Nashville Area Indian Health Service

Office of Public Health Newsletter

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Who May Submit Articles: Anyone!

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Questions? Comments? Contact Dr. Tim Ricks, OPH Director, at 615-467-1508 or tim.ricks@ihs.gov.

Area Unveils New Substance Abuse Plan

The Nashville Area Substance Abuse Program, operating within the Area Behavioral Health Program, has just released the "***Plan for Preventing Substance Abuse***." This in-depth 70-page manual was created by Liz Neptune, Area Substance Abuse Consultant and principal author, along with assistance by Dr. Palmeda Taylor, Area Behavioral Health Consultant, and Dr. Tim Ricks, Area Office of Public Health Director.

The manual was developed to assist Nashville Area Tribes/Nations in planning evidence-based activities in the prevention of alcohol and substance abuse. The prevalence of substance abuse continues to grow in the U.S. In the 2006 National Survey on Drug Use and Health, 37.2% of Native Americans or Alaska Natives reported consuming alcohol. Over 70 million Americans smoked/used tobacco at least once per month in 2004, and the prevalence of other substance abuse such as the "club drugs" (MDMA -ecstasy, Rohypnol, GHB, and ketamine), inhalants, prescription drugs, and methamphetamine continues to rise throughout the U.S.

The plan details each of the most common substances that are abused, information on the health hazards associated with them as well as the social and economic costs. The plan also provides a template to Tribes/Nations in conducting any prevention activities related to substance abuse, using the "POARE" model for establishing a prevention program (identify and research a problem, set clear objectives, plan activities specifically designed to meet those objectives, identify the personnel and budgetary resources to support the activities, and evaluate the program).

This plan will be distributed throughout the Area in mid-February and was distributed at the USET Impact Week earlier this week.

Welcome to the new CMO!

As most of you are aware, the Nashville Area has a new Chief Medical Officer, Dr. (CAPT) Harry Brown. We look forward to working with Dr. Brown. Should you need his assistance on any issues, he may be reached at 615-467-1531 or harry.brown@ihs.gov.

GPRA, Workload, and User Population: A new year begins

Kristina Rogers, Nashville Area Statistician
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Ways to Improve GPRA

- Have a prepared and active care team, which includes a multidisciplinary team
- Use iCare to identify patients who need services
- Perform other services patients are due for while they are in the clinic – Max pack visits
- Utilize group visits for patient education, immunizations, GPRA screenings, etc.
- Use iCare to test improvements in a small scale to find weaknesses and strengths
- Document refusals

The Government Performance and Results Act **(GPRA)** is a federal law that shows Congress how the IHS is performing based on a set of specific measures. It is a way for federal agencies to show how they are using appropriated funds to benefit the customer and to meet agency missions and goals. Local sites can use it to monitor their patient population health status and patient access to the minimum standard of care. Patient participation in GPRA not only helps improve their health status, but ultimately increases workload for the clinic.

Ways to Improve Workload

- Make sure clinicians know the proper ways to documents visits on PCC forms, PCC+ forms or in EHR
- Make sure data entry staff is up-to-date to combat data entry backlog early
- Run error reports monthly
- Utilize the reports sent by the Area Statistician to identify problems with workload counts
- Encourage patients to visit the clinic for routine screenings or treatment related to GPRA

Workload is considered direct or contracted inpatient stays, ambulatory care visits or dental visits. All of the GPRA measures can be met in the ambulatory clinic as well as through CHS visits. It takes proper documentation, efficient data entry and the ability to get the patient involved to improve GPRA, Workload and inevitably User Population numbers. The more patients you have participating in GPRA, the higher your User Population will be at the end of the year.

Ways to Improve User Population

- Update patient records in RPMS at every visit, regardless if any information has changed
- Utilize the Registration Record Information reports from the Area Statistician to locate missing data
- Look at employing CHRs to help update patient registration information
- Advise staff not to use communities of residences of [NAME OF STATE] unk when registering patients
- Make sure registration records are complete. They must include: first, middle and last name, SSN, community of residence and Indian Status

User Population is calculated on a yearly basis. It contains a count of Indian Registrants who have had at least one direct or contract inpatient stay, ambulatory care visit or dental visit within the last three years. It is calculated based on the workload that is submitted to the National Data Warehouse. Data transmissions are the mechanism used to export data to the national center; therefore, these must be done monthly in order to ensure timely processing of the data submitted. Accurate and appropriate data entry at the local level not only affects User Population and Workload, it also affects the GPRA numbers for the year.

Data affects many aspects of the clinic and the work done by the clinic. Whether it is using a patient list to identify patients who fit the criteria for certain GPRA measures, updating patient registration information to reflect accurate User Population or ensuring that the workload being transmitted is complete and able to be loaded into the data warehouse, data helps the clinic function and improve.

Fast Food and Your Mood

Harry Brown, M.D., Nashville Area Chief Medical Officer
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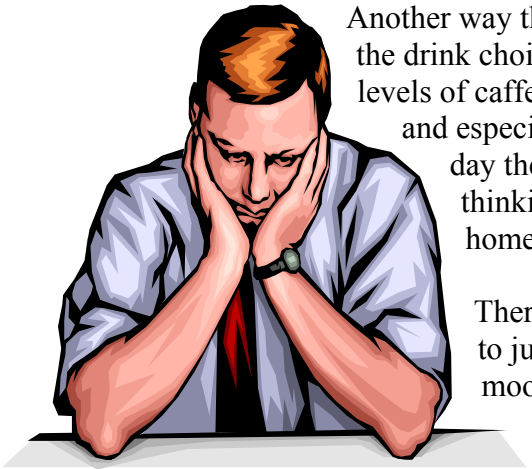
In the early 21st century in America, we live in a world of fast food. In the past 30 years, fast food sales in this country have increased 900%. About half the money spent on food in our country goes toward food eaten away from home. How has this affected us?

Typical fast food is high in fat, salt, sugar, caffeine, and calories. It is low in vitamins, minerals, fiber, and beneficial phytochemicals. There is no question that fast food has contributed greatly to the increase in obesity seen across the country. Interestingly, obesity and depression are related – people who suffer from obesity tend to also suffer much higher rates of depression. There is some question about which causes which: does depression cause obesity, or does obesity cause depression? The answer is probably that both are true.

Let's look at other ways that fast food may affect our mood. The high calorie, high sugar content of a fast food meal will dramatically raise a person's blood sugar. While this may give a person a few minutes of a good feeling, it soon leads most people to feel tired, sleepy, and unable to concentrate. It isn't hard to see how this could have a very negative affect on a young student's school performance. In the late 1990's a school in Wisconsin, the Appleton Central Alternative High School, decided to replace their typical school lunch of fast food type meals (burgers, fries, soft drinks) with healthy foods: fresh cooked vegetables, healthy meats, whole grain bread, salads, and water. The results were dramatic. Grades went up, attendance went up, students reported that they could think more clearly and concentrate better, and fights and arguments in school went down.



Another way that fast food may affect all of us, but especially school children, is that the drink choices tend to be high in caffeine. Iced tea and many soft drinks have high levels of caffeine. If these are consumed for supper, it can easily affect the amount and especially the quality of sleep. If a child does not get enough sleep, the next day they are almost certain to be grumpy, have a hard time concentrating and thinking, perform poorly in school, and be unpleasant with their family at home.

There are times when fast food may be almost unavoidable (unless you want to just go without eating). In this case the best advice for health and good mood is to eat small amounts of it (never do the "super-size thing"), and try to find the healthier choices on the menu, such as drinking water or low fat milk instead of soft drinks.

Issues in Substance Abuse: Never forget the other 1/2

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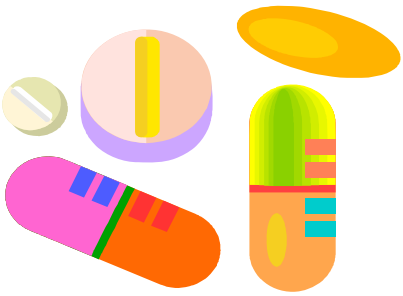
Often, when we think about substance abuse in tribal communities we think of it in a vacuum. It is such a staggering and dangerous issue that it could do what hundreds of years of assimilation could not do in terms of decimating tribes, and killing cultures. HIV and its advance in tribal communities through drug use, as well as the secondary effects of Methamphetamine are known to be killers. Lest we forget alcohol, which has killed more tribal members and left our youth damaged, has done more harm than any other 20th century single phenomena. Yet we are still only speaking about substance abuse. Statistics tell us that substance abuse is fast changing its face. We no longer have tribal members addicted to only one substance; rather we see poly-substance abuse. We no longer just face addiction issues because we know from The Substance Abuse Mental Health Service Administration (SAMHSA) that dual diagnosis is now more common nationally than having just substance abuse alone.



This factor has even greater relevance for tribal communities and the interventions, and treatment for substance abuse we offer. We know the devastation of historical trauma. Literature reviews inform us that Post-Traumatic Stress Disorder (PTSD) is epidemic in Native Communities across the nation. In fact, we know that in the most common mental health problems in Indian Country part of the diagnostic information includes probability of substance use. PTSD increases the chances of a person using substances to self medicate; the same is true for depression, bi-polar disorder, and anxiety disorders.

We have just listed the most frequent diagnoses in our communities. Yet when we send people to treatment or offer treatment, we frequently ignore the mental health issue which is a guarantee for failure.

Think of the person who in treatment learns about addiction, but not about PTSD, who returns and has an increase in flashbacks and constant anxiety. His/her chances for sobriety dwindle with each memory or moment of discomfort. Think of the person who was sexually abused as a child and when he is sober becomes terribly depressed…We need to look at both sides of the problems our tribal members face. Our substance abuse treatment programs must become linked to our mental health services. We must know what is the other half of the problem. Since many of our tribal members live in places where there are few mental health resources it means that we must design resources when we treat substance abuse that include mental health assessment and diagnosis and offer treatment for both.

Tribal people are resilient and our culture is a foundation for strength and healing. Healing requires that we know the extent of the wounds and that we do not ignore them because they fall in a different domain. We deal and we treat whole people in substance abuse treatment and therefore we must always treat mental health wounds as well as substance abuse.

► **See the next page for more information on co-morbidity between substance abuse and mental health.**

Substance Abuse & Mental Health: SAMHSA Resources

The Co-Occurring Center for Excellence (COCE) was created by SAMHSA in 2003 to provide information and a range of services to mental health and substance abuse administrators and policymakers at state and local levels, their counterparts in tribal and Native populations, clinical providers, other providers, and all other agencies and systems through which clients may enter the treatment system.

COCE is your go-to resource for co-occurring disorders (CODs) by providing you with state-of-the-art and sustainable technical assistance, training, information and resources, and links to other resources. COCE's service delivery and product development focus on the following categories that provide the "building blocks" essential for systems change in support of any new or enhanced initiative:

Read the full news bulletin

COCE Overview Paper 6—Services Integration (393 KB)
COCE Overview Paper 7—Systems Integration (457 KB)
COCE Overview Paper 8—The Epidemiology of Co-Occurring Substance Use and Mental Disorders

Preventing & Reducing Underage Drinking

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In the January 2008 issue of the "Monitor on Psychology" (American Psychological Association), it is reported that 50 percent of children have started drinking by eighth grade and that the ramifications are devastating. For example, every year 5,000 people under age-21 die from alcohol-related injuries (1,600 homicide and 300 suicides). Other problems associated with underage drinking include:

- Possible adverse effects on the developing brain
- A higher risk of physical and sexual assault
- Unintended sexual activity
- Poor academic performance

Moreover, children who begin drinking by age-13 have a 38 percent higher risk of developing alcohol dependence later in life (National Institute on Alcohol Abuse and Alcoholism). The risk is even higher for those who start drinking early and have a family history of alcoholism. Considering these dire consequences, increased efforts to prevent and reduce underage drinking must be made.

Accordingly, SAMHSA (in collaboration with Marvel Entertainment and the Elks USA) has developed *Hard Choices*, a special comic book which features Spider-Man and the Fantastic Four successfully battling underage drinking and urging kids to become real-life heroes by making healthy choices. Order your free copy now! Intervene early. *Hard Choices* contributes to the Surgeon General's Call to Action To Prevent and Reduce Underage Drinking

IHS Tackles Alcohol Abuse with Brief Interventions

Sandra Basu

WASHINGTON—Indian Health Service (IHS) officials are embarking on a new program that they hope will prevent alcohol-related illnesses and injuries in the population it treats.

Alcohol abuse among American Indians and Alaska Natives (AI/AN) has been a serious problem that tribal leaders and health professionals have been working to address. According to a Substance Abuse and Mental Health Services Administration (SAMHSA) report, *Substance Use and Substance Disorders among American Indians and Alaska Natives,* which is based on data from 2002-2005, 10.7 percent of AI/AN reported having a past-year alcohol use disorder compared with 7.6 per cent of other racial groups in the U.S.

Dr. Anthony Dekker, DO, associate director of the Phoenix Indian Medical Center (PIMC) and director of Ambulatory Care and Community Health, said that IHS is embarking on instituting a program in all of its hospitals called Alcohol Screening and Brief Intervention (ASBI). The program entails screening patients for a potential alcohol problem who come to an emergency department and then encouraging those patients who need it to seek help. Through the program, health care officials are hoping to decrease the number of alcohol-related injuries and illnesses among IHS beneficiaries.

According to the Centers for Disease Control and Prevention, alcohol misuse is the leading risk factor for serious injury in the United States, and the third leading cause of preventable death. It accounts for more than 75,000 deaths overall annually.

Alcohol-related injuries and illnesses have had a big impact on Indian communities. Seventy-three per cent of AI/AN deaths that are attributed to motor vehicle accidents are alcohol-related, and 84 per cent of AI/AN deaths due to suicide are alcohol-related, according to statistics from the IHS and the National Highway Traffic Safety Administration.

“Cirrhosis is eight times more likely to cause death in American Indians than in the Caucasian population. When you look at accidents, the leading cause of death of Navaho in Arizona is from motor vehicle injuries and nonintentional traumas, of which the majority is related to alcohol. It actually exceeds cardiovascular death,” Dr. Dekker said.

ASBI entails the health care provider, or other caregiver, such as a nurse or social worker, asking some questions to a patient who comes in to the emergency room to determine whether they have an alcohol abuse problem. If it appears that they do, the health care provider gives the patient a brief motivational interview designed to help encourage the patient with a potential alcohol problem to seek help.

Dr. Dekker said that PIMC is looking to launch the program at its facility sometime in May and that IHS is seeking to incorporate ASBI in all of its hospitals this year.

“What we are hoping is that all 48 [IHS] hospitals will incorporate this during fiscal year 2007, that every patient that comes in to the emergency setting will receive an alcohol screening and a brief intervention and a referral, if necessary for treatment. Based on studies on the majority status population (general U.S. population), that brief intervention will reduce alcohol-related injuries by between 40 and 50 per cent. If we could make that happen, it would be remarkably beneficial for the Indian community,” Dr. Dekker said in an interview with U.S. MEDICINE last month.

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Grappling With Alcohol-Related Problems

Dr. Dekker said that there are several theories as to why alcohol abuse has been a challenge to American Indian and Alaska Native communities.

Genetics, he said, is one of the theories that has been studied to explain why AI/AN have higher rates of alcohol abuse than other people do. "There is a genetic theory that is yet to be proven that the American Indian has not been exposed to alcohol with the exception of the past 200 years. And for the most part for the last 50 years [is] where they have been significantly exposed to it and they have not developed genetic resistance," Dr. Dekker said. "The Italians have had alcohol for at least 2,000 to 3,000 years. The Irish have had alcohol for at least 1,000 years. The American Indians have had alcohol for at least 200 years. The Italians have had 3,000 years of time to cull out those who are susceptible. In other words, those people who drink themselves to oblivion and injure themselves many times die off before they can reproduce. The Irish had alcohol for a 1,000 years. Now the incidence of alcoholism is higher in Ireland than it is in Italy, and the incidence of alcoholism is higher among American Indians than it is in Ireland. Now that is a very fatalistic genetic explanation, but it is an interesting explanation."

A genetic explanation is fraught with issues because while it could help in providing assistance to American Indians and Alaska Natives, some people could use it as a reason to discriminate against these populations, Dr. Dekker said. "On one hand you could say, 'you know what, your grandpa was an alcoholic, your dad is an alcoholic and you have the genes, so you may be an alcoholic, too. So we need to provide additional intervention for you to decrease the likelihood that you are going to have negative effects from alcohol.' But it's also possible someone could say, 'you know what, I don't want to hire that guy because his dad's an alcoholic and his grandpa is an alcoholic and he has the marker.' The two-edged sword is a very significant issue," Dr. Dekker said.

Dr. Dekker said that American Indians and Alaska Natives have often gotten negative news coverage about the alcohol abuse in their communities and that some people mistakenly think that all American Indians and Alaska Natives are alcoholics. In fact, he said, these populations have been working to address the issue of alcohol abuse in their communities. "It's important to understand that there has been a lush history of American Indian communities, including today, working to try to address the issue of alcohol use in their communities," Dr. Gentilello said.

Embarking On A New Strategy

Dr. Larry Gentilello, who is a professor of surgery at the University of Texas Southwestern Medical Center in Dallas, developed the first project where alcohol screening was incorporated into trauma center care, while he was a physician at Seattle's Harborview Medical Center. "It was about 20 years ago when I was on the trauma service, I just noticed that everybody was drunk. Patients came in and we treated their injuries and nobody as so much as mentioned the alcohol use to the patient," he said.

Screening patients for alcohol use in trauma centers was unusual, and Dr. Gentilello said that he began to advocate for routine alcohol screening in the 1990s. The standard way of dealing with patients who come into an emergency room as a result of an alcohol-related accident has traditionally been to give them care and then to maybe tell them that they should stop drinking. Harborview began a different approach in dealing with these patients, many of whom made multiple visits to the emergency room for alcohol-related events.

"Trauma centers treated the injuries, [but] they never tried to screen or do anything about the other problems, so I incorporated alcohol screening and intervention into trauma center care," said Dr. Gentilello. In a study that he conducted in Seattle's Harborview Medical Center that was published in 1999, he found that there was nearly a 50 per cent reduction in alcohol-related injuries and illnesses in those patients at the facility that received brief counseling.

Dr. Gentilello said that ASBI's use in IHS is a good fit and should make a big difference in addressing alcohol-related injuries and illnesses. "It's a natural place for it to be done, alcohol takes such a high toll there," he said.

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ASBI

ASBI entails screening every patient who enters the emergency room for alcohol use and abuse by asking them a few questions like, 'Do you drink beer, wine or distilled spirits? If you do, do you think that your injury or your illness could be related to your alcohol intake? And would you be interested in getting some help?' followed by additional questions to assess their risk of having an alcohol-related disorder. If the patient has an alcohol problem, a brief intervention follows in which the health care provider gives the patient information about alcohol abuse and motivates the patient to seek help.

The program, Dr. Dekker said, is most effective in preventing alcohol abuse for patients who are not yet dependent on alcohol.

"Now, if I have a patient that I know is an alcohol-dependent patient and they come in all the time intoxicated, they don't stop drinking, they go into withdrawal every time they try to stop drinking, [so] doing a brief intervention doesn't help because the patient knows and we know the patient has a significant alcohol problem. The person who benefits the most from ASBI are the people who are intermittent alcohol users, those that drink too much for them to handle and they end up making mistakes that result in injury, or they end up having alcohol-related illnesses," he said.

Dr. Dekker said he believes that ASBI can be very effective among AI/AN. He believes that the alcohol problem in Indian communities is one of binge drinking and not alcoholism.

"This is the Tony Dekker theory. I actually believe that in Indian country the major problem is binge drinking. I don't believe it is alcoholism. There are a lot of people that would say, 'Dr. Dekker is a nut.' Let me tell you why I am saying that binge drinking is a bigger problem than alcoholism. Alcoholism causes significant loss of livable years, because of Cirrhosis and because of mental illnesses that result in homelessness. Binge drinking results in people getting killed in car accidents, it results in lower thresholds for impulsive behavior, so it is related to suicidal behavior and homicidal behaviors," he said. "The common denominator for many of the Natives I see is poverty. Second off, the common denominator for many Natives who live on reservation communities is that alcohol is only intermittently available…In the Native community, you actually have to make an effort to get to the alcohol. So what happens is that you work all week long, you get the money, you drive off of the reservation, you buy six cases of beer, you drive back on the reservation. While you are driving you open up a case and start drinking while you are driving. You have your family in the back seat or in the bed of the trunk and you roll the truck and people die."

Dr. Dekker said that studies need to be done to determine whether binge drinking is the real issue. In addition, educating AI/AN about binge drinking is key. ASBI, he said, offers an opportunity for health care providers to help binge drinkers before they become alcoholics.

"We actually address two problems. We address the problem of immediate drinking and intoxication and health-related events secondary to alcohol injury or alcohol-related illness, and we provide an avenue for people to get intervention before they become alcohol-dependent," he said.

Implementing ASBI

Dr. Dekker said that ASBI will be launched this year throughout IHS hospital emergency rooms, and secondly in ambulatory care. "The biggest reward that we have to promote is that American Indians have a much higher rate of alcohol-related death, alcohol-related injuries and illnesses and that we have not had any significant intervention that has changed that. This is an opportunity for us to use intervention strategies that worked in the general community to improve the health of American Indian patients," he said.

IHS Emergency Medical Services Coordinator in the Office of Emergency Services in Rockville, Md., Dr. David R. Boyd, said that he believes that IHS can do better than the 50 per cent reduction in alcohol-related injuries and illnesses that studies have shown with ASBI, in part because of the familiarity that health care providers in the IHS system have with the beneficiaries. "We know our population. Our physicians know these people. I think we will do better than 50 per cent. I think we can do better. We know who these kids are," he said.

Diabetes: A Game of Chance and Choices

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"Diabetes is like being dealt a bad hand in a game you never intended to play," say mental health professionals, Edelwich and Brodsky (1998). They explain:

"Walking through the casino of life, you see a table marked "Diabetes" and think, "I'll pass on that one, thanks. I don't really understand the game, but I know the odds aren't good." Suddenly, you find yourself seated at the table – and down a pile of chips before you even get started. Even as you are collecting your wits, the dealer is laying down cards and picking up chips. You'd better learn the game – while there's still time. You didn't choose the game – or the stakes, which are higher than you would ever bet willingly. But diabetes isn't just a game of chance; there are plenty of choices you can make along the way, and important ones, too. There's skill as well as luck to this game. We all have our long and short suits; there's no denying that. But you can learn to minimize your losses, win some big hands along the way, and find satisfaction in meeting the challenge."

Some famous names who have played (play) the "Diabetes Game" well include: Jack Benny, Arthur Ashe, Dizzy Gillespie, Ella Fitzgerald, Mary Tyler Moore, Patti LaBelle, and Waylon Jennings. So how did (do) they do it? With a winning strategy and a winning spirit.

Their Winning Strategy: They learned all they could about diabetes, including both medical and emotional facts. For example, they learned that maintaining good blood sugar control will improve the odds of not developing complications. They learned that depression and stress are common in diabetes, and associated with less active self-care and high blood sugar levels. They put their diabetes knowledge to good use by making good choices. They recognized that the choices they made really did matter. That choosing not to take their medication, eat carefully, or walk regularly could result in higher blood sugar levels.

Their Winning Spirit: They learned to rise to the occasion. They sometimes felt angry, depressed, and/or frustrated about their diabetes. But they applied their diabetes knowledge anyway. They make smart choices about their diabetes care, and affirmed that while they had diabetes, diabetes did not have them.

Like Jack Benny, Arthur Ashe, Dizzy Gillespie, Ella Fitzgerald, Mary Tyler Moore, Patti LaBelle, and Waylon Jennings, you, too, can play the "Diabetes Game" to win. This requires:

- Learning all you can about diabetes.
- Putting your knowledge to good use by making good choices.
- Rising to the occasion, even when you sometimes feel, angry, depressed, and/or frustrated about your diabetes.
- Affirming that while you may have diabetes, it does not have you.

-This article is intended for the healthcare professional who may be seeking novel ways to educate his or her patients about the human side of diabetes. It is based on a presentation which the author made to a group of elders.

-Note: ***March is American Diabetes Alert Month***

Vitamin D Helps Reduce the Risk of Falls

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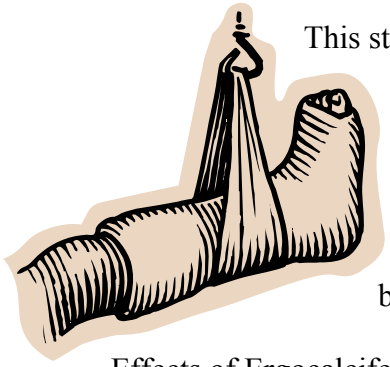
In a recent study of vitamin D supplementation those elderly women who were given 1000 miu of Vitamin D daily for one year fell 20% less often than those given a placebo or sugar pill. The average age of the women given the vitamin D supplements was 77.2 years and they were all at high risk for falls, having fallen at least once in the previous year. The effect was strongest in the winter, when there is not as much sunlight to help people make vitamin D naturally.



This study adds to others that have been published in recent years that show that vitamin D supplements help reduce the risk of fall in the elderly. Vitamin D and calcium supplements also help the elderly to develop stronger bones and decreases the chance that a fall will cause a broken bone.

One strategy we can use is to offer all elders aged 65 and older a daily supplement of a calcium and vitamin D combination. Certainly all elderly at high risk for falls should be offered calcium and vitamin D supplements.

Effects of Ergocalciferol Added to Calcium on the Risk of Falls in Elderly High-Risk Women. R.L. Prince, N. Austin, A. Devine, I.M. Dick, D. Bruce, K. Zhu. Archives of Internal Medicine. 14 January 2008, Volume 168, Issue 1, Pages 103-108.

Long-Term Care Grants Program

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Long Term Care Grants Program expected in the Spring.

Long-term care is often defined as the medical, social, and personal services needed to support elders or younger persons with disability over a prolonged period of time. In the coming months the IHS expects to publish a national request for applications (RFA) grants aimed at supporting Tribal development of long-term care services and programs. Tribes and Tribal organizations will be eligible to apply for 2 year grants for either assessment / planning (up to $50,000 per year) or implementation (up to $75,000 per year) of long-term care services or programs. We will send an email to notify Health Directors when the RFA is published; it might be worth beginning discussions about this with your elderly services programs. The last long-term care grants RFA was published in 2006.

Waist Circumference

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Many of us are familiar with using body mass index (BMI) to screen patients for overweight and obesity. Waist circumference (WC) is another measure used to evaluate body fat and is most closely associated with central adiposity. WC is obtained by measuring abdominal girth or circumference at the level of the iliac crests.
Both WC and BMI are used to estimate body fat, but evidence suggests that WC provides metabolic and cardiovascular risk information above and beyond that of BMI alone.
Like BMI, risk associated with WC is on a continuum; the higher the WC the higher the health risk. However, for ease of use within clinical practice, thresholds for elevated WC have been defined:

- *Women: WC > 88 cm (35 inches)*
- *Men: WC > 102 cm (40 inches)*

Patients with WC above these thresholds are considered at highest risk for metabolic and cardiovascular health problems. It is possible for patients who are normal weight (BMI < 25) or overweight (BMI ≥25 and <30) to have increased waist circumference and thus be at risk for obesity-related health problems.

Waist Circumference as a Health Risk Factor

Central adiposity, commonly referred to as having an apple-shaped body build, increases risk for a range of disorders including type 2 diabetes, hypertension, non-alcoholic steatohepatitis (NASH, or fatty liver), and cardiovascular disease. Excessive fat deposits in abdominal organs (visceral fat) can be toxic to surrounding tissue and cause destruction through a process called lipotoxicity. This plays a central role in NASH development and patients with metabolic syndrome are at higher risk for lipotoxicity in the pancreatic beta-cells and heart tissue, resulting in type 2 diabetes and cardiomyopathy, respectively.
In epidemiological studies, excess central adiposity is an independent predictor of certain weight-related comorbidities, regardless of BMI, gender, race, and ethnicity. WC is a better indicator of cardiovascular disease risk than BMI alone because WC is better correlated with visceral fat as compared to BMI.
Although different methods have been uses to assess abdominal fat such as waist to hip ratio, WC requires only one measurement and provides information for individual risk stratification that is just about as good as other methods of assessing abdominal fat. Technique is important when measuring WC. WC should be measured by placing a tape measure parallel to the ground at the top of the iliac crests (hip bones) and the measurement should be obtained at the end of normal expiration.

While WC is an independent predictor of risk beyond BMI in epidemiologic studies, it is clinically most useful for risk stratification in patients who are normal weight or overweight. WC provides little in the way of additional risk information for obese patients (BMI ≥ 30) since these patients are already at high-risk for obesity-related health problems and their management most likely would not change based on WC measurement.

Waist Circumference and RPMS

The RPMS has the capability for anyone who does the data entry to enter the patient's waist circumference. Like other measurements that can be queried in registries or Q-MAN, waist circumference can be queried too. This option is available to use at sites with RPMS access who are interested in implanting a Cardiovascular Risk Reduction program, Metabolic Syndrome program or Overweight/Obesity Weight Reduction Program. RPMS can retrieve those patients who meet program parameters via Registry or Q-MAN reports to "Risk Triage" patients who are low, intermediate or high risk for program development.

Body Mass Index Pointers

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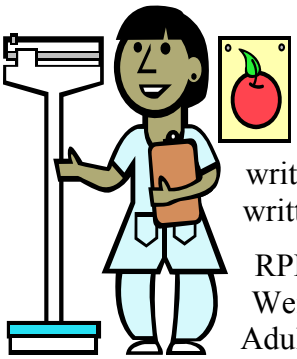
Whether or not your facility is on RPMS, BMI measures are useful for Patient Care Plans, evaluating progress of individuals or programs, assessing risk for chronic disease, and leverage for future funding and grants. BMI is in two GPRA measures: Comprehensive CVD assessment and Childhood Weight Control.

BMI does correlate in most cases to a person's weight status. It does not measure body fat directly, but is a useful screening tool. BMI numbers that cause concern should signal the need for further assessment and intervention.

The first step is to get accurate measurements, using good technique, so all staff should be measuring consistently. A great start is the online Anthropometrics training on the IHS website. (See Resources). Ideally this training could be required of new staff at orientation or as part of their yearly in-service.



Some common problems with measurements that could really mess up your data include asking and not measuring. Self-report on height or weight is not accurate and older adults may be losing height due to bone loss. Also, if height is recorded in feet and inches, it may be entered into RPMS as only inches if the writing is not clear. For example height written as 5' 2" may be incorrectly entered into RPMS as 52". Height should always be written in inches only.

RPMS does calculate BMI in the Health Summary. It will also give a % of Recommended Weight. Other ways to calculate are with a BMI chart, wheel, online calculators, or formulas. Adults and children use the same formula, but the criteria for interpreting the BMI is different for under age 19. In this age group BMI relates to age and sex.

For children, Expert Committee recommendations were released last December suggesting the category of BMI in the 85th to 95th percentile be called 'Overweight' instead of 'At Risk for Overweight'. It was thought this term was too vague and overweight can denote high weight from lean body mass as well as body fat, so was appropriate. Over the 95th percentile 'Obesity' is preferred to 'Overweight' since clinically it denotes excess body fat and the serious health risks it may have.

For adults, 'Extreme Obesity' is a newer term recommended to replace 'Morbid Obesity', a BMI of 40 and above.

RPMS and CRS determine BMI according to the parameters below.

Age Group	RPMS and CRS data
18 years and under	Height and weight measured on the same day in the last year.
19 to 50 years	Height and weight done in last 5 years, does not have to be the same day.
Over 50	Height and weight within last 2 years, not required to be the same day.

Document and enter refusals: REF (refused), NMI (not medically indicated),UAS (unable to screen). Refusals in the last year will be counted.

On RPMS, you can run reports related to your BMI data to clean it up and look for missing and incorrect numbers. On the PCC menu, go to ARP, then BMI menu. There's lots of useful stuff here! If you don't have the BMI menu option, ask your Site Manager about adding it.

Helpful Resources:

- Training for anthropometrics: www.ihs.gov click on National Pediatric Ht and Wt Study
- Online BMI calculators for adults and children.: www.cdc.gov Click on BMI calculator
- Pediatrics Dec. 2007 Supplement on childhood obesity/Expert Committee recommendations.: http://pediatrics.aappublications.org/content/vol120/Supplement_4/index.shtml

Tips for Teens' Oral Health

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At the recent American Dental Hygiene Association (ADHA) Meeting, Teen Oral Health was highlighted. Several issues such as oral piercings, consumption of sugar sweetened drinks such as soda and sports drinks, tobacco use, eating disorders, and mouthguard use are some topics to consider when treating adolescents in your clinical practice or in community settings. Several resources are available that may help the oral health professional initiate conversations about these topics, or provide valuable resources for programs or individual patient education.

Plan Carefully

At first glance, the dental staff may want to develop intensive patient education programs for all of these topic areas. However, considerable time is required to develop a comprehensive intervention. One solution may be to have patient education pamphlets available for each topic mentioned above and review these materials with your staff. Then discuss with your entire dental staff what oral health problems most often present in your adolescent population. Does your staff perceive oral piercings are increasing? Do many teens wear (or show signs of) wearing grills? Is tobacco use increasing? Once your staff has decided what the most pressing issue is, conduct an in-service on that topic with referral resources, on-line education, written patient education materials, and education strategies.

Resources

Listed below are some on-line resources for various oral health topics of interest to adolescents. In addition to these resources, check locally in your clinic and community to determine what programs or support may be available to help you with your intervention. Remember to carefully document screening information such as tobacco use and any patient education provided in a clinical or community setting.

Check these sites as you develop your patient education program:

ADHA's Fact Sheet for Teen Oral Health
http://www.adha.org/downloads/adolescents_factsheet.pdf

Ask, Advise, Refer- National organization for tobacco cessation
http://www.askadviserefer.org/

"Stomp Out Tobacco Use" Poster
http://www.adha.org/downloads/2004_NDHM_poster.pdf

American Dental Association Patient Education Resources on multiple topics such as Grills, Meth Use, Tobacco. Oral Piercings and much more. Excellent Pictures and easy to read text.
http://www.ada.org/prof/resources/pubs/jada/patient.asp

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Thanks to all who contributed to this issue of the newsletter:

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Dr. Palmeda Taylor

If you would like more information about any of the articles in this newsletter, contact the authors above.

Upcoming OPH Events

February 2008	National Children's Dental Health Month American Heart Month
March 2008	National Colorectal Cancer Awareness Month Dental Assistants Recognition Week (2-8) National Poison Prevention Week (16-22) National Native HIV/AID Awareness Day (20) American Diabetes Alert Day (23)
April 2008	Alcohol Awareness Month "Kick Butts" Day (5) National Public Health Week (6-12) National Infant Immunization Week (20-26)
May 2008	National Mental Health Month Children's Mental Health Awareness Week (4-10) National Nurses Week (6-10)
July 2008	**3rd Annual Nashville Area Health Summit** (Dates to be determined)