Nashville Area Indian Health Service

Office of Public Health Newsletter

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Next issue: January 2008
Who May Submit Articles: Anyone!
Deadline for Submissions: Dec. 15, 2007
Questions? Comments? Contact Dr. Tim Ricks, OPH Director, at 615-467-1508 or tim.ricks@ihs.gov.

2nd Annual Health Summit a Resounding Success

The Airport Marriott was the setting for the 2nd Annual Nashville Area Health Summit, held August 7-9. Over 130 people participated in the Summit, the theme of which was "Motivating Behavioral Change in Our Patients."

The first day of the meeting featured a general session on Motivational Interviewing by Dr. Robert Scales and Joseph (Bo) Miller from the University of New Mexico, national experts in the concept of motivational interviewing. Motivational Interviewing is an evidence-based approach to overcoming the ambivalence that keeps people from making desired changes in their lives, even after seeking or being referred to professional treatment (Miller WR & Rollnick S, Motivational Interviewing: Preparing People For Change. New York: The Guildford Press, 2002).

After introductions and welcoming remarks by Rear Admiral Richie Grinnell, Nashville Area Director, Mike Cook, USET Executive Director, and Commander Tim Ricks, Nashville Area OPH Director, the 80+ participants learned about the different aspects of motivational interviewing. Dr. Scales and Mr. Miller explained the concept of motivational interviewing, noting that motivational interviewing was not simply discussing with patients their health problems and telling them that they need to change, which is often the techniques health care providers use when discussing health care with their patients.

After using several audience members to demonstrate some of the basic concepts of active listening, participants were able to practice the techniques on one another. Some participants talked about the difficulty

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New Addition to OPH

The Nashville Area Office of Public Health is pleased to announce the addition of Commander Neil Dial as the Area Clinical Applications Coordinator (CAC). Neil, a pharmacist, will assist tribes on clinical RPMS issues, Electronic Health Record (EHR) implementation, and Managed Care issues. Welcome aboard, Neil!

► COVER STORY, continued from page 1

of actively listening to their motivational interviewing partner without interrupting. In fact, Dr. Scales noted that most health care providers allow their patients only 23 seconds to speak without interruption. Thus, a major focus of motivational interviewing was learning to be an active listener.

Participants listen as Bo Miller explains Motivational Interviewing. Over 80 people attending the opening session of the 2nd Annual Nashville Area Health Summit.

After several interactive practices by the audience, Dr. Scales and Mr. Miller moved into techniques on how to help lead the patient (or motivational interviewing partner) in the conversation, reinforcing their attitudes and beliefs but at the same time discussing positive changes that the patient could embrace to improve their overall health.

In the afternoon session, participants were able to watch and then practice as Mr. Miller demonstrated how to empower the patient and reinforce positive behavioral changes. The key to motivational interviewing is just that – self-empowering the patient to recognize his/her health problems, the negative behaviors that contribute to those problems, and, after education and positive reinforcement by the health care provider, the patient recognizing those positive behaviors and developing a course of action to begin them.

Overall, the presentation was well received by the diverse audience that included health care providers, other health care workers, and health administrators. To learn more about Motivational Interviewing, go to one of the following links:

► http://www.motivationalinterview.org/
► http://www.midattc.org/accessed/mi.htm

or order Motivational Interviewing, Second Edition: Preparing People for Change by William R. Miller and Stephen Rollnick, available at Amazon.Com.

Managed Care Meeting To Be Held

Wanda Lyons, CHS Coordinator

As the fiscal year draws to a close, OPH staff has been busy planning a Managed Care Training Meeting that will address **Medicare-Like Rates**, **CHS issues** and **other managed care activities** for the week of September 10-14, 2007 at the Willis Conference Center, 26 Century Boulevard, Nashville, TN. Monday and Friday will be travel days.

The Nashville Area Office is sponsoring the training and will add up to $2,000 ($1,000 for one person up to two people per tribe/Nation) to tribes/Nations Annual Funding Agreement to support the cost of sending participants.

The training is timely and relevant, and the staff is working on ideas to make it enjoyable as well as educational. So mark your calendars and come for the training; start the new fiscal year off right!

For more information, call or e-mail Wanda Lyons:
► (315) 682-3167 x18
►Wanda.Lyons@hhs.ihs.gov

Emergency Medical Services

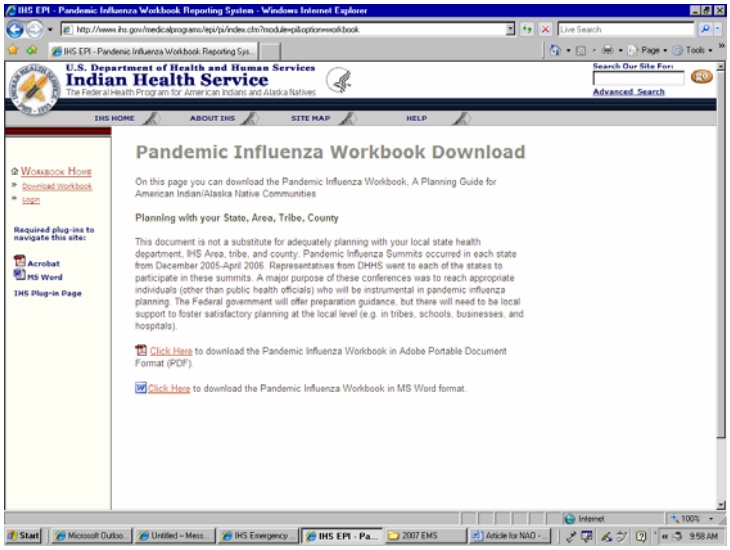
Mary Wachacha, Nashville Area EMS Coordinator
828-292-1175 or Mary.wachacha@ihs.gov

Emergency Medical Services (EMS) range from the long-standing programs such as those "full-service programs" offered by the Eastern Band of Cherokee, Mississippi Band of Choctaw, Passamaquoddy Pleasant Point, the Poarch Band of Creek Indians, and the Seminole Tribe of Florida; and, we have a new EMS tribal program at Wampanoag Tribe of Gayhead. Other Nashville Tribes are contemplating the development of their own EMS Programs. This article will briefly share information concerning many aspects of EMS services. For more information or if your Tribe is interested in discussing how to develop new EMS programs, you may contact Mary Wachacha.

TRANSAM Program: Assistance in developing Tribal EMS program may come from the TRANSAM program. The National Defense Authorization Act of 1995 created PROJECT TRANSAM. PROJECT TRANSAM is a Civilian-Military Cooperative Action Program between the Indian Health Service (IHS) and the Department of Defense (DOD) which distributes excess medical equipment and supplies (this includes reconditioned ambulances) obtained from the closure of military bases as well as other sources such as the GSA Excess program, and Direct Transfers from other Federal agencies. The TRANSAM program ensures the direct shipment and delivery of TRANSAM items to the Tribes. The Eastern Band of Cherokee is the latest recipient of a "new" ambulance. For more information on TRANSAM – go to www.ihs.gov and type in TRAMSAM in the Search slot or contact Mary Wachacha.

Hurricane Season: Hurricane forecasters expect this year's hurricane season to be busier than average. The national weather information services estimates that, in 2007, up to 16 tropical storms are likely to form, with nine of them becoming hurricanes. The Atlantic hurricane season runs from June 1 to November 30th but August typically marks the start of the most active period. Last year, there were 10 tropical storms in the Atlantic and just two made landfall in the US. The northeast is not exempt from hurricanes – bizarre weather patterns seem to be the norm in recent years and the 2007 Hurricane season may well include some cities and towns along the northeastern section of the US. Tribes need to prepare for all disasters – including hurricanes.

Pandemic Flu: Tribal programs must adequately plan with your local state health department, IHS Area Office, and county governments. The Federal government will offer preparation guidance, but there will need to be local support to foster satisfactory planning at the local level (e.g. in tribes, schools, businesses, and hospitals). The most immediate defense that Tribal programs have is to ensure that appropriate patients receive their flu and pneumovax vaccinations. The IHS has develop a Pandemic Influenza Workbook that is available on-line from www.ihs.gov

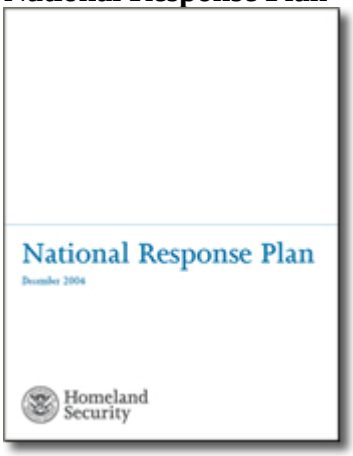


Suicide Prevention: The IHS EMS programs are being asked to work with tribal hospitals/Clinics to intervene, as appropriate, more readily in the event of suicide attempts. Assistance on interventions can be found at the Indian Health Service's (IHS) Community Suicide Prevention Website. The purpose of this website is to provide American Indian and Alaska Native communities with culturally appropriate information about best and promising practices, training opportunities, and other relevant information regarding suicide prevention and intervention. The goal of the Website is to provide Native communities with the tools and information to create, or adapt to, their own suicide prevention programs.

Alcohol Intervention: EMS personnel and Hospital Emergency Rooms are being asked, after an injury, to complete a brief negotiated interview during the appropriate teachable moment. This intervention can be the CAGE. Research has demonstrated that brief interventions can be effective in reducing re-injuries (recidivism) up to 50% for several years. For more information, contact Mary Wachacha.

National Native American Emergency Medical Services Association Meeting. Las Vegas, NV October 28-November 2, 2007 – some scholarships are available to tribal programs. In addition to the EMS meeting, there will also be a two-day Billing and Reimbursement Workshop beginning on Thursday November 1st with a morning session to include Basic Coding and afternoon session on Advanced Billing and Reimbursement. For more information, contact Mary Wachacha

National Response Plan



"One team, one goal...a safer, more secure America" - The National Response Plan establishes a comprehensive all-hazards approach to enhance the ability of the United States to manage domestic incidents. The plan incorporates best practices and procedures from incident management disciplines — homeland security, emergency management, law enforcement, firefighting, public works, public health, responder and recovery worker health and safety, emergency medical services, and the private sector — and integrates them into a unified structure. It forms the basis of how the federal government coordinates with state, local, and tribal governments and the private sector during incidents. It establishes protocols to help save lives and protect the health and safety of the public, responders, and recovery workers; prevent imminent incidenta, including acts of terrorism, from occurring; and protects and restores critical infrastructure and key resources. This guide is also available through www.ihs.gov or by contacting Mary Wachacha.

What's Nutrition Got to Do With Marketing?

Lisa Martin, MA,RD,CDE, Nutritionist Catawba Service Unit
Nashville Area Nutrition Contact

The idea of **Social Marketing** is not brand new, but it bears looking at because as Health Providers we truly are competing with private corporations with huge advertising budgets as we 'sell' our ideas about health, nutrition, etc. Occasionally, we may feel we are waging a losing battle against food and beverages that are cleverly marketed but may or may not have any redeeming nutritional qualities. Fighting back with equally clever marketing is a smart strategy.
READ ON for a few pearls of wisdom and resources from Health Summit presenters and the audience:

Start thinking of your patients and community members as consumers. Find out what they perceive as barriers and benefits of changes such as eating more fruits and vegetables, being more active, or eating less fast food. Plan *with* them, not *for* them. If a new behavior can be presented as **Easy**, **Fun**, and **Popular**, it's more likely to be accepted by more individuals. Making lists of perceived benefits vs. perceived barriers to a behavior is helpful Working on the lists till the benefits outweigh the barriers will give you your marketing strategy. Understanding what your target group is thinking is the key.

For example: In one community no one signed up for a 'Weight Loss *Contest*' (sounded like too much work), but later, after doing some research, the organizers had more than the expected number sign up for a 'Weight Loss *Competition*' (sounded like fun).

In the long run it pays to do some surveys, community assessments, or focus groups to find out what your target audience wants. If you have ever done any of these, you know the results are often different than what **YOU** might think people want to learn about or do. These don't have to be complicated and can be done by support staff, such as CHRs, or help from a local college with a Social Work program. Short surveys in the waiting room are another way to find out what a particular group likes. For instance, when sports physical season starts, a survey to find out what youth activities might be popular should be easy to do as people are waiting.

Good resources:
►Promoting Community Change: Making it Happen in the Real World, by Mark S. Homan
►www.ihs.gov/hpdp Click on Best Practices, Training and other links for good ideas.

On the topic of Workplace Wellness programs, all of the above also applies. If the tribe has a HPDP-Health Promotion/Disease Prevention Committee, this may be an area they can take on. Include on your team folks who may be less health-conscious than the others to give some good insight. Vending machines in schools and workplaces are an easy place to start. Working with a supplier to stock more water, sugar free drinks, or better snack options gives people more choices. Healthy Beverages Community Action Kit, a wonderful how-to manual for help with this can be downloaded from the IHS website:
►http://www.ihs.gov/medicalprograms/diabetes/resources/healthbev06_index.asp
Other resources to help with Workplace Wellness Programs and Ideas:
►http://www.welcoa.org
►http://www.the-hero.org
►http://www.healthpromotionjournal.com

Workplace potlucks provide folks who are otherwise not interested in 'healthy' foods another opportunity to try something tasty and low fat. Here's a recipe by the Pharmacist at Catawba, Rosalind Chorak, that frequently shows up at Staff Pot Lucks. It's so delicious no one would even notice they were getting lots of fiber and vitamins along with their salsa. So it fits the description of Easy, Fun and Popular!

Black Bean Salsa

1 15 oz. can black beans, rinsed and drained
1 15 oz. can corn (any type-niblets, white corn-your choice), drained
1 16 oz. jar of your favorite bottled salsa
2 Tbs. Cilantro, chopped, or more, to taste
Optional but not necessary- lime juice, mint, cumin or other spices.

Mix all ingredients; chill if you have time. Serve with tortilla chips. Double the amount for a potluck

Utilizing Traditional Storytelling To Promote Wellness

Michelle Ruslavage, BSN, RN, CDE
Nashville Area HP/DP Coordinator

In an article from the *Journal of Transcultural Nursing,* Vol.13 No.1, January 2002 6-11, Utilizing storytelling to transmit educational messages is a traditional pedagogical method practiced by many American Indians tribes. American Indian stories are effective because they present essential ideas and values in a simple, entertaining form. Different story characters show positive and negative behaviors. The stories illustrate consequences of behaviors and invite listeners to come to their own conclusions after personal reflection. Because stories have been passed down through tribal communities for generations, listeners also have the opportunity to reconnect and identify with past tribal realities.

Cranberry Day: A Wampanoag Harvest Celebration is just one of many stories that have been put into print. Others stories that have been put to print from a collaboration between IHS and CDC are *Through the Eyes of The Eagle, Knees Lifted High, Plate Full of Color, and Trick Treats*. (These can be obtained for a nominal fee of 50 or more from the web-linked provided http://www.cdc.gov/diabetes/pubs/eagle.htm. The books or story telling can be used in Head Start Programs, Well child visits, Dental visits, Community health fairs, schools, and after school programs.

Some of the stories used fall into one of the three types:

1. **Creation stories**, which recount the giving of life to American Indians.
2. **Origin stories**, which explains the roots of a problem or event.
3. **Animal stories**, which use animal characters to personify human traits. Coyote for example is the traditional trickster; Owl is wise, and Snake is clever.

The storytelling has also been used in Talking Circles as noted in *Cancer,* Vol. 78 No. 7, October 1996 1592-1597. A cervical cancer screening and prevention project focused on developing a culturally acceptable mode of communication called Talking Circles. They used the Talking Circles format to provide cancer screening education and to improve adherence to cancer screening.

A **Talking Circle** is commonly composed of 5 to 10 members, who meet periodically to share information, support, and/or to solve problems. A Talking Circle facilitator opens a session with a traditional story and the health topic, then the floor is opened to the participants for discussion.

So, what are your local stories, who are the keepers of the stories, where are they kept for people to access, when do you use them and finally how are they used in promoting wellness in your communities?

Infective Endocarditis Guidelines Revised

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

The American Heart Association (AHA) released new guidelines for Infective Endocarditis prophylaxis in April 2007. The new guidelines significantly change previous protocols that included antibiotic prophylaxis for dental procedures in patients with many cardiac conditions. According to the AHA:

> *Taking antibiotics before certain dental procedures and surgeries is not necessary to prevent infections of the heart muscle in people who do not have an established heart defect or problem. In fact, the risk of such drugs can outweigh the potential benefits, which are small in the general population, according to a large group of experts from many medical fields who looked at the current medical data on the topic.* [1]

Taking antibiotics before certain dental procedures and surgeries is not necessary to prevent infections of the heart muscle…the risk of such drugs can outweigh the potential benefits…

The new guidelines recommend prophylaxis for only most serious cardiac conditions. These include individuals:

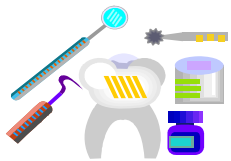
- With artificial heart valves.
- Who have already had infective endocarditis.
- Whose serious congenital heart defects have been incompletely repaired or have not been repaired.
- Who have a congenital heart defect that that was completely repaired using artificial material or a device for six months after the procedure.
- Whose heart defect was repaired but who have some of a defect near a patch or device made of artificial material.
- Who have had a heart transplant but has a defect in a heart valve.[1]

The full American Heart Association report can be viewed on the American Dental Association (ADA) website:
http://www.ada.org/prof/resources/topics/infective_endocarditis.asp

Tips for Advising Patients on the New Guidelines

Many patients have taken prophylactic antibiotics for heart murmurs or other cardiac conditions that no longer require this precaution. Such patients may be reluctant to forgo premedication for dental appointments. To address these concerns the American Dental Association suggest discussing the following:[2]

- The new guidelines are based on increasing evidence that the risks of taking antibiotics outweigh the benefits. Risks include adverse reactions to antibiotics as well as developing drug resistant strains of bacteria.
- The heart is exposed to bacteria every day through routine activities such as eating and brushing. Daily care and healthy gums are the best protection.
- Some people with no history of a cardiac condition develop IE and others who take the recommended dose of antibiotics still develop IE
- Patients and families should consult with their primary care physician regarding IE prophylaxis



What You Should Do

Physicians:

1. Review the AHA guidelines to determine which patients should receive prophylactic antibiotics for dental procedures.
2. Advise patients and families of the recommendations and the reasons for changes.
3. Advise the patient's dental provider IN WRITING of :
   a. A change in recommendation or,
   b. A continuing recommendation for prophylactic antibiotics.

Patients and Families:

1. Review the new AHA recommendations.
2. Consult with your primary care physician or your dentist regarding your need for prophylactic antibiotics.
3. Relate your informed decision to your physician and dentist.

Dentists:

1. Review each patient's updated medical history to determine if the patient falls into a high risk category for IE.
2. If there has been no written recommendation for antibiotic prophylaxis and the patient's condition is not in the current guidelines for IE prophylaxis, consider discontinuing antibiotic prophylaxis for dental procedures.
3. If the patient's physician HAS recommended antibiotic prophylaxis (either orally or in writing), consult with the physician for the need of continued antibiotic treatment before providing dental care.

Medical Ethics

Changes in recommended treatment will often cause concern and be a potential source of disagreement between patients, families and providers. In considering whether to premedicate or not, the relevant medical ethics principles are: patient **autonomy** (patients have the right to be involved in decisions regarding their medical care), **beneficence** (all medical treatment must produce a clear benefit), and **nonmaleficence** (do no harm).[3] According to the principle of informed consent, competent patients have the right to accept or refuse medical treatment.[4] However, medical providers are under no obligation to offer treatment that will not benefit or may harm a patient.[3] If a patient and dentist are at an impasse regarding the appropriate course of treatment, the best way to resolve the issue may be a joint consultation with the patient, family, primary care physician, cardiologist (if appropriate), and the dentist. During the consultation all relevant issues of risks and benefits can be presented and a course of treatment developed. Such a consultation may be very time consuming, but it will communicate to the patient the seriousness of the issue, the most recent scientific evidence available, and the desire of the entire health care team to provide the best possible medical treatment.

Policies and Procedures

Both medical and dental providers should review existing Policy and Procedures regarding Antibiotic Prophylaxis. Because the recommendations changed significantly, existing policies will need to be revised to comply with AHA recommendations. A sample policy for IE Prophylaxis is available on the United South and Eastern Tribes, Inc. website at www.usetinc.org. From the USET home page, select Dental Support Center.

The sample policy SHOULD NOT be used as is. Providers should consult with appropriate medical, dental and administrative staff to determine appropriate Policy format and language. It IS recommended to adopt the content of the policy because the values in the sample policy comply with AHA recommendations as these form current Standards of Care.

References

1. American Heart Association, (2007)Prevention of infective endocarditis. Accessed 8/18/07: http://www.americanheart.org/presenter.jhtml?identifier=3048396
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3. Beauchamp TL, Childress JF. (1994). Principles of biomedical ethics. New York, Oxford University Press.
4. American Medical Association, (2007). Informed consent. Accessed 8/18/07: http://www.ama-assn.org/ama/pub/category/4608.html

Substance Abuse and Its Effect on Child Welfare

Liz Neptune
Nashville Area Acting Substance Abuse Consultant

Across tribal communities we are seeing a resurgence of substance abuse. New drugs of choice are entering our communities and making them less safe for our children and families. Methamphetamine and opiate use are sweeping tribal communities. The Northeastern tribes have epidemic opiate addiction with the widespread highly addictive misuse of prescription drugs. Southern, Central and Western Tribes are being inundated with Methamphetamine. Alcohol is also once again on the rise. The result has been devastating for child well being. Currently, according to NICWA figures, **85%** of tribal children in child welfare custody come from families affected by substance abuse. In the non-native population the numbers are also epidemic but lower with an estimated 65% of child welfare cases involving substances.

The nature of substance abuse is that it puts the substance needs of the parents before the welfare of the child. For many children this means that to support a habit a parent will sell food stamps, furniture, clothes, virtually anything to maintain their drug or alcohol needs. Children, especially young children, are most vulnerable and are living in situations where there basic needs are not being met. Often children are left unattended or are dealing with parents whose judgment is impaired by their addiction. Parents in their pursuit of their drug are unavailable to the needs and demands of their children. Lack of supervision and lack of provision of basic needs is leading to more children being in child welfare custody in our communities. It is also interrupting the developmental process of childhood, putting the child at risk for failure in school, mental health issues and eventually substance abuse issues. Treatment choices are scarce and many parents are in a revolving door with child welfare in which they regain custody only to loose it again because they have not received adequate treatment for their substance abuse. *Parents and their children are both victims of the addiction.*

Depending on the substance, the child may be in heightened physical danger of abuse. Alcohol and methamphetamine are "uninhibitors" of violence. An angry parent who when sober or straight might not be physically confrontational may become that way when under the influence. Methamphetamine use can cause psychotic thought processes and severe paranoia. Communities have seen a rise in serious physical abuse as Meth takes hold with parents lashing out and children becoming the victims. Younger children are at the greater risk with babies who place the greatest demands on parenting being the most at risk of serious harm or death.

The addiction cycle may due what generations of trauma and historical abuse have been unable to do. It may break our native family structure and fracture our communities. The issue is not a child welfare issue or just a substance abuse issue. It is a crucial community health issue. We need to be teaching the effects of substance abuse on families and parenting. We need to be actively involved in prevention programs. We must educate the entire community for the signs and symptoms of abuse and its implications. Every child who loses a parent to substance use even if the parent is still in the next room is at risk of repeating the cycle.

New Dental Services: Catawba, Micmac

Tim Ricks, DMD, MPH, Nashville Area Dental Consultant

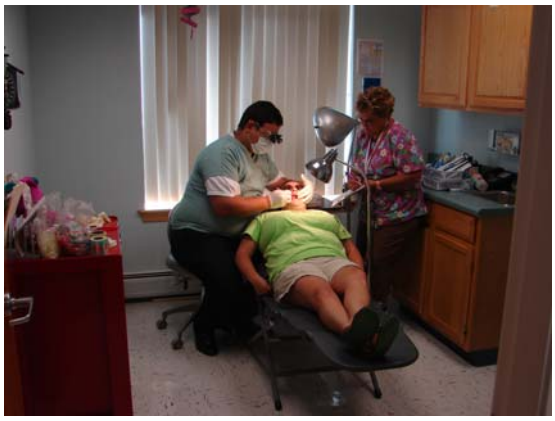
Drs. Tim Ricks and Cathy Hollister recently provided dental screenings to over 225 patients at the Micmac Service Unit in Presque Isle, Maine, and the Catawba Service Unit in Rock Hill, South Carolina. These two programs are on the verge of beginning new dental programs to address the oral health needs of their communities.

The purposes of the dental screenings were:

►Identify patients with urgent needs so that appropriate referrals could be made;

►Identify overall community needs to aid in the recruitment of dental staff catered to those needs;

►Allow the Area Dental Officer and Dental Support Center to work directly on patients, to aid in future dental program planning activities and to maintain clinical relevance.



Dr. Ricks, with Deborah Roshon, LPN, assisting, examines a patient at the Micmac Service Unit in August 2007.

At the Micmac Service Unit, over 80 patients were evaluated in a 3-day period in August 2007. Many of the patients received fluoride varnish in addition to the evaluation. Plans call for the initiation of part-time comprehensive dental services at Micmac beginning by January 2008.

At the Catawba Service Unit, 145 patients were evaluated in two 4-day periods in July and August 2007 by both Dr. Ricks and Dr. Hollister. Again, many of these patients took part in the fluoride varnish program, a program that will be assumed by the medical program until the new 4-chair clinic is built and ready for operation in the early spring of 2008. Dental staff, which will consist of a full-time dentist, dental hygienist and two dental assistants, recruitment will begin in the next few months, with staff set to be in place by February 2008.

Staff assisting dental at the Catawba Service Unit include (L to R): Melissa Martin, Beth Sanders, Karen Beck-Lyner, and LT Tonya Cornwell, RN.

Staff assisting dental at the Micmac Service Unit were Debbi Roshon, LPN (left) and Lynn Maillett (right).

A special thanks to those who helped make the dental screenings happen, especially Beth Sanders at Catawba and Debbi Roshon at Micmac – two great dental assistants!

Micmac becomes an IHS Integrated Diabetes Education Program

Dianna Richter, RD, MPH, CDE, Nashville Area Diabetes Consultant

Aroostook Band of Micmac recently received notification of their accreditation as an IHS Integrated Diabetes Education Recognition Program for the upcoming 3 years. Aroostook Band of Micmac becomes the third tribe in this Area to receive this credential. Other tribes include Oneida Indian Nation, and Mississippi Band of Choctaw. Eastern Band of Cherokee's diabetes education program is recognized from the American Diabetes Association (ADA). These tribes are to be commended on their efforts to provide this accreditation.

The IHS Recognition Program acknowledges quality diabetes education and care services offered by a tribe within the community. Currently, the ten standards of the National Standards for Diabetes Self-Management, May 2000 are the framework for IDERP, and local programs are measured via a comparison to these nationally accepted standards. Each of the ten standards is divided into three sections: developmental, educational and the integrated public health approach. Programs applying for the IDERP must meet the review criteria listed in the developmental (level 1) and educational (level 2) sections. The ADA uses the same 10 Standards of Diabetes Self-Management for their recognition program. The IHS and ADA education recognition programs are approved by the Centers for Medicare and Medicaid Services (CMS) as national accreditation organizations. Programs accredited by these organizations may be eligible to seek Medicare reimbursement of their diabetes self-management education (DSM E).

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Further information is available from the following link Diabetes National Program, as well as from Dianna Richter, USET Diabetes Consultant at drichter@usetinc.org

The Three-Stage Approach to building successful programs

Level 1 - Developmental
Completion of all elements at this level shows your community that your health services are starting work to develop a quality diabetes program.

Level 2 - Educational
Completion of all elements at this level shows your community that you provide quality diabetes education services.

Level 3 - Integrated Diabetes Program Completion of all Elements
At this level shows your community that you provide quality diabetes education, clinical and public health services. Recognition at this level is the best you can be! It means that your facility offers the best in diabetes care and education practices. This includes community-wide prevention programs, diabetes clinical systems and educational programs for people with diabetes and their families.

Credentialing and Privileging

Bruce Finke, MD, Nashville Area Acting Chief Medical Officer

Credentialing is the process of obtaining, verifying, and assessing the qualifications of a healthcare practitioner requesting to provide patient care services in or for a health care organization.

Privileging is the process through which a clinic or hospital ensures that their practitioners are working within their scope and skills when they provide care.

We credential and privilege practitioners because it ensures that the professionals caring for our communities are who they say they are, have the training and the skills that they say that they have, and work within their areas of expertise. It is also an essential step toward accreditation, either AAAHC or JCAHO, and many states require it as a condition of participation in the Medicaid Program. A system for credentialing practitioners is an essential part of a quality medical program.

The Albuquerque Area has led the way in the Indian Health System by developing standardized processes to support credentialing and the Service Unit and Tribal program. Cora Boone, the Albuquerque Area Credentialing expert will be training Mollie Denson in the Area Office to play a similar role for the Nashville Area Tribal hospitals and clinics and the federally operated health centers. As a part of this process Cora will be holding a training in Catawba on September 12th where she will provide a basic introduction to credentialing and share applications and policies. We are grateful to the Albuquerque Area for sharing Cora's expertise with the Tribes and Services Units of the Nashville Area.

Facts About Falls and the Elderly

Bruce Finke, MD, Nashville Area Elder Care Consultant

- More than one third of adults 65 and older fall each year in the United States (Hornbrook et al. 1994; Hausdorff et al. 2001).
- Among older adults, falls are the leading cause of injury deaths. They are also the most common cause of nonfatal injuries and hospital admissions for trauma (CDC 2006).
- In 2004, 14,900 people 65 and older died from injuries related to unintentional falls; about 1.8 million people 65 and older were treated in emergency departments for nonfatal injuries from falls, and more than 433,000 of these patients were hospitalized (CDC 2006).
- The rates of fall-related deaths among older adults rose significantly over the past decade (Stevens 2006).
- Twenty percent to 30% of people who fall suffer moderate to severe injuries such as bruises, hip fractures, or head traumas. These injuries can make it hard to get around and limit independent living. They also can increase the risk of early death (Alexander et al. 1992; Sterling et al. 2001).
- Falls are the most common cause of traumatic brain injuries, or TBI (Jager et al. 2000). In 2000, TBI accounted for 46% of fatal falls among older adults (Stevens et al. 2006).
- Most fractures among older adults are caused by falls (Bell et al. 2000) and the most common fractures are of the spine, hip, forearm, leg, ankle, pelvis, upper arm, and hand (Scott 1990).
- Many people who fall, even those who are not injured, develop a fear of falling. This fear may cause them to limit their activities, leading to reduced mobility and physical fitness, and increasing their actual risk of falling (Vellas et al. 1997).
- In 2000, direct medical costs totaled $0.2 billion ($179 million) for fatal falls and $19 billion for nonfatal fall injuries (Stevens et al. 2006).
- The risk of being seriously injured in a fall increases with age. In 2001, the rates of fall injuries for adults 85 and older were four to five times that of adults 65 to 74 (Stevens et al. 2005).
- Nearly 85% of deaths from falls in 2004 were among people 75 and older (CDC 2006).
- People 75 and older who fall are four to five times more likely to be admitted to a long-term care facility for a year or longer (Donald et al. 1999).

From:
http://www.cdc.gov/ncipc/factsheets/adultfalls.htm.
Accessed August 24, 2007

The 2nd Annual Health Summit: Dental Meeting

Dr. Tim Ricks, Nashville Area Dental Officer

Over 30 people participated in the Annual Dental Meeting, and half of these attended the Motivational Interviewing General Session on August 7th.

The Dental Meeting began with welcoming remarks by Rear Admiral Richie Grinnell, Area Director, who highlighted the strong working relationship between the Area Dental Office and Dental Support Center. This was followed by Dr. Cathy Hollister, Dental Support Center Director, who discussed the roles and responsibilities of her office and the Area Dental Officer.

Day 1 speakers included several distinguished speakers, including Rear Admiral Chris Halliday, Chief Dental Officer of the U.S. Public Health Service and Chief Dental Officer of the Indian Health Service, who spoke to over 30 participants about the importance of integrating dentistry into overall health and "thinking outside the box" by finding innovative ways to address oral disease burdens in the communities we serve. His interactive presentation was enhanced by a number of non-dental folks (mostly CHRs) posing questions and offering solutions for dental problems.

Following RADM Halliday, three state dental directors and an urban program spoke on various topics. One reason for inviting state dental directors to the meeting was to show participants how tribal and IHS sites could work more closely with the states in addressing oral health disparities. Dr. Lynn Mouden, the State Dental Director of Arkansas, and the founder of the world-known "Prevent Abuse and Neglect Through Dental Awareness" (PANDA) spoke for two hours on child abuse prevention and family violence prevention, a difficult subject but important for dental staff to hear and understand their responsibilities in reporting. Susan Roth, the Director of Native American Lifelines in Baltimore, presented on how oral health affected socioeconomic status and provided the audience with a handful of successful cases. Dr. Mark Mallatt, the State Dental Director of Indiana, provided the audience with information on methamphetamine abuse and its oral effects. Dr. Nick Mosca, the State Dental Director of Mississippi, discussed community-based approaches in addressing oral diseases, and this was followed by an interactive discussion on the Government Performance and Results Act (GPRA) indicators, with participants helping outline some successes in meeting GPRA dental objectives by "thinking outside the box."

The second day of the dental meeting began with presentations by Mary Wachacha on health education documentation and Dr. Ricks on dental documentation and coding. Dr. Carl Gustke, a Coast Guard periodontist, provided the audience, by this time all dental, with information on managing patients with periodontal disease and periodontal instrumentation. Kit Grosch, Environmental Health Officer, provided an interactive infection control presentation to the group, discussing the "If Saliva Were Red" video (which is available at the Area Office). Finally, Dr. Bruce Finke provided the audience with an overview of the IHS Chronic Care Initiative, followed by Dr. Brian Berg discussing how dentists can be involved in the initiative, especially in the area of nutrition.

Nashville Area Dental Awards:

IHS Clinical Excellence Award (national award):
Dr. John Otteson, Oneida

Excellence in Dental Assisting:
Carol Taylor-Sprague, Pleasant Point

Excellence in Dental Hygiene:
Florance Thomas, Miccosukee

Excellence in Clinical Documentation:
Dr. Brian Berg, MS Choctaw

Program Accomplishment: Dental Prevention
MS Choctaw, Cherokee

Program Accomplishment: Infection Control
Penobscot

Congratulations!

The 2nd Annual Health Summit: Behavioral Health Meeting

Palmeda D. Taylor, PhD, Nashville Area Psychologist

The Annual Behavioral Health Conference/Meeting of the Nashville Area Indian Health Service, Office of Public Health, was held in conjunction with the Area's 2nd Annual Health Summit. Total meeting attendance was at 46, with attendees representing 16 Nashville Area Tribes and all three urban programs. A carefully selected panel of tribal and non-tribal health care professionals and educators applied their knowledge and expertise to the conference/meeting sessions. Presenters also included staff from Headquarters, Indian Health Service, and the United South and Eastern Tribes, Inc. (USET). Participants were awarded continuing education unit credits by Tennessee State University.

On the second day of the Health Summit, the Behavioral Health Meeting began, with Bo Miller and Dr. Robert Scales continuing their presentation on Motivational Interviewing from the first day, largely to an audience of behavioral health professionals. Whereas on the first day of the Summit the presenters introduced participants to fundamental skills and strategies for motivating patient adherence, the presentation goals for the second day were to identify more advanced skills/strategies for inspiring change in primary care patients and provide opportunities for skill rehearsal. Demonstrations on/practice with "rolling with patient resistance" were particularly helpful, and left participants wanting more of the same.

The aim of Day 3 was to present available evidence on effective prevention and intervention initiatives/programs in Indian Country today; encourage the integration of behavioral health in Nashville Area primary care facilities; educate participants about methamphetamine (meth) use in general, and about meth use among Native Americans, particularly; address the core issues surrounding substance abuse case management; and showcase a Nashville Area model program for effective case management.

Bryan E. Wooden, LICSW, LCSW-C, DCSW, Deputy Director for the Division of Behavioral Health, Indian Health Service, provided his division's perspective relative to the Director's 3 Initiatives, GPRA, Suicide Prevention, and Meth Reduction. Christy Duke, MPH, USET epidemiologist, described her program's current efforts to promote the overall health of Nashville Area tribal communities through data-driven models pertaining to substance use/abuse. Christina Krause, PhD, Aurora University, and Maria Kuhn, Integrated Health Advocacy Program, Geneva, Illinois, advocated for the use of an integrated "whole-person" approach in the delivery of primary health care services to "participants" vs. "patients". Dr. Susan Dreisbach, University of Colorado at Denver, identified meth use as a serious problem in Indian Country, stated the reasons why, and gave suggestions for preventing HIV/STD and other diseases among meth users. Dr. Kathy Masis, USPHS (ret), provided a method for addressing meth use in primary care, and shared the "good news" that people can and do successfully recover from meth use/abuse. Dr. Frances Clark, Behavioral Health Director, Metro Nashville Public Health Department, built a strong case for case management in primary care and identified the role and characteristics of a culturally competent case manager or single point of contact. Finally, Mose Herne, MA, Associate Director for Behavioral Health, and John Szwyd, MS, LCDC, Tecumseh House Director, North American Indian Center of Boston (NAICOB), described NAICOB's multidisiciplinary case management practices, and facilitated a mock treatment team meeting, stimulating a lively group discussion.

Overall, the 2007 Behavioral Health Conference/Meeting evaluations were positive with regard to content, presenters' knowledge and style of delivery, relevance to the objectives, and accommodations. The meeting was deemed a success. Planning for next year's meeting has already begun.

Thank you to all who participated in this meeting!

The 2nd Annual Health Summit: HP/DP Meeting

Michelle Ruslavage, BSN, RN, CDE
Nashville Area HP/DP Coordinator

If you attended the HPDP breakout session, you would have thought you were a game show contestant. This year we utilized an Audience Response System (ARS). The ARS is an interactive data system that gathered real time attendee responses to questions provided by the presenters. The questions came in True/False, Multiple Choice and Yes/No formats. To ensure everyone understood how to use ARS, we started with some opening questions:

"Dr. Grim is the Director of IHS"
True or False
(We had a 100% correct response rate, thank goodness)

The ARS also provided information that 81% could correctly identify Dr. Grim's 3 Initiatives. The remaining 18% were equally divided among the remaining 3 multiple choice responses.

The Translating Community Assessment into Action presentation was well received by the attendees who ranked the overall presentation 4.65 out of 5. During the presentation 36% responded as having no experience with community assessments and of those that had some experience, 66% responded they received no feedback and were unaware of feedback to the community about the results.

Worksite Wellness Programs went over very well too, scoring 4.79 out of 5. Attendees learned how to apply *"Population Based Group"* approach to employee worksite wellness, new concepts and terminology such as *"Presenteeism"* and revisiting *"Health Risk Appraisals"* which 89% of the attendees answered correctly.

The Social Marketing Fundamentals presentation received the highest marking of 4.8 out of 5 and the presenter receiving 5 out 5. Those in attendance received an eye-opening figure that food, beverage, candy and restaurant advertising hit $11.26 b-b-billion in 2004, compared to a mere $9.55 m-m-million to advertise the "Five-A-Day" campaign, which promotes eating five or more servings of fruits and vegetables daily.

So, it was not surprising when the attendees were asked "How many sites have a budget to counter the food, beverage, candy and restaurant message being delivered?", the response rate for "No Budget" was 100%.

The beauty from the all-day presentation (this is usually a 4 day training) was that it was the very tip of the Social Marketing iceberg that provided the attendees with:

1. Information about what social marketing is and is not.
2. The reality that you do not need an astronomical budget to compete but rather a modest budget for social marketing training and implementation would suffice (The work smarter not harder approach).
3. Fundamental skills and tools attendees could take back to practice.
   and
4. Stressing the importance of community involved respecting the value of their input.

Due to the overwhelming response for Social Marketing training, I am looking forward to working with those sites who have requested such services.

In closing, a big thank you to attendees for your comments and feedback, supervisors for juggling staff coverage, and colleagues who held down the clinics.

"Of all the Health Summit Joints in all the towns in all the world, she walks into mine."

The 2nd Annual Health Summit: CIP Meeting

CAPT Michael Rathsam REHS, MSEH
Deputy Emergency Management Coordinator
Area Community Injury Prevention Specialist

This article has been written for those of you who missed the Community Injury Prevention presentations at this year's HEALTH SUMMIT. We all were disappointed that you couldn't attend but then there is always next year! Here are just a few of the highlights and how participants rated individual presenters. Our first day started off with Richard Malone, Deputy Senior Medical Investigator, from Gallup, New Mexico. Mr. Malone has investigated over 1,000 motor vehicle crash deaths in past years, many of which were on the Navajo Nation. He carefully and effectively visually reconstructed and shared numerous crash scenarios with both professionalism and passion. He consistently made the correlation between contributing factors such as fatigue, faulty vehicle maintenance, substance abuse, and not wearing seatbelts with the fact that motorists choose whether or not to drive. The person that chooses to drive when fatigued is at greater risk for ending up in a crash/collision that is someone that is alert. Similarly, the person that chooses to drive without using their seatbelt is 50% more likely to sustain serious injury in a crash, than someone that does use their seatbelt. Crashes are predictable and therefore they are preventable. Mr. Malone entitled his presentation "Choose to Live" and those that experienced his presentation honored him by giving him perfect scores.

Our next scheduled presenter was Ms. Carmen Hayes, Deputy Regional Administrator, National Highway Traffic Safety Administration-Region IV. Unfortunately, her 6:30 am flight from Atlanta, Georgia had been cancelled. She called to ask whether the agenda could be altered and, after being assured that it could, Ms. Hayes drove 4.5 hours arriving at 11:30 am. Her presentation outlined NHTSA's role and numerous programs designed to prevent severe injury resulting from motor vehicle crashes. NHTSA Region VI oversees funding of the BIA Highway Safety Program in Albuquerque, NM. The BIA Highway Safety Program reportedly has an abundance of highway safety related funding and not enough projects to fund! Perhaps Nashville Area/USET Tribes would like to apply?

Next to present was SGT Gary Kemper of the Metro Nashville Specialized Investigation Unit – Gangs. SGT Kemper shared photos and personalized comments of numerous Nashville Gangs. He explained their origins, colors, symbols, and relationships with other tribes. He further explained how gangs survive and why members are unwilling to leave. SGT Kemper's presentation was excellent and attendees gave him perfect scores. Attendees further expressed their desire to have SGT Kemper return next year and to allow more than 1 hour for his presentation.

After lunch, Bernard Alkire, PhD from Michigan Technological University provided guidance for conducting Road Safety Audits. Among other responsibilities, Dr. Alkire is the Director of a Regional Tribal Technical Assistance Program (TTAP) which was established to serve as transportation consultants for Eastern and Southern Tribes. Funding for the TTAP comes from the Federal Highway Administration and training is what the TTAP does best. Any Tribe that is concerned about Transportation issues, including roadway/highway design, safety, and maintenance issues can request assistance from the TTAP. We plan to invite Dr. Alkire to provide more extensive trainings and hope that you will make sure that appropriate personnel attend.

All work and no play isn't much fun …… so it was great when the last presentation for the day was given and 22 attendees shared dinner and entertainment in downtown Nashville at B.B. Kings. Both the food and music were terrific…..rumor has it that all 22 were seen up and dancing at the same time!

Our second and final day focused more on hands on Community Injury Prevention Program Activities. Nashville Area's Acting Chief Medical Officer, Dr. Bruce Finke spoke eloquently about piloting an Elder Fall Prevention Project and several Tribes have received special funding for implementation. Lynne Thompson, St. Regis Mohawk and Eldon Espling, Aroostook Band of Micmac combined to provide an excellent explanation of their experiences developing and implementing Home Risk Assessments. Both received perfect scores! Attendees were then trained to conduct seatbelt surveys that reduce bias from the results. After a short classroom presentation, participants were separated into 3 groups and each group went to a different location (via motorized vehicle) to conduct a survey. Results were discussed over lunch at the Cracker Barrel Restaurant!

The afternoon concluded after a presentation by CAPT Mickey Rathsam, Nashville Area Community Injury Prevention Specialist, on the topics of Injury Data Collection and a special project CAPT Rathsam conducted on the West Coast regarding the timing of amber intervals at signalized intersections and the correlation amber interval timing has on red-light running. The Institute of Transportation Engineers (ITE) has a specific formula that should be used to provide motorists with adequate time to "clear" an intersection. If the formula is not followed, drivers face the dilemma whether to run a red light or stop abruptly risking collision from behind. Videos of local news segments regarding amber intervals were shared with participants. The content of videos documented a process that resulted in updating of 250+ traffic timing units, the use of the ITE formula, and a reduction of motor vehicle crashes at signalized intersections.

We hope you'll join us next year! Until then, "**Choose to Live!"**

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

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