence of overweight in children. So the more of these a child is doing, there is some evidence they are at higher risk is for becoming overweight:

- Drinking sweetened beverages.
- Skipping breakfast.
- Eating meals away from home, particularly fast foods/fried foods.
- High levels of sedentary behavior (more than 2 hours a day of screen time).

A history that asks about food, activity and patterns of weight gain/loss will often give the clues to what may have caused the weight gain, so it becomes clear which areas are in need of change. Typically it is not just one thing, but a combination. Plotting growth and BMI on growth charts is informative for the family and the provider. Families should understand where the child is on the growth chart by looking at it with the provider. This is more effective than just saying the child 'weighs more than they should for their age'. If there is an abrupt change in the child's weight pattern on the growth chart, asking about any changes that may have happened around that age will also give more clues to where to head the intervention. For example, a change in caregivers with different food and activity environments, Mom going back to work and bringing in fast food instead of cooking, or loss of a parent through separation/divorce/death etc. can signal the need for simple lifestyle changes or a need for behavioral health intervention if anxiety, depression or grief is affecting diet and activity.

Very often overweight children are doing at least one of the behaviors mentioned above for a variety of reasons. Having the child set 1 or 2 goals related to changing them for the next visit clarifies the direction to take for them and the family. Motivational interviewing can help the child set the goals.

Screen Time

These are the recommendations from the American Academy of Pediatrics related to time spent on TV, video games and computer time:

- Less than 2 hours a day screen time.
- No TV in bedrooms.
- No TV for children under 2.

Half of 8-18 yr. olds asked say they have no rules about TV. Making sure the parents or other caregivers understand it is up to them to enforce these recommendations is key! It has been shown that a goal related to reducing screen time often works better than simply trying to increase activity. It's unclear why, but since screen time is often tied to snacking, by

Preventing Childhood Obesity-continued

• continued from previous page

reducing the screen time, snack intake may be less.

The weight goal for an overweight or obese child is weight maintenance or loss until their BMI is less than the 85th percentile. For very overweight or obese young children, losing a pound a month is ok, and up to 2 pounds a week for older children and teens.

Weight loss may not happen just by increasing activity without cutting calories. But since there are other benefits to being more active, those need to be considered. An easy way to cut calories if the child is drinking more than a cup a day of sweetened beverages or juice is to change to a calorie free drink. Singling out the overweight child for food restriction is not recommended, and changes should involve the whole family so there is a supportive food environment. Problem solving by having the child help brainstorm solutions to their food, drink and activity options helps come up with goals that are more relevant.

Resources

- Pediatrics (December 2007, 120, (Supplement), http://pediatrics.aappublications.org/content/vol120/Supplement_4/index.shtml

- Managing Early Childhood Obesity in the Primary Care Setting (Stoplight Diet by Epstein mentioned) http://www.medscape.com/viewarticle/448019_7

Nashville Area Announces Recipients of $50,000 Childhood Obesity Challenge

By Michelle Ruslavage, BSN, CDE, HP/DP Coordinator and Chief Nursing Officer, and Dr. Tim Ricks, OPH Director

The Nashville Area Director, RADM Richie Grinnell, recently announced the program award recipients of the **2008 $50,000 Childhood Obesity Challenge:** "***Honey I Shrunk the Kids***."

This initiative, led by the Office of Public Health, was designed to raise awareness of the childhood obesity epidemic and encourage Area health programs to develop a pediatric registry, encourage pediatric patient visits, and promote nutritional and exercise counseling to these patients.

Eleven Area programs participated. Programs awards were based on measurable criteria. Awardees were:

(1) Chitimacha Tribe of Louisiana
(2) Coushatta Tribe of Louisiana
(3) Passamaquoddy Indian Township

These sites will receive program awards in the amount of $25,000 (1st), $15,000 (2nd), or $10,000 (3rd) in the coming weeks to support future initiatives, and the Area Director has notified tribal leaders of these awards.

Programs are urged to continue to develop and update pediatric registries and to identify youth who are at risk and provide them with counseling and clinical interventions.

Micmac Holds 11th Annual Health Fair

By John Ouellette, Micmac Service Unit Director

Even the rain could not stop the spirit of the 11th Annual Micmac Service Unit Health Fair, as members of the Aroostook Band of Micmac Indians turned out in large numbers to check out the various booths and receive screenings such as blood pressure, blood sugars, lead in children, cholesterol, heights and weights, and lung capacity testing. New this year was an identification program conducted by the Presque Isle, Maine Police Department; the identification process included retinal scanning as a way to identify your child.

The opening ceremony of the health fair included dignitaries such as Donna Augustine (opening prayer), John Dennis (honor song), and the Women's Drum Group. All Micmac Service Unit departments set up displays and had information available for tribal members. During the day, participants signed up for prizes that were made available by tribal programs and/or various vendors, including talking bears for children, native baskets, and gift cards. This year we were able to highlight three important programs—Child Safety Seats, Welcome Baby Bags; and bicycle helmets that were given out to all those in need.

The Elders were able to sit and enjoy a day of friendship and bingo with prizes donated by tribal programs. A light lunch was provided to all participants. A special thanks goes out to all of those who made this year's Health Fair a resounding success.

Micmac to Get IHS Public Health Nursing Grant

By Robert Lemoine, MSN, FNP-BC, Supervisory Nurse Practitioner, Micmac Service Unit

The Micmac Service Unit was recently notified it is a recipient of the Indian Health Service Public Health Nursing Program Grant.

Micmac will use the grant to address three key areas of public/community health within the tribal membership: 1) Family Safety-elder and child safety, emergent incident management, domestic violence and suicide prevention; 2) Family Health- teen pregnancy/STD education, well-health screening education for men and women; and 3) Cardiovascular Disease- decreasing risk stratification, decrease obesity, increasing fitness and decreasing non-ceremonial tobacco usage.

As the sole Area health program to receive the IHS Public Health Nursing Grant, the Micmac Service Unit hopes to continue to demonstrate a commitment to the health and welfare of those they serve and seek innovative ways to mobilize the tribal community to become healthier.

The team responsible for obtaining the Public Health Nursing Grant included: Deborah Bell, Contact Representative; Arlene Wright, LPN; Pamela White, RN Community Health Nurse; Lisa Henderson, Contract Health technician, Rebecca Smith, RD Nutritionist; Georgie Smart, Field Health Technician; Theresa Cochran, Supervisory Contract Health Specialist and Robert Lemoine, FNP Supervisory Nurse Practitioner.

Unity Healing Center Re-Opens

By Hillane Lambert, Unity Healing Center Director

On July 31, 2008 the newly renovated Unity Healing Center celebrated its Grand Re-Opening after more than three years of planning and construction. More than 50 people attended the ceremony and toured the building throughout the day. Speakers included Vice Chief Larry Blythe from the Eastern Band of Cherokee Indians and RADM Richie Grinnell from the Nashville Area Office. Mr. Lloyd Owle, the Cultural Specialist at Unity, gave the opening prayer and Mr. Greg Leadingfox, also a Unity employee, did a blessing song. Mr. Daniel Tramper provided a special Hoop Dance inside the building later that morning. A ribbon cutting by RADM Grinnell and Acting Director Hillane Lambert concluded the formal portion of the ceremony.

Major Building Improvements

- Mold Remediation
- New Metal Gabled Roof
- New Kitchen
- New Laundry for Females
- Redesigned Counselor Offices
- Redesigned Observation Desk
- New Observation Room
- New Arts and Crafts Room
- New Heating and Cooling System
- New Mortar and Sealant for Exterior
- New Sprinkler System
- New Flooring, Lighting, Wall Surfaces, Ceilings, and Insulation
- Redesigned Entries
- Improved Electrical Systems
- New Security and Telephone Systems
- Redesigned Classroom
- New Family Counseling Room

Program Enhancements

Many enhancements have also been added to the program:

RAP

A follow-up program, Recovery Aftercare Program (RAP) was established and is managed by Louise Parris, a certified counselor. Louise contacts discharged residents regularly by phone and mail as a means of providing support and to gather information.

Tele-Health Project

A tele-health project to provide contact with residents, families and tribes is expected to be fully functional before December 2008. We are excited about this program as it is another tool to aide in provision of aftercare for discharged residents.

Staff Development

Staff development programs were added including certification for all staff as Residential Child Youth Care Professionals (RCYCP). This program enhances staff's ability to interact with adolescents in a therapeutic environment. Staff is also in the process of completing the Managing Aggressive Behavior (MAB) certification. Addition of this program will enhance the ability of staff to de-escalate and manage potentially violent situations successfully. Both the RCYCP and MAB programs were developed by the Oklahoma University and are considered best practice programs for use in the care of adolescents.

Many thanks go to the Nashville Area Staff who supported Unity during the construction process, to the tribes for their understanding and patience, to the many community supporters, as well as the staff who worked so hard to ensure the success of the re-opening celebration. We look forward to carrying out our mission of "**Breaking the cycle of addiction and restoring hope and wellness to Native American youth, families, and communities**" in our new environment.

Manlius Service Unit Hosts Health Seminar Series

By Blanche Jones, Manlius Service Unit CHS Representative

This spring through early summer, IHS/CHS, in conjunction with the Onondaga Nation Health Center (ONHC), held a series of Health Seminars for the Onondaga Nation community. They were attended by 33 community members overall.

A survey was given to patients at the ONHC to involve the community in the selection of subjects to be covered. Based on the results we came up with four health topics.

The topics included: "We Are What We Eat," "Elder Exercise," "Controlling Diabetes," and "Preventing Diabetes Complications." Presenters were Deb McCasland, R.D., C.D.E., C.D.N., Carol Cariotti, N.P., C.D.E., both from the Onondaga Nation Health Center; and Karen Kemmis, M.S., P.T., C.D.E. from the Joslin Diabetes Center through University Medical Center.

At each seminar, attendees were given health education materials and were entered to win door prizes donated by staff. One community member was given a special gift for attending all four seminars. There was also an information table and light snacks, donated by staff, local businesses and drug representatives.

The topics presented were well received and informative. We had a lot of positive feedback and suggestions on changes for future seminars through evaluations handed out at the end of each topic. Upon completing each evaluation each attendee was given a coffee mug donated by the Onondaga Nation Health Center.

The most prominent comments being that the presenters really took the time to answer individual questions and the subjects were presented in a way that was easily understood. Many also commented on how the presenters gave suggestions on realistic and attainable changes they could make to improve their health. Attendees also commented on how much they enjoyed the snacks served. "Have food – they will come"

Attendees are looking forward to our next series being planned for the fall month.

Catawba Cultural Center Receives CDC Grant

Submitted By Lisa Martin, R.D., Nashville Area Nutrition Contact

Congratulations to the Catawba Indian Nation Cultural Center in receiving a grant recently from the Centers for Disease Control and Prevention.

The grant is for 'Using Traditional Foods and Sustainable Ecological Methods to Prevent Diabetes in AI/AN'. Only eight grants were awarded out of over 70 applicants!

Grants are for $75,000 - $100,000, and the Catawba project is aimed at initiating gardening/farmer market projects, emphasizing the youth and using the gardening expertise we have in the community, and a few other projects. It's a great boost for the Cultural Center as they have been wanting to do more in this area for some time.

Developing a Support Network for Exercise

By Dixie L. Thompson, Ph.D., FACSM

Reprinted with permission from American College of Sports Medicine

Submitted by Michelle Ruslavage, BSN, RN, CDE

Staying active after beginning an exercise routine can be a challenge. Frequently reported barriers for maintaining activity include lack of time, waning motivation, and lack of enjoyment. Research has clearly demonstrated that individuals that have a strong support system for exercise are much more likely to remain active than those who have less support. Support for exercise can take many forms. Friends, family, coworkers, exercise groups, and personal trainers are only a few examples of people who can provide support for exercise. Regardless of who makes up your support system, it is important to communicate your desire to be active and express to others how they can help you fulfill this very important goal.

Support at Work

Many people spend a major portion of their days at work. Those businesses that have a built-in exercise program have a major advantage because these facilities generally have staff that can provide advice and encouragement for exercise. If your office does not have such a facility, check with your human resource office to find out if there are discounts offered to employees by local gyms. Alternately, find a coworker who will exercise with you during lunch break. There is real truth in the fact that people exercise more regularly when they have someone to whom they are accountable. You also can discuss with your boss the possibility of setting up a work schedule that allows you to more flexibility plan exercise into your routine. Ultimately, if you are healthier, you will be a better employee.

Support at Home

Ironically and unfortunately, home can sometimes be a difficult place to find support for exercise. Finding ways to meet family obligations and maintain personal goals can be a challenge. Time away from family, even when it is for good reason, can create feelings of jealousy, envy, and guilt. It is important to communicate to family members the important health benefits of regular exercise and in fact that choosing to exercise is not merely a selfish request on your part. In the best case, you can find ways to exercise together. For example, choose weekend hikes rather than afternoon matinees. Fitness facilities offer family rates, child care, and activities for different age groups. Taking advantage of these kinds of programs will give everyone in your family a chance to benefit from an active lifestyle.

Support From Friends

Friends can be one of the most valuable forms of support for exercise. Whether it is a person who exercises with you or someone who provides supportive encouragement, finding someone who shares your value of regular exercise can be very beneficial for remaining active. One effective way to get support from a friend is to find someone who can exercise with you on a routine basis. Even if this joint workout is only one time a week, that one session may be enough to encourage you to exercise on your own on other days.

Other Support

For some, joining an exercise class is a great way to get regular exercise. Having a scheduled time to workout, investing money in an exercise program, and having supportive

• **SEE PAGE 24 FOR CONCLUSION**

Our Traditional Teachings & Western Science Find Some Common Ground

By Phoebe A. Mills, MSW, Behavioral Health Program Coordinator, American Indian Community House of New York City

Health springs from the balance of every part of our being, including spirit, mind, and body. And, because all of these are related, health in one directly affects the health of the others. This is a teaching common to many of our tribal nations. Yet, historically, these traditional teachings and others similar have not been understood or embraced by the mainstream American science of medicine. Science has even sought to discredit these approaches as irrelevant or pseudo-medicine at times. But, this opposition is changing, and Indian Health Service (IHS) is a natural platform for the two worlds to begin joining. The content of the 2008 IHS Nashville Area Office (NAO) Health Summit proved that our traditional teachings and Western science can truly find common ground, and that this joining can be powerful.

A poignant illustration of this common ground was made by Dr. Frederic Luskin in his Health Summit presentation "Spirituality and Healing in Medicine: The Importance of Forgiveness." Luskin's research provides scientific data that support the spiritual truism that forgiveness is good for us, correlating forgiveness with improved mental and physical health. Luskin's studies have shown that "forgiveness training may be an effective clinical intervention for some hypertensive patients with elevated levels of anger," and that "forgiveness has been shown to reduce anger, hurt, depression and stress and lead to greater feelings of optimism, hope, compassion and self confidence." Through his presentation, Luskin identified the direct relationship between spiritual health affecting mental, physical, and social health. Additionally, Luskin spoke of the universality of forgiveness across faiths, religions, wisdoms, and cultures. Sierra Leone and Ireland are just some examples of the regions Luskin has brought the work of the Stanford University Forgiveness Projects he heads.

An equally stirring Health Summit presentation was Deborah A. Gray's (LCSW) "Childhood Trauma—Big T's and Little T's: Using Emotional Freedom Techniques as an Intervention." Ms. Gray introduced the audience to Emotional Freedom Techniques (EFT), which she describes as "a simple tapping procedure that gently realigns the body's energy system." Ms. Gray invited volunteers from the audience to experience an EFT intervention. The tapping procedure that she used was fairly quick, lasting about 5 to 10 minutes on each volunteer. And, each volunteer expressed significant and rapid improvement in their mental, social, and physical health.

It is exciting for me as I grow in this health field to see the different worlds of healing come together and mutually benefit each other, and to see our traditional teachings being honored and recognized by more people. I am grateful for the opportunity my coworkers at the American Indian Community House in New York City and I had to attend the 2008 IHS NAO Health Summit; the Summit was clearly in synch with the premise of our traditional teachings and with the overall IHS mission "to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level."

Tibbits, D., Ellis, G., Piramelli, C., Luskin, F., & Lukman, R. (2006). Hypertension reduction through forgiveness training. *Journal of Pastoral Care and Counseling*. 60(1-2):27-34.

Harris, A.H, Luskin, F.M.., Benisovich, S.V., Standard, S., Bruning, J., Evans, S. and Thoresen, C. (2006) Effects of a group forgiveness intervention on forgiveness, perceived stress and trait anger: A randomized trial *Journal of Clinical Psychology*. 62(6) 715-733.

Screening for Domestic Violence in Medical:
October is Domestic Violence Awareness Month

By Palmeda Taylor, Ph.D., Nashville Area Behavioral Health Consultant

Domestic violence against women in the United States is common. Research indicates that 30% of all women in the United States will experience domestic violence at some point in their adult lives. Ethnic minority status elevates this risk, and studies show that among Native American women, 1 in 3 will be physically/sexually abused as an adult.

The consequences of domestic violence are harmful to the victim's physical health and psychological well-being. The physical consequences include injury and a range of somatic complaints such as gastrointestinal or respiratory problems and chronic pain in any organ system. The psychological or mental health consequences include loss of self-esteem, depression, anxiety and post-traumatic stress disorder. In addition, there are a host of social repercussions such as ostracism from the community and fear of reprisals.

Indeed, domestic violence victims are high utilizers of the health care system. It is estimated that all women emergency visits are the result of battering and that 14% of patients in ambulatory medical clinics have abuse-related problems. Fifty percent of female psychiatric patients have a history of abuse. Battering occurs in 15% of all pregnancies. Thus, regardless of the medical setting in which they work, health care providers are likely to encounter female victims of domestic violence. Yet, studies consistently show that the medical community identifies only about 2% to 10% of these victims.

Health care providers have said that they do not screen for domestic violence because they lack the necessary training, time, tools, and resources, and they do not feel they can make a difference. A recent survey funded by the Agency for Healthcare Research and Quality (AHRQ) found that many primary care clinicians, nurses, physician assistants, and medical assistants lack confidence in their ability to manage and care for victims of domestic violence.

- Only 22 percent had attended any education program on domestic violence within the previous year.
- Over 25 percent of physicians and nearly 50 percent of nurse, physician assistants, and medical assistants stated that they were not at all confident in asking their patients about physical abuse.
- Less than 20 percent of clinicians asked about domestic violence when treating their patients for high-risk conditions such as injuries, depression or anxiety, chronic pelvic pain, headache, and irritable bowel syndrome.
- Only 23 percent of physicians, nurse, physician assistants, and medical assistants believed they had strategies that could assist victims of domestic abuse.

Following AHRQ-funded training sessions, providers increased their screening for domestic violence from 3.5 percent prior to the training program to 20.5 percent after training.

Hence, all medical staff should be taught the why, when, who and how of screening for domestic violence.

Routine screening, with its focus on early identification and its capacity whether or not symptoms are immediately apparent, is a primary starting point for improving the practice of medicine relative to domestic violence. In IHS facilities, screening is more likely to occur in facilities with policies and procedures for handling domestic violence.

First Candle Launches Bedtime Basics Campaign

Adapted and Submitted By Palmeda D. Taylor, Ph.D., Nashville Area Behavioral Health Consultant

According to First Candle, a leading infant health organization, research and statistics continue to indicate that babies who sleep in adult beds are at up to 40 times greater risk to die than those sleeping on their back in a safe crib. In fact, in many jurisdictions, a shared sleep surface is implicated in more than 50 percent of all sudden unexpected infant deaths. Bedtime Basics is a campaign to help prevent infant deaths caused by unsafe sleep practices.

The campaign features a unified public health message on safe sleep practices that encourage breast feeding while offering safe alternatives to bed sharing. The widely accepted concept of room sharing, placing a separate, safe sleep area alongside the adult bed to reduce the risk of SIDS and accidental infant deaths, will be emphasized.

September is "Safe Baby Month"

Native Americans have the highest rate of SIDS in the United States.

"Parents are not receiving important information about the dangers of adult beds for sleeping babies, says Dr. James Kemp, a leading researcher in the field of Sudden Infant Death Syndrome (SIDS) and issues related to unsafe sleep practices. " Dr. Kemp adds, "They [parents] are being led to believe that bed sharing somehow protects their baby during sleep" There is no evidence to support this theory. To the contrary, there is much evidence that shows the adult bed, as we know it in the U.S., can greatly increase the risk of SIDS and other sleep-related deaths."

Dr. Rachel Moon, pediatrician and member of the American Academy of Pediatrics Task Force on SIDS, agrees. "We can no longer ignore the compelling data that exists in regard to the correlation between sudden infant deaths and bed sharing. We want babies close to their parents, but we want babies to be safe. Room sharing accomplishes both."

Bedtime Basics will teach parents how to create a "safe sleep zone" for their baby, every time they place the baby down to sleep. You can also download these materials at http://www.firstcandle.org/bedtimebasics/

This information was provided by Judith Baker, Public Health Program Director, BSMS/EM, CRR, CLPPP, and SIDS, Maternal and Child Health, Tennessee Department of Health. Child and Family Protection is a major focus area of the Behavioral Health Division of the IHS.

Developing a Support Network-from page 21

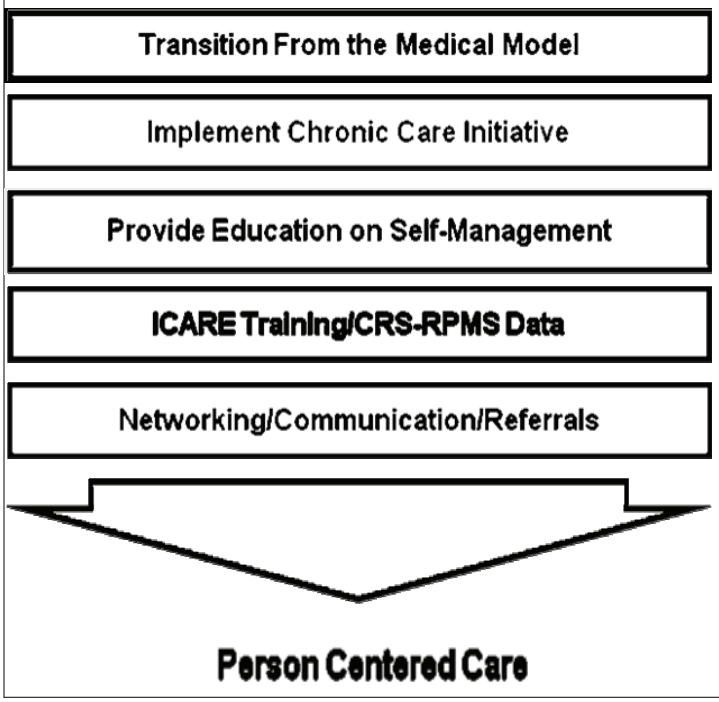
people in the group are all reasons that this is a good option. Some people benefit from having a personal trainer. Although this expense is prohibitive for some, having one-on-one training can give some individuals the motivation and accountability needed to build a regular exercise routine. A number of less expensive community-based resources exist for people wanting to be active. Examples include senior center exercise programs, running clubs, and adult recreational leagues.

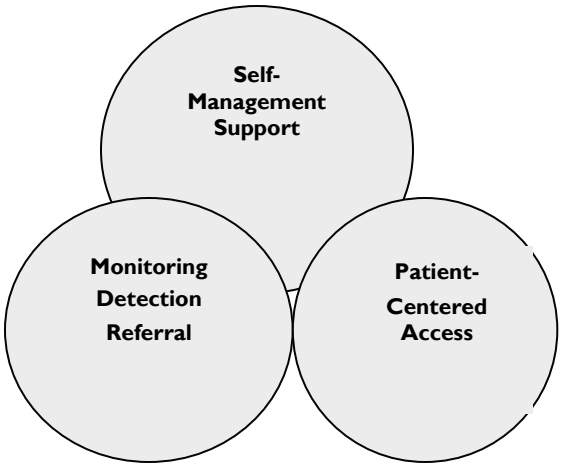
The mental and physical benefits of regular exercise are undeniable, so getting others to support your exercise habit is not an unreasonable request. It may be that others will begin to see you as a role model for exercise and find ways that they also can build exercise into their daily lives.

Self-Management in Chronic Care

By Kristina Rogers, Improvement Advisor for the Nashville Area Chronic Care Improvement Support Team (IST)

The management of chronic diseases is a tough battle for the patient. The Indian Health Service, under the direction of Mary Wachacha and other IHS personnel, will lead a new initiative to build an integrated process of patient care that produces optimal health outcomes by establishing a culture of self-management with the patient and their family. This new "skill set" will assist not only the patient to better manage and understand their chronic disease but the integration and consistent use of the infrastructure already in place within the Tribal programs will help providers to provide improved services. The utilization of this "set of skills" by those providers that are participating the IHS Chronic Care Initiative will enhance the services provided to patients with chronic diseases. The IHS is moving away from the "Medical Model" and towards a more Patient Centered approach.





This Self-Management Support will include:

- Development/implementation of an IHS version of the **Primary Care Resources and Supports for Chronic Disease Self-Management (PCRS)**
- How to document and code using the PEPC
- Knowledge of health factors, learning preferences, etc.
- iCare training
- Share specific RPMS/EHR data from each of the sites to determine strengths and weaknesses in PEPC, health factors, etc.
- Strengthen the Chronic Care Initiative sites so that they can go back to their sites and better implement the RCRS
- Integration of safe patient care and optimal health outcomes focusing on medication reconciliation and ensuring that the self-management is delivered in an appropriate forum that systematically institutionalizes safe pharmacy practices.
- Integrate, as appropriate, eHealth and telehealth into the Chronic Care Initiative sites

2008 Health Summit

- 123 attend this year's Nashville Area Health Summit

By Dr. Tim Ricks, OPH Director

The third annual Nashville Area Health Summit, co-sponsored by the Nashville Area Indian Health Service Office of Public Health, the United South and Eastern Tribes, Inc., the IHS Clinical Support Center, and Tennessee State University, was held July 15-17 in downtown Nashville with 123 in attendance.

The theme of this year's meeting was "Integrated Primary Care: Reunification in Practice of Mind, Body and Spirit." The keynote speaker was Dr. Peter Stuart, the IHS Psychiatry Program Consultant, who discussed the benefits of integrated primary care, various models, and keys to successful integration of the primary care team.

The plenary session also included a panel presentation and interactive case study of how integrated care can be carried out in a primary care setting, the sharing of a model of integrated care in the Nashville Area (St. Regis), and focus groups designed to identify current practices, barriers, and opportunities for integrated care in Area health programs. Following the plenary session on the first day, almost 40 breakout sessions, mostly related to the meeting theme, were held in five rooms.

Evaluations of the meeting by participants were overwhelmingly positive, with comments made about the organization of the meeting, the broad range of topics and presentations available to all health care disciplines, and the knowledge and expertise of the speakers. A planning committee consisting of OPH, USET, and field staff helped plan the meeting.

3rd Annual Nashville Area Health Summit

2008 Best Practices Conference

By Dr. Tim Ricks

Almost 30 medical providers attended the 2008 Medical Best Practices Conference held in downtown Nashville September 3-4. The theme of this year's meeting was "Improving Patient Care Through Use of Best Medical Practices and the Integration of the Care Team in the Management and Support of Patients with Chronic Disease."

Sponsored by the United South and Eastern Tribes, Inc. (USET) and co-sponsored by the Nashville Area Indian Health Service, the conference was organized by Dr. Byron Jasper, the USET Tribal Health Program Support Deputy Director, and Dr. Harry Brown, Area Chief Medical Officer.

Nine Nashville Area Health programs sent medical providers to the conference, and surprisingly, five providers traveled all the way from Alaska to attend the meeting.

The keynote speaker at the meeting was Dr. Charles North, the Acting Chief Medical Officer for the Indian Health Service. Presentations included algorithm-based diabetes care, new asthma guidelines, effects of stress and trauma in chronic disease, geriatric assessments, notifiable disease and external cause of injury reporting, pain management, management of congestive heart failure, and a review of case management.

Summarizing the meeting, Dr. Brown stated: "It was an excellent meeting with knowledgeable speakers. It also provided a unique opportunity for medical providers to network and discuss common case management issues in a relaxed atmosphere with their peers."

Medical Best Practices Conference

Caring for Children's Teeth

By Cathy Hollister, RDH, PhD, Director, Nashville Area Dental Support Center, United South and Eastern Tribes, Inc.

Children have many, many health needs. New parents may be overwhelmed learning all they need to know about caring for infants and toddlers. Health care professionals may inadvertently overload new parents with so much information that very little is actually retained by new parents.

One strategy to parent education is to assess current knowledge, and then slowly begin to increase knowledge. Oral education can be supplemented with written instructions. Culturally appropriate materials that are easy to read may be the most useful. But for any education to be effective, whether oral or written, parents must be ready to learn, value the information, and be able to make immediate use of the information provided.

How can health providers give timely, appropriate education to parents that they will value and be able to use? Individual assessment is time consuming so much education given often falls into the "rote" category; such education is unlikely to change a patient's behavior.

Health Education Tip: Assess current knowledge

Therefore the provider's challenges are:

- How to assess knowledge in the limited time available?
- How to determine a parent's level of interest?
- How to provide timely information that can be readily used?
- How to measure changes in parent's knowledge?

One tool available for providers is a pre-test. If the test is very brief, it can allow a very basic assessment, point out the most obvious educational needs, and may be used to determine changes in knowledge. Tests do not have to be highly detailed; carefully chosen questions can identify knowledge areas for education.

Health Education Tip: Provide only relevant information

For example, a short 5-question test may include questions regarding: functions of teeth, importance of baby teeth, professional care, oral hygiene and the role of sugar in tooth decay. Based on the answers, the professional may choose to offer education on just one topic area, leaving others topics for future appointments. A handout with answers to the questions can reinforce verbal education and lead to more education at future appointments.

Patient education should always be customized for each patient and adapted to fit ever changing needs. Providers should resist the temptation to tell patients everything they need to know at a single encounter. Distribute your "pearls of wisdom" in small packets and let patients slowly grow in knowledge and adapt behaviors as their knowledge and confidence grows.

Dental Sealants—Effective for Adults?

By Tim Ricks, DMD, MPH, Dental Public Health Specialist, Nashville Area Dental Officer

Sealants should be placed on pits and fissures of adults' permanent teeth when it is determined that the tooth, or the patient, is at risk of experiencing caries.[1]

This one sentence seems to make perfect sense to public health advocates, but to many dentists who were trained using a private practice model, this sentence could represent a major paradigm shift in the way we think of sealants and caries risk.

It has long been known that dental sealants are effective at reducing caries incidence in children and adolescents, especially when applied within the first year following the eruption of posterior teeth.[2] However, sealants may also be effective on adults that are at high risk of developing caries.

Unlike children, where dental caries starts predominantly on the occlusal (grinding) surface of the teeth, adult caries predominantly begins interproximally (between teeth). Dental sealants, which are applied to the occlusal surfaces, are not effective for these types of lesions. However, as many dentists experience throughout our Area programs, many adults present with occlusal caries nevertheless, and for these patients, dental sealants could have been effective at preventing caries development.

The American Dental Association, the primary dental organization that advises dentists on practice guidelines, states that "adults can benefit from sealants too, because one never outgrows cavities."[3]

Dentists often want "hard data" to embrace new practices, so below are a list of other research articles that discuss sealant effectiveness on adults. Dentists in the Area are encouraged to peruse PubMed or journals to review these articles.

Once dentists become satisfied in the efficacy of sealants for adults, it is hoped that Area programs will encourage dentists and staff to place dental sealants on adults to help prevent caries incidence.

References:

[1] Beauchamp, J. et al. Evidence-Based Clinical Recommendations for the Use of Pit-and-Fissure Sealants: A Report of the American Dental Association Council on Scientific Affairs, *J Am Dent Assoc*, Vol. 139, No. 3, 257-268.

[2] Ahovuo-Saloranta A, Hiiri A, Nordblad A, Worthington H, Mäkelä M. Pit and fissure sealants for preventing dental decay in the permanent teeth of children and adolescents. Cochrane Database Syst Rev 2004(3):CD001830.

[3] Dental Sealants: Protecting Your Teeth. Fact Sheet published in *J Am Dent Assoc,* Vol. 134, July 2003.

Other References:

[4] Llodra JC, Bravo M, Delgado-Rodriguez M, Baca P, Galvez R. Factors influencing the effectiveness of sealants: a meta-analysis. Community Dent Oral Epidemiol 1993;21(5):261–268.

[5] Ahovuo-Saloranta A, Hiiri A, Nordblad A, Worthington H, Mäkelä M. Pit and fissure sealants for preventing dental decay in the permanent teeth of children and adolescents. Cochrane Database Syst Rev 2004(3):CD001830.

[6] Weintraub JA, Stearns SC, Rozier RG, Huang CC. Treatment outcomes and costs of dental sealants among children enrolled in Medicaid. Am J Public Health 2001;91(11):1877–1881.

[7] Bravo M, Montero J, Bravo JJ, Baca P, Llodra JC. Sealant and fluoride varnish in caries: a randomized trial. J Dent Res 2005;84(12):1138–1143.

[8] Dennison JB, Straffon LH, Smith RC. Effectiveness of sealant treatment over five years in an insured population. JADA 2000;131(5):597–605.

News In Brief

Data Indicate Child Obesity is Leveling Off

By Tim Ricks, DMD, MPH, OPH Director

While childhood obesity continues to be a problem among American Indians and Alaska Natives, new data from the National Center for Healthcare Statistics (NCHS) shows that the epidemic is leveling off in the U.S. general population.

The prevalence of obesity among children and adolescents showed no significant changes between 2003 and 2006, according to data obtained through the National Health and Nutrition Survey (NHANES). Based on the study, 16.3% of children and adolescents aged 2-19 years were obese, or at or above the 95th percentile of the Body Mass Index-for-age growth charts.

However, the same cannot be said for the continuing adult obesity epidemic. Between the 2003-04 data collection period and the 2005-06 data collection period, NCHS found that the prevalence of obesity in adult men had increased from 31.1% to 33.3%, and the prevalence of obesity in adult women had increased from 33.2% to 35.1% in the same time period.

The rate of obesity among adults is of concern because it increases the risk of many diseases and health conditions such as hypertension, osteoarthritis, dyslipidemia (high total cholesterol or high triglycerides), type 2 diabetes, coronary heart disease, stroke, gallbladder disease, sleep apnea, and some cancers (endometrial, breast, and colon).

For more information on this topic, go to: http://www.cdc.gov/nccdphp/dnpa/obesity/ or http://www.washingtonpost.com/wp-dyn/content/story/2008/05/27/ST2008052702219.html.

U.S. Measles Cases Are Highest in a Decade

By Tim Ricks, DMD, MPH, OPH Director

Parents rejecting vaccinations for their children based on fear may help explain the sudden rise in measles cases in the U.S., according to CDC officials. The number of children contracting the measles virus this year thus far is almost three times the total number of cases last year, and the number of cases is now higher than it has been in over a decade.

Measles is thought by many in the general public to be a mild “childhood disease”, but it usually causes a fairly severe illness and is potentially deadly. It is caused by a highly contagious virus that spreads through contact with a sneezing, coughing infected person.

Experts believe that that some of the children who have contracted the virus had received at least one measles vaccination (less than 10% of the total cases, however), but that most of the children who contracted the virus were from families who did not vaccinate for some reason – parents objecting to vaccinations due to fears of an autism connection, children home-schooled and thus not required to become vaccinated, and children traveling to the U.S. from other countries.

To learn more about this story, go to http://www.chicagotribune.com/features/lifestyle/health/sns-ap-med-measles-outbreaks,0,5833260.story or http://www.cdc.gov/media/transcripts/2008/t080808.htm. It is important that health providers educate parents about the safety of vaccinations, potential life-threatening complications of measles, and the importance of

News In Brief

When Elderly Fall, Injuries to Head Outweigh Hip

By Tim Ricks, DMD, MPH, OPH Director

While elders often fear the debilitating effects of hip fractures as a result of falls, new research suggests that injuries to the head can also have significant effects.

A study published in the Journal of Safety Research in June concluded that in 2005, over half of all unintentional fall deaths among persons 65 and over were the result of traumatic brain injuries from head injuries. The severity of brain injuries "isn't always immediately apparent, and some people may not lose consciousness" (Mike Stobbe, published in the Tennessean June 24, 2008). As a result, elders may suffer significant brain injuries from falls that go unnoticed. The study also found that traumatic brain injuries from head injuries account for eight percent of all hospitalizations for non-fatal falls.

For more information on this topic, go to: http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6V6F-4SM0P07-1&_user=10&_coverDate=12%2F31%2F2008&_alid=784198330&_rdoc=1&_fmt=high&_orig=search&_cdi=5813&_sort=d&_docanchor=&view=c&_ct=1&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=26e2b82605c7c19398f7a276b823e70a or http://www.tennessean.com/apps/pbcs.dll/article?AID=/20080624/NEWS07/806240361/-1/ARCHIVE01.

Risk of Breast Cancer Recurrence Low After 5 Years, Study Reports

By Tim Ricks, DMD, MPH, OPH Director

Women who survive five years after being diagnosed with breast cancer have a good chance at remaining cancer free, according to a recent study.

Researchers tracked almost 3,000 women who had been cancer-free for five years following an initial diagnosis and treatment and found that the risk of recurrence was low. Among women with a diagnosis of stage I breast cancer (small tumor that had not spread), 93% did not have a recurrence after 5 years; among stage II breast cancers (larger tumor that may have spread to the regional lymph nodes), 89% did not have a recurrence of the cancer; and among stage III breast cancers (larger tumor that may have spread to the regional lymph nodes, chest wall, or skin), 87% of the women did not have a recurrence of the cancer.

The study was published in the Journal of the National Cancer Institute. For more information on this study, go to: http://jnci.oxfordjournals.org/cgi/content/abstract/100/16/1179 maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=risk+of+breast+cancer&searchid=1&FIRSTINDEX=0&volume=100&issue=16&resourcetype=HWCIT or http://www.reuters.com/article/healthNews/idUSN1248209720080812?feedType=RSS&feedName=healthNews.

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Nashville Area News

Nashville Area Indian Health Service
Office of Public Health
711 Stewarts Ferry Pike
Nashville, Tennessee 37214

Phone: 615-467-1600
Fax: 615-467-1585
E-mail: tim.ricks@ihs.gov

Nashville Area
Indian Health Service
Office of Public Health (OPH)

- Assisting Tribes in Promoting Health

The goal of the Office of Public Health is to provide consultative and technical support to tribes and nations in the Nashville Area to improve the health of Native Americans.