NASHVILLE AREA

OFFICE OF PUBLIC HEALTH
QUARTERLY NEWSLETTER

Volume I, Issue 2 April 2007

WELCOME!

The Nashville Area Office of Public Health has been very busy over the last three months since the release of the first newsletter. In February, OPH staff met with the health directors at Impact Week in Arlington, Virginia, providing presentations on methamphetamine abuse prevention, GPRA, clinic workload and user pop numbers, behavioral health, HP/DP, oral health, and a summary of FY '06.

Since the beginning of the year, our small but energetic OPH staff has provided trainings, site visits, and technical assistance at multiple sites in the Nashville Area, and though many of us "wear many hats," we are all committed to providing you with quality technical support in a timely manner. Our goal is to get out and provide as much technical assistance **on site** (at your clinic) as possible, but occasionally, when there are common issues, it is best to bring everyone to a central location.

In addition, some health directors and business office staff have asked our office about the NPI number and the patches for 3rd party billing, Point of Sale, and Accounts Receivable. By now, hopefully all of you have acquired either or both the facility (Type 2) and provider (Type 1) National Provider Identifier number; if you haven't, there are four ways of getting the NPI number:

1. Complete the online application at: https://NPPES.cms.hhs.gov?nPPES/Welcome.doc
2. Download the paper application form at: www.cms.hhs.gov/NationalProvIdentStand/
3. Download the application form from www.trailblazerhealth.com
4. After asking you for your permission, authorize your employer or other trusted party, such as the IHS Area Business Office Coordinators, to obtain an NPI for you.

As far as the patches, the Kernel Patch XU*8*1013 and 1014 have been released – these allow clinics to enter the NPI numbers into RPMS. The Third Party Billing Software version 2.5 patch, Point of Sale V1.0 patch 19, and Accounts Receivable V1.8 patch 1 have not been released yet and are still being beta tested, with expected release dates of early May.

Tribal programs not participating in the IHS RPMS must ensure their individual systems are compatible with NPI to assure payment of Medicare Claims. For more information on the managed care aspect of NPI, contact Liz Neptune in the Office of Public Health (see directory in this newsletter); for IT questions, contact Floyd Dennis in the Nashville Area DIRM at 615-467-1526.

The other big announcement is that the Second Annual Nashville Area Health Summit, which will be held August 7-9 here in Nashville, will consist of three meetings: Health Promotion/Disease Prevention (physicians, nurses, HP/DP coordinators, health directors, others interested), Dental (dental staff and others interested), and Behavioral Health (behavioral health providers and others interested). The theme of this year's meeting is "Motivating Behavioral Changes in Our Patients." We have many distinguished speakers for this 3-in-1 meeting:

Area Dental Meeting – Dr. Chris Halliday, Chief Dental Officer of the U.S. Public Health Service; Dr. Nick Mosca, MS State Dental Director; Dr. Mark Mallat, IN State Dental Director; Dr. Lynn Mouden, AR State Dental Director; and others

Area Behavioral Health Meeting – Brian Wooden, Deputy Director of IHS Behavioral Health; Dr. Susan Driesbach from the University of CO; Dr. Kathy Masis from the Rocky Mountain Tribal Epidemiology Center; Dr. Christina Krause, Aurora University; Dr. Frances Clark, Nashville Metro BH Director; and others. Particular attention will be paid to meth use/abuse and utilization of the multidisiciplinary team in primary care.

HP/DP – Joseph (Bo) Miller and Dr. Robert Scales from the University of New Mexico, experts in the area of motivational interviewing techniques.

More information on the Health Summit will be sent out in the near future, but please mark your calendars for this important event. **Plans are underway for the Nashville Area Office to support funding for travel for your clinic staff to attend all 3 meetings.**

Sincerely,
Tim Ricks, D.M.D., M.P.H.
Director, Office of Public Health, NAO

Health Promotion/Disease Prevention

Michelle Ruslavage, B.S.N., R.N., C.D.E.
Area HP/DP Consultant

2007 Healthy Native Communities Fellowship (HNCF)

As part of the Health Promotion and Disease Prevention (HPDP) Initiative, funding has been provided to support training, fellows and faculty's travel, lodging and meals for the 4 one week-long fellowship training retreats. The purpose of the "Fellowship" is to provide the participants with the knowledge, skills, tools and support they will need to:

- **Help their community realize their vision of health and wellness**
- **Create effective teams and coalitions to improve community health**
- **Mobilize their community for positive change and**
- **Energize and deepen their own leadership skills**

We are now in our third year for providing the Fellowship training. During 2005 and 2006, 15 teams have been selected. This past year, over 30 team Healthy Native Communities Fellowship applications were received and another 15 teams were selected to participate. The Nashville Area had a team apply for the Healthy Native Communities Fellowship and was one of those selected. The team name is ***"Indigenous Women of the Future"*** (Indian Island, Maine) and the team members are:
Wenona Lola (Cultural Education Coordinator, Penobscot Nation, Penobscot Nation & Passamaquoddy),
Miigam'agan (Youth Wellness & Outreach, Anikwom WholeLife Center, Mi'kmag Nation & Wabanaki Confederacy), and **Kathleen Paul** (Native American Program Specialist, The River Coalition, Penobscot).

These women have completed 2 out of the 4 training retreats with the remaining 2 to be held in July and September. I had the pleasure of meeting with them during this last Fellowship Retreat in Norman, OK and we discussed their plans for community wellness. The team will have peer support from previous and current Fellows via conference calls, utilizing the internet based "workstation", and the 4 retreats. The Area HPDP Coordinator will be able to provide support to the team upon return with planning, implementing and evaluating progress of the community wellness plan.

For more information about the Healthy Native Communities Fellowship please visit:
www.healthynativecommunities.org

And for more information about the Health Promotion and Disease Prevention Initiative please visit:
www.ihs.gov/NonMedicalPrograms/HPDP

MARK YOUR CALENDARS!!!

2nd Annual Nashville Area Health Summit

August 7-9, 2007
Nashville, TN

Theme: "Motivating Behavioral Changes in Our Patients"

Concurrent meetings – Health Promotion/Disease Prevention Meeting, Nashville Area Behavioral Health Meeting, and Nashville Area Dental Meeting

Intended Audience – HP/DP Coordinators, Health Educators, Behavioral Health Providers, Dental Staff, Physicians, Nurses

Additional Information will be sent out in the near future!

Injury Prevention

Mickey Rathsam, REHS, MSEH
Area Injury Prevention Coordinator

What's your CIP-IQ?

I suspect that everyone reading this article is familiar with the abbreviation for IQ? If you are not, it's no big deal! IQ (Intelligence Quotient) most commonly refers to a measure of intelligence. I am not exactly sure how IQ measurements are made (if you know, please write me!) but I do know that the tests are standardized so that the IQ of one person, or persons, can be compared to others.

The science of **community injury prevention (CIP)** focuses on reducing the incidence of severe injury in a specific community. **A comprehensive program starts with establishing an active surveillance system that identifies severe injury cases.** Once identified, specific information regarding each injury incident is collected. This information is gained from asking six questions; who; what; where; when; how; and why. Once this information is gathered and combined with information regarding a community's population, it is possible to establish the incident rates of serious injuries by cause.

Guess what? (this is so cool!) We can then compare the incident rates of serious injuries between communities, by Gender, Age, Ethnicity, Location, etc! I guess you could say this information could be used to establish an Injury Quotient (IQ) that is very similar to the Intelligence Quotient (IQ) we mentioned earlier. It is with this information that an experienced injury prevention specialist investigates clusters of similar information and with the assistance of local programs/departments develops culturally appropriate injury intervention strategies that maximize potential for success.

Can you guess why Community Injury Prevention Specialists do this? We know that severe injuries are predictable (i.e., driving intoxicated on a windy road will likely result in a single vehicle run off the road rollover crash; a child trying to cross a busy, non-signalized intersection is more likely to be struck by a vehicle; and an adult that does not wear a personal flotation device (PFD) when fishing from a boat is more likely to drown if the boat capsizes than someone who wears a PFD) therefore severe injuries are preventable!

Our goal is to help keep American Indians/Alaska Native people alive and families and communities together. Readily available information shows higher severe injury-related death rates for American Indians and Alaska Natives than Whites, and African Americans. A comprehensive Community Injury Prevention Program can make a difference and we stand ready to assist you in your efforts.

For more information on Injury Prevention, or if you would like assistance in starting an injury prevention program, please contact

CAPT Rathsam, Nashville Area Injury Prevention Coordinator, at (615) 467-1509 (Michael.Rathsam@ihs.gov)

or visit the IHS Injury Prevention home page at:

http://www.ihs.gov/MedicalPrograms/InjuryPrevention/index.cfm

Statistics, Epidemiology

Kristina Rogers, Area Statistician

The National Data Warehouse: User Population and Workload

The National Data Warehouse (NDW) has become the primary system used by the agency to meet many reporting requirements. It is an electronic environment that contains more complete information where the integrity of the data is carefully monitored and maintained. It is considered the "single version of the truth" when it comes to clinical and administrative applications. There are separate sections, known as Data Marts, which collect information for corresponding data categories. The Workload and User Population Data Mart is the source that is used to calculate the Workload and User Populations each fiscal year.

Data is exported from local systems where it is put through data quality checks that determine if data is clean, complete and able to be loaded into the NDW. There are many data quality checks that are in place at the Data Warehouse. If any component is missing, it may cause the data to be "rejected" at the Data Warehouse, causing the data to not be loaded into the NDW.

Patient Registration is very important for both Workload and User Population. If a patient does not have a Unique Patient Registration identifier, those patient registration records, as well as any encounters associated with that patient, are not loaded into the Data Warehouse. In order for patient registration data to be successfully loaded into the NDW, the data must meet the following requirements:

- **The patient record must:**
  - have an ASUFAC
  - have a valid chart number
  - have a valid First or Middle name
  - have a valid Last name
  - be an ACTIVE record
  - list the patient as being a member of a federally recognized tribe (Tribe Code = 000-997) *or* as having a Tribe Code = 998 or 999 and have a beneficiary classification = 01 *or* as having a Tribe Code = 998 or 999 and a Blood Quantum listed
  - have a Community of Residence, which is in the Standard Code Book
- **To help with the undpulication 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).**

Workload data must also pass data quality checks, which are associated with encounter record information. There are five types of encounters the Data Warehouse reports: Direct Outpatient, Direct Inpatient, CHS Outpatient, CHS Inpatient or Dental. The encounter records must contain appropriate Service types and categories listed in order to be loaded into the NDW. An encounter record is counted in the Official Workload if it is a true "face-to-face" contact that meets the following criteria:

- **Direct Outpatient Encounter:**
  - Service Types include I (IHS), T (Tribe, Non-638/Non-Compact), O (Other), 6 (Tribe, 638 Programs), P (Tribe, Compacted Program), or U (Urban Program)
  - Service Categories include A (Ambulatory), S (Day Surgery), or O (Observation)
- **Direct Inpatient Encounter:**
  - Service Types include I (IHS), T (Tribe, Non-638/Non-Compact), O (Other), 6 (Tribe, 638 Programs), P (Tribe, Compacted Program), or U (Urban Program)
  - Service Categories include H (Hospitalization)
- **Contract Outpatient Encounter:**
  - Service Types include C (Contract)
  - Service Categories include A (Ambulatory), S (Day Surgery), or O (Observation)
- **Contract Inpatient Encounter:**
  - Service Types include C (Contract)
  - Service Categories include H (Hospitalization)
- **Dental Encounter:**
  - Service Types include I (IHS), T (Tribe, Non-638/Non-Compact), O (Other), 6 (Tribe, 638 Programs), or P (Tribe, Compacted Program)
  - Service Categories include A (Ambulatory), S (Day Surgery), O (Observation), C (Chart Review), R (Nursing Home), or T (Telecommunications)
  - Clinic Codes include 56 (Dental), 57 (PSDT), or 99 (Third Party Dental)
  - Provider Codes include 52 (Dentist)
  - First ADA Code must not be blank

Keeping both Patient Registration and Workload data clean will help ensure that all data is updated correctly at the National Data Warehouse and counted toward User Population and Workload.

Behavioral Health

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

CHILD ABUSE AND NEGLECT: QUESTIONS AND ANSWERS

What is Child Abuse/Neglect (CA/N) and how do you identify it? Public Law 101-630, the Title IV Indian Child Protection Act, defines **Child Abuse** as follows: Any case in which a child is dead or exhibits evidence of: skin bruising, bleeding, malnutrition, failure to thrive, burns, fractures of any bone, subdural hematoma, soft tissue swelling, and such condition that is not justifiably explained or may not be the product of an accidental occurrence; and any case in which a child is subjected to: sexual assault, sexual molestation, sexual exploitation, sexual contact, or prostitution. Conversely, **Child Neglect** includes but is not limited to: negligent treatment or maltreatment of a child by a person, including a person responsible for a child's welfare, under circumstances which indicate that the child's health or welfare is harmed or threatened. A child is an individual who is not married, and has not maintained 18 years of age. **Child Abuse and Neglect** falls under the broader category of **Family Violence**.

Does available data show that CA/N is a problem? Nationally, 2,672,000 referrals of CA/N were received by Child Protective Services (CPS) in 2001. An estimated 903,000 of these cases were considered victims of abuse and neglect, with AI/ANs accounting for 2% of the victims (Bureau of Indian Affairs, 2006). CA/N, like all other forms of Family Violence, is linked with diverse psychological problems ranging from aggression to anxiety to depression. Practical consequences of CA/N include foster care placement, adoption, and lost social support, to name a few. Obviously, CA/N is a significant and disturbing problem nationally and in Indian Country alike.

What must you do if you suspect or have knowledge of CA/N? Public Law 101-630 mandates that any person who, while engaged in a professional capacity of activity on Federal land or in a federally-operated (or contractual) facility learns of facts that give reason to suspect a child has suffered an incident of Child Abuse, shall as soon as possible make a report of the suspected abuse to the agency designated to receive such reports. Is your program following the guidelines of PL 101-630 for reporting CA/N? Do you have policies and procedures in place for handling incidents of known/suspected CA/N?

Are there any promising prevention approaches? Research shows that a number of supportive interventions have been developed in an attempt to reduce violent behavior within families. According to Besharov & Laumann-Billings. University of Virginia, home-visitor programs for new parents living in difficult circumstances are especially promising forms of prevention. Home-visitor programs simultaneously assist with material needs (e.g., cribs, child-care, and transportation), psychological needs (e.g., parenting education and stress management), and educational needs (e.g., job skills). This approach represents a return to the roots of a social service delivery system originally intended to support families, not simply to police them. Certainly, supporting families is consistent with the Indian way!

Are there any Native American specific interventions for CA/N that are effective? Dr. Dolores Bigfoot's Project Making Medicine, University of Oklahoma, gets the nod here. The program focuses on the importance of traditional teachings and beliefs in the healing process, and trains licensed mental health professionals in the treatment of CA/N. You may contact Dr. Bigfoot at: The Center on CA/N, University of Oklahoma, 405-271-8858.

SUMMING IT UP:

- CA/N is a significant problem nationally and tribally. There's no denying it!
- Health-care professionals are required by law to report known or suspected cases of CA/N. Systems for reporting need to be in place, at the tribal level.
- Reporting CA/N is more than the law, it's prophylactic. Reporting saves lives!
- Approaches that support families appear to be especially promising for reducing CA/N.
- All professionals in Indian Country need training on CA/N in order to recognize and report it.
- Working together to prevent CA/N is a major challenge with significant pay-offs.

APRIL IS CHILD ABUSE PREVENTION MONTH

Chief Medical Officer

Bruce Finke, M.D., NAO Acting Chief Medical Officer

Palliative Care

The **Guidelines for Palliative Care in the Indian Health System** are now available for your use. I'll be sending these out by email to the Health Directors List as well as the Clinical Directors in the coming week.

The World Health Organization has defined palliative care as "the active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families."

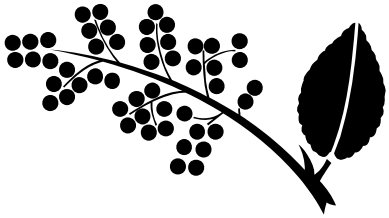
The National Consensus Project states that "Palliative care ideally begins at the time of diagnosis of a life-threatening or debilitating condition and continues through cure, or until death, and into the family's bereavement period. It can be delivered concurrently with life-prolonging care or as the main focus of care."

American Indians and Alaska Natives are now living longer, and for the most part, dying of chronic diseases. Those we serve need and deserve quality palliative care to ensure comfort and quality of life as they near the end of life. Yet, formal palliative and end-of-life care services have been largely unavailable to the majority of users in the Indian Health System (Tribal, IHS, and Urban Indian health programs), while services that have been available have been largely ad hoc and improvised. There is no common understanding of what constitutes the basic essentials of palliative care in a comprehensive health system.

These guidelines are intended as a tool to help you think about what kind of palliative and end of life care is available to your members and to provide a framework for the core palliative and end-of-life services that are an essential part of a comprehensive set of health care services. The guidelines rely heavily on the Clinical Practice Guidelines for Quality Palliative Care developed by the National Consensus Project for Quality Palliative Care (released in May of 2004) but were adapted specifically for programs delivering care within the unique circumstances of the Indian health system. Dr. Mary Jo Crissler (White Earth) led the national development workgroup and this effort was significantly supported by the National Institutes of Health, National Cancer Institute Division of Cancer Control and Population Sciences through the Quality of Cancer Care Committee (QCCC).

The guidelines provide a minimum standard for palliative care as a basic health care service. The target populations for these services are those living with a life-threatening or debilitating illness, or a persistent or recurring condition, that adversely affects their daily functioning or will predictably reduce life expectancy. Health centers, clinics, hospitals, and Service Units, in consultation with their tribes/communities have the flexibility to target these palliative care services to those at highest need in their individual communities.

We hope that these guidelines will help you as you develop services so that those seeking care in our hospitals and clinics can receive compassionate and competent care when they need it most. I'd love to have your feed back about the guidelines, both positive and negative. I also welcome you to call or email me if I can be of any help as you think about how to ensure access to palliative and end-of-life care in our Tribes and communities.



Oral Health Update

M. Cathy Hollister, M.P.H., Ph.D.
Director, Nashville Area Dental Support Center

Add a Little BLING to Your Smile

The world of Hip Hop has invaded oral health as dental Grills have become popular fashion accessories. Grills come in a variety of metals and styles; they may be made from an impression or come with "do-it-yourself" instructions. Grills are often fashioned from an impression taken at by a jeweler or specialty shops. Online sites offer grills that do not require "waiting around for the molding process, one size fits all".

Whether made from an impression or pre-formed, the snap on appliance can be made from non-precious to precious metal. Options include stones, cut-outs, or vampire teeth. Prices range from $18.00 to several thousand, depending on materials and style.

Fashion Statement or Oral Health Hazard

Most Grill wearers consider the appliance a fashion accessory- much like any other jewelry. Some schools prohibit wearing grills during school hours, so the grills may be worn after school or on weekends. Some dental professional have noted that with proper care, grills do not increase risk of oral disease. However, poorly made grills may have sharp edges or become plaque traps, increasing risk for both gingivitis and caries. Patients may have reactions to metals, particularly with the less expensive metals containing high nickel content.

Warnings on the ADA website include allergic reactions, increased risk for periodontal disease and caries, and possible shifting of teeth. The ADA stresses that people who wear grills should be especially careful about brushing and flossing. The ADA also advises wearers to limit the amount of time the grill is worn.

Patients may not advise their dental professionals that a grill is being worn so routine oral hygiene instructions may not give patients the information needed to maintain oral health. Patients should be carefully questioned especially if unexplained discoloration or gingival inflammation may be due to an allergic reaction or a poor fitting grill.

Dentistry's Response

The ADA recommendations regarding grills:

- Stress good plaque control
- Explore unexplained gingival irritation or decalcification
- Advise patients of the risks associated with grills
- Limit time grills are worn

Alternatives:
Some dental practices are offering "Sparkles" as an alternative to Grills. Sparkles are dental jewelry that are permanently bonded to teeth, reducing the risk of plaque and gingival irritation. Sparkles may also be an incentive to complete comprehensive care if they are not placed until all preventive and restorative work has been completed.

Fads and fashions come and go. Due to the popularity of Hip Hop and Rap, Grills may well be worn by teens in your dental practice. Rapper Paul Wahl claims in one of his songs, his mouth has "more carats than Bugs Bunny's lunch."

Other dental news….

Patch 17 has been released! Patch 17 installs the new CDT codes for dental. The Nashville Area DIRM is in the process of installing this patch throughout the Nashville Area sites. For more information, contact DIRM at 615-467-1526.

Health Education

Mary Wachacha, Lead Consultant, IHS Health Education

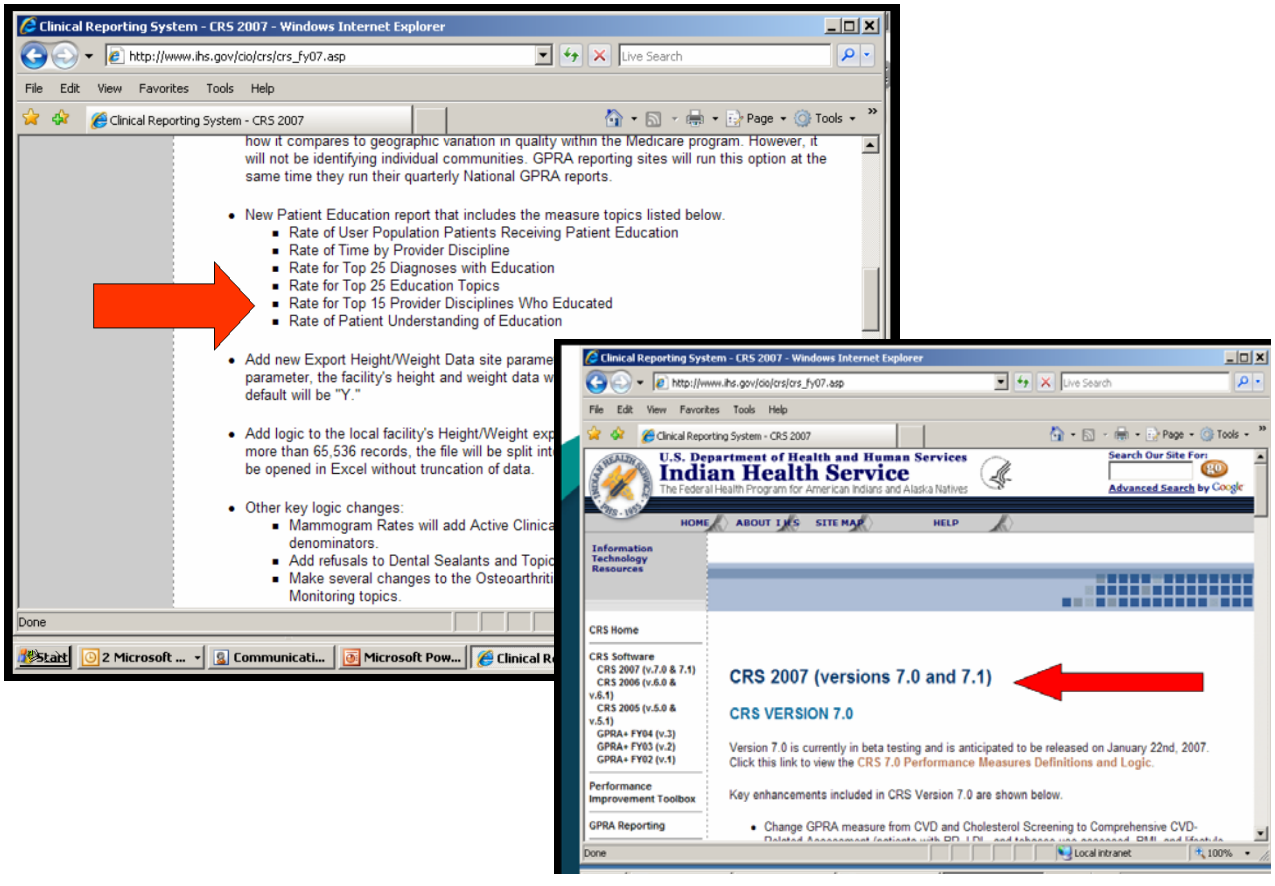
CRS Indicators – Patient Education

In February of 2007 the IHS added the tracking of Patient Education as a new Clinical Reporting System (CRS) Indicator to the RPMS system (Resource Patient Management System). CRS Indicators are used locally (i.e., the reports may be generated at your site); regionally (i.e. the reports are used by the Nashville Area Office) and nationally (i.e. by all of IHS) to determine if health issues are becoming more troublesome for our Native American clients.

Currently, CRS Indicators are being tracked for:

- Patient Education
- Appropriate Treatment for Children with Upper Respiratory Infection/Pharyngitis
- Tobacco Use and Exposure Assessment
- Antidepressant Medication Management
- Obesity Assessment/Nutrition and Exercise Education for At Risk Patients
- Appropriate Medication Therapy after a Heart Attack/Beta-Blocker Treatment After A Heart Attack
- Persistence of Appropriate Medication Therapy after a Heart Attack
- Chlamydia Testing
- HIV Quality of Care
- Osteoporosis Management/Osteoporosis Screening in Women
- Rheumatoid Arthritis Medication Monitoring\Osteoarthritis Medication Monitoring
- Asthma/Asthma Quality of Care/Asthma and Inhaled Steroid Use
- Chronic Kidney Disease Assessment
- Prediabetes/Metabolic Syndrome
- Medications Education
- Breastfeeding Rates
- Drugs to be Avoided in the Elderly
- Functional Status Assessment in Elders

For additional information any of the above Indicators or for more information on how to document and code the above, please refer to www.ihs.gov under the Information Technology Resources: Clinical Reporting System or contact: Mary Wachacha at mary.wachacha@ihs.gov

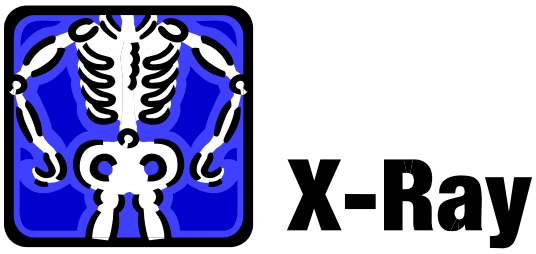


Office of Public Health Update

Tim Ricks, D.M.D., M.P.H., Director

Important Information about Radiation Dosimetry Badges

Attention Nashville Area Health Directors, Clinical Directors, and Dental Staff:



The IHS Division of Environmental Health Services (DEHS) at IHS Headquarters has been paying for a radiation dosimetry badge contract that supplies the radiation dosimetry badges for IHS dental clinics and IHS medical imaging programs since the mid-1990's when the FDA stopped providing this service. **Beginning in FY 08, DEHS will no longer provide funding for this contract.**

Below are guidelines from John Smart, Institutional Environmental Health Program Manager:

Recommendations for Dental programs:

- Radiation exposure potential from dental x-ray units is very low
- Administrative procedures for radiation protection currently in use in dental settings are effective
- Historical occupational x-ray exposure data shows no or very low radiation exposure to dental staff. **In a recent review of dental dosimetry readings, the Nashville Area Environmental Health Office found no dental staff radiation exposure for staff utilizing the DEHS service over the previous two years; this mirrors national trends. This makes it hard to justify routine dosimetry badges for dental staff except for those deemed to be at high risk.**
- **Should consider providing dosimetry badges for pregnant staff**
- Routine dosimetry services for dental staff **is not recommended unless radiation risk assessments indicate otherwise.**

Recommendations for Medical Radiology:

- Historical occupational x-ray exposure data shows that medical radiology staff working with fluoroscopic equipment are exposed to occupational radiation doses that should be monitored with x-ray badges
- Medical radiology staff, physicians, nurses and other staff working in or around environments where x-ray equipment with power settings of greater than 60 kVp is in use and where shielding is not available (especially mobile units) should consider use of x-ray badges for exposure monitoring
- **Pregnant staff should continued to be monitored with x-ray badges**

Personal dosimeters for external exposure measurement should be considered for workers likely to be exposed to 1 mSv annually. (This is equivalent to 100 mR). Personal dosimeters should be provided for known pregnant occupationally-exposed personnel and probably women of child-bearing age. Funding for dosimetry badge monitoring will need to be incurred by the clinic itself; the Nashville Area Office will not be able to provide funding for this service and is merely making recommendations to your facility based on guidance we have received from Headquarters.

If you have additional questions about these recommendations, please contact your local environmental health person or the Nashville Area Institutional Health Officer, Kit Grosch, at 615-467-1622.

OFFICE OF PUBLIC HEALTH
DIRECTORY – 2007

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Elizabeth Neptune
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Area Managed Care Consultant (detailed to EHR)/EHR Contact

Deborah Burkybile
Cell: **615-519-6320**

OFFICE OF PUBLIC HEALTH
Calendar of Events/Announcements

OPH Meetings/Events of Interest

- The Nashville Area Indian Health Service and the Eastern Regional Bureau of Indian Affairs will co-sponsor an **Indian Child Protection Conference, "Protecting Indian Children", April 24-26, 2007**, in Mobile, Alabama. The Poarch Creek Indians will serve as the host-Tribe. The focus of this conference will be the *Indian Child Welfare Act*, the foundational regulation guiding child protection and child welfare practices on Indian reservations. For registration information, contact the Poarch Creek of Indians Family Services Department @ 251-368-9136, ext. 2600. Registration closes, April 18th.
- **Oneida Elders Conference May 7-8, 2007** Dr. Taylor and Michelle Ruslavage to present (Dr Taylor should have the presentations titles, I don't have that info)
- **Nashville Area Community Health Representative PCC and RPMS Training June 18-22** in Nashville, TN at the Area Office For more information contact: Michelle Ruslavage @ (615) 467-1628 or michelle.ruslavage@ihs.gov.
- **Nashville Area Health Summit – HP/DP Meeting, Area Dental Meeting, Area Behavioral Health Meeting, August 7-9, 2007,** in Nashville, TN (location to be determined). See related information on page 1 and in the HP/DP article.
- The **3rd Annual AIAN Long Term Care conference** will be in Albuquerque, **September 5-7**, 2007. We're still looking for presenters for IHS and Tribal Long Term Care programs and are hoping once again this year to have travel stipends available for presenters through a grant from the Retirement Research Foundation. Please take a minute and send in an abstract before April 30th - we hope to select the presenters shortly after that deadline and offer invitations. This will give both Tribal and federal programs plenty of time to make their arrangements for travel. Visit the conference website at http://www.aianlongtermcare.org. In addition to promising practices and model programs in LTC, we will have intensive daylong workshops on the PACE and Green House models of long term care.

OPH Staff Site Visits

- **Dr. Tim Ricks, OPH Director** (Area Dental Officer, EHR Contact):
  - April 16-18 – Cherokee
  - April 23-26 – Seminole Tribe of Florida
  - May 29-31 – MS Choctaw
  - June 4-6 – USET Meeting, Houston
  - June 11 – Passamaquoddy Pleasant Point
  - June 12 – Passamaquoddy Indian Township
  - June 13 – Maliseet
  - June 14 – Micmac
  - June 15 – Penobscot
- **Michelle Ruslavage, HP/DP Coordinator** (Area Nursing Officer, CHR Consultant):
  - April 16 - Coushatta Tribe of LA
  - April 17 - Chitimacha Tribe of LA
  - April 18 - Tunica Biloxi Tribe
  - April 19 - Jena Band of LA
  - April 25-26 - Seminole Tribe of FL
  - May 7-10 – Oneida (Elders Conference)
  - June 27-28 - Passamaquoddy Pleasant Point

- **Dr. Palmeda Taylor, Behavioral Health Consultant** (Urban Program Coordinator)
    - April 23-27 – Poarch Creek (Indian Child Protection Training)
    - May 7-10 – Oneida (Elders Conference)
    - May 23-24 – American Indian Community House
    - May 29-June 1 – Baltimore Lifelines
    - June 27-28 – Passamaquoddy Pleasant Point
- **Kristina Rogers, Area Statistician** (Area Chronic Care Consultant)
    - May 14-20 – Chronic Care Initiative (as part of MS Choctaw Team), Boulder
    - June – MS Choctaw, Chronic Care Initiative, date to be determined
- **Dr. Bruce Finke, Elder Care Consultant** (Acting Chief Medical Officer, Chronic Care Lead for IHS)
    - May 7-10 – Oneida (Elders Conference)
- **Elizabeth Neptune, Managed Care Consultant**
    - April 23-27 – Poarch Creek (Indian Child Protection Training)
    - June 27-28 – Passamaquoddy Pleasant Point

We hope that you have enjoyed this issue of the Nashville Area Office of Public Health Newsletter.

If you have comments or suggestions as to how to make this newsletter better, please contact Dr. Tim Ricks at tim.ricks@ihs.gov.

Thanks to all of those who contributed articles for this issue of the newsletter!