Importance of Improving the Quality and Timeliness of Drug Overdose Death Reporting.

LT Carissa Haney, MSN, APRN-BC, USPHS, Nurse Practitioner, Centers for Disease Control and Prevention

Cause of death data are the basis for epidemiological studies and medical research. At both the state and national level, mortality data compiled from death certificates is used to track disease trends, set public health policies, and allocate health and research funding. In 2016, there were more than 63,600 drug overdose deaths in the United States (Hedegaard, 2017). Deaths from drug overdose are an increasing public health emergency in the United States. Deaths are classified using the International Classification of Diseases, Tenth Revision (ICD10). Several factors influence drug overdose reporting including certifier training and reporting on the standard certificate of death, state use of electronic death registration systems (EDRS), ICD10 expertise of the medical technician with drug overdose terminology and coding, as well as the Medical Examiner or Coroners ability to identify and report the overdose and the lag time between time of death and toxicology screening. For us to navigate this myriad of influences there needs to be a holistic approach to gathering and disseminating the most accurate information to improve quality of life, reduction in the number of drug overdoses, improve research in the field of addiction, as well as make an impact on the opioid mortality crisis that currently plagues our country.

At the end of this session attendees will be able to:

- Describe the role of the CDC’s collection of data and dissemination of mortality reporting.
- Present recommendations for improvement of drug overdose reporting.
- Identify factors that affect the quality of drug overdose death reporting.

Public Health/Private Healthcare Sector Initiatives to Forward Domestic Tuberculosis Elimination

Erica Stockbridge, PhD, MA, USPHS, Assistant Professor, Health Services Research, University of North Texas Health Science Center; Thaddeus Miller, DrPH, MPH, Associate Professor, University of North Texas Health Science Center

US public health agencies have long strived to achieve the goal of domestic tuberculosis (TB) elimination, but progress towards this goal has stalled in recent years. Given that an estimated 86% of new TB cases occur in individuals who had latent TB infection (LTBI) that progressed into active TB disease, renewed headway could be made by better addressing LTBI in the up to 13 million people in the US with the condition. While public health agencies have historically provided TB control and prevention services, including LTBI testing and treatment, such agencies have limited resources. Working alone, they are unable to conduct targeted identification and treatment of such a large group of people.

However, the US Preventive Services Task Force recently gave a Grade B rating to the practice of screening for LTBI in high-risk persons. Consequently, in accordance with the provisions of the
Affordable Care Act, such testing must be covered by insurers with no out-of-pocket costs to high-risk patients. This rating will also raise awareness with primary care providers in the private healthcare setting. With these recent developments, public health agencies could significantly increase targeted testing and treatment of LTBI by partnering with private sector healthcare.

The Center for Disease Control and Prevention and its Tuberculosis Epidemiologic Studies Consortium has begun to explore these issues in research that provides insight into the LTBI testing and treatment already occurring in the private sector. This presentation will include a review of our research and discuss examples of and opportunities for public health/private sector healthcare partnerships which forward domestic TB elimination efforts. Such partnerships will help ensure health for generations to come.

At the end of this session attendees will be able to:

- Describe recent regulatory changes which are likely to increase rates of LTBI testing and treatment in the private sector.
- Identify opportunities for public health/private healthcare sector initiatives which increase targeted LTBI testing and treatment in the private sector.
- Describe recent research on LTBI testing and treatment already occurring in the private sector.

2:30 pm -- 3:00 pm

Serving the Needs of the LGBT Community During Disasters

LCDR Allen Applegate, DrPH, MPH, CPH, USPHS, Senior Emergency Management Specialist, Administration for Children and Families, Office of Refugee Resettlement; LCDR Sharyl Trail, PsyD, USPHS, Supervisory Psychologist, Oneida Behavioral Health, Bemidji Area, Indian Health Service

According to the U.S census, 8.8 million Lesbian, Gay, Bisexual, & Transgendered (LGBT) individuals and families live and work in 99.7 percent of U.S. counties. Additionally, according to the American Community Survey, there are approximately 777,000 same-sex couples of which approximately 20% are raising children under the age of 18. Like all Americans, LGBT individuals and families are vulnerable to disasters and often experience a sense of loss, stress and trauma that will require seeking assistance. However, LGBT populations have also been identified as an “at-risk” population in an emergency, meaning they are more likely to experience social and cultural isolation, making the population more vulnerable while in shelters as well as during the recovery phase. LGBT populations may experience additional stress and trauma due to fear of discrimination from governmental, non-governmental organizations and emergency workers providing assistance, including Commissioned Corps Officers supporting state, tribes and territories in disaster response and recovery. One measure of the strength of a PHS response is its attentiveness to its most vulnerable citizens/patients. During this session, leadership from the USPHS Sexual Orientation and Gender Diversity Advisory Group (SOAGDAG) will address knowledge gaps among Commissioned Corps Officers who will serve the LGBT community following a disaster. The session will provide demographic information on LGBT individuals and families; guidance on interaction with LGBT individuals and families; and steps to meet the specific needs of LGBT individuals and families in emergency response. Additionally, this session will highlight how SOAGDAG can provide subject matter expertise and assistance to response teams and officers in better preparing to meet the needs of the LGBT community before, during and following disasters.

At the end of this session attendees will be able to:
• Review the five categories of identified Vulnerable, At-risk, and Special Needs Populations and how LGBT populations fit into multiple categories, including: economic disadvantage; language and literacy; medical issues; isolation; and age.
• Review practical clinical, safety, and administrative/policy strategies that increases culturally competent care of LGBT populations in a disaster setting.
• Describe successful outreach, communication and engagement strategies to effectively reach LGBT communities that have experienced a disaster.

3:00 pm -- 3:30 pm
**Bringing Precision Public Health to Global Neonatal Mortality and Stillbirth Surveillance: Early Experience from the CHAMPS Network**

LCDR Kevin Clarke, MD, USPHS, CHAMPS Reproductive Health Unit Lead, Centers for Disease Control and Prevention; LCDR Michelle Dynes, PhD, MPH, MSN, RN, CNM, USPHS, Reproductive Health Scientist, Centers for Disease Control and Prevention

Worldwide, an estimated 5 million children under five years of age died in 2016, many of preventable causes. Neonates represent 44 percent of all under-five deaths. In addition, there were an estimated 1.7 to 2.6 million stillbirths worldwide. Relative gains in mortality reduction have been lower among stillbirths and neonates as compared to older children. In addition, large geographic disparities exist with the highest stillbirth and neonatal rates located in Sub-Saharan Africa and South Asia. Cause of death ascertainment in low-resource, high-mortality settings commonly relies on verbal autopsy methods with limitations in diagnostic specificity.

Conceptually, precision public health is the application of emerging diagnostic innovations or methods to guide focused preventive or therapeutic strategies. The Child Health and Mortality Prevention Surveillance (CHAMPS) network involves population-based under-five mortality surveillance in seven sites across Sub-Saharan Africa and South Asia, each implementing diagnostic innovations to specifically guide mortality reduction efforts from village to globe. Within CHAMPS, stillbirth and neonatal mortality surveillance has been implemented. Data sources utilized for cause of death assignment include clinical record abstraction, verbal autopsy, minimally invasive tissue sampling, and innovative, comprehensive laboratory and pathology diagnostic approaches. Early findings in stillbirth and neonates will be highlighted, including opportunities for improved mortality estimates and data use.

At the end of this session attendees will be able to:

• Explain global neonatal mortality and stillbirth trends and associated barriers to understanding their causes.
• Identify specific surveillance innovations to improve our understanding of neonatal mortality and stillbirth causes.
• Describe the concept of precision public health as it relates to global child mortality reduction efforts.

3:30 pm -- 4:00 pm
**Evaluation of the Tubex TF Rapid Typhoid Test to Enhance Patient Management in the US/Mexico Border Region**

Otis Layne, MD, Medical Director, Mision de Candelilla; Thaddeus Miller, DrPH, MPH, Associate Professor, UNT Health Science Center
The United States and Mexico have deep and longstanding geographic, cultural, historical, societal, and economic ties. These are especially apparent in the border region running from California to Texas. US based clinicians in the border region often see patients who have received care in Mexico; some also provide care to patients in Mexico in a volunteer or other capacity. In both settings, US clinicians may encounter unfamiliar diagnostics and clinical practices, especially those related to illnesses that are rare in the US but remain prevalent in Mexico.

One example is the febrile agglutinins test. The test was abandoned in the US due to its low sensitivity and specificity but is used in Mexico to diagnose indolent fevers such as typhoid, brucellosis, and proteus infections. Patients with positive febrile agglutinins test results leave a therapeutic quandary for US physicians. While some experts recommend prolonged courses of antibiotics for treatment of chronic typhoid, this can also have significant complications. A rapid bedside test to help guide treatment decisions for these patients may allow better patient outcomes, reduce overuse of antibiotics, and help protect populations on both sides of the border from exposure to insufficiently managed typhoid or other contagious diseases. The Tubex TF rapid typhoid test may have potential to enhance patient care, but it is not approved in the US or used in the Mexican system and its utility in cross-border populations is unknown.

We evaluated use of Tubex TF by US physicians staffing volunteer clinics in rural Mexico. Results were obtained for 35 patients with and 29 without self-reported history of typhoid fever, treatment, or positive febrile agglutinins. We found no significant association between test results and potential indicators of typhoid fever and conclude it has limited utility in that context.

Our findings suggest that substantial barriers exist to effective evaluation and management of cross-border patients. Continued work to address these barriers is a potentially important means to enhance individual and population health in this critical population.

At the end of this session attendees will be able to:

- Identify challenges facing US clinicians serving cross-border populations.
- Describe how clinical management of cross-border patients may impact individual and population health in the wider US-Mexico border region.
- Describe the utility of a bedside test to evaluate Mexican patients presenting with a history of typhoid fever, treatment, or positive febrile agglutinins test.

Primary Care Physical Therapist in a Rural Setting

CDR Steven Spoonemore, PT, DPT, OCS, FAAOMPT, USPHS, Physical Therapist, San Carlos Apache Healthcare Center

Physical Therapists (PT) are neuromuscular experts and uniquely qualified to work as part of the primary care team. Prior research indicates PT are safe, effective and reduce overall healthcare costs in a primary care setting. In October 2016, a full time PT was placed in a rural primary care clinic to supplement the existing full time FNP and contract PA. Prior to October a PT had been providing part time therapy services on an interim basis with a total of 312 patient visits for FY 2016. The mean wait time for completion of a PT consultation was 11 calendar days in October; a total of 23 new consultations were placed that month. In January screening procedures utilizing the nursing staff
opened the door for patients to access PT directly from triage or direct access without a referral. Over FY 2017, the mean times to completion of a consultation (or examination in case of a self-referred patient) decreased to 6.5 days respectively with a majority of patients seen the same day. Total visits in FY 2017 increased to 859 with a total of 399 new patient examinations, 47 (17%) of those seen via direct access. Completion of new patient consultations averaged 70.8%. Innovative scheduling, direct communication with other primary care team members and community education foster a positive team-based healing environment. Additional services added via PT in the primary care clinic include manual therapy, dry needling, splinting, screening for cardiorespiratory fitness, objective return to work and play criteria and testing.

At the end of this session attendees will be able to:

- Identify barriers to success in implementing Physical Therapists into a primary care role.
- Apply lessons learned in implementing PT in the primary care team at their duty station.
- Describe how to incorporate subjective and objective outcome measures to guide triage and direct a plan of care.

Thursday, June 7
10:00 am –10:30 am

InTransition: Maintaining Continuity of Care across Transitions
CDR Michelle Tsai, PsyD, RPh, USPHS, Division Chief, Department of Defense

According to the 2007 report from Department of Defense’s (DoD) Task Force on Mental Health, there is a concerning number of service members (SMs) who disengaged from mental health care treatment as they transitioned from the DoD to Veteran Affairs (VA) health care system or civilian health care providers. It also noted that disengagement of care was leading to the deterioration of SMA’s health status.

To support DoD’s efforts in maintaining continuity of care for SMs, the inTransition program was developed to provide support to SMs receiving mental health services as they transition between health care systems and providers. inTransition connects SMs with transition support coaches to provide one-on-one assistance during the transition period. The coach offers individual support and encouragement to the SMs, connects them with a new provider, and empowers them with tools to continue making healthy life choices.

In August 2014, Presidential Executive Action directed that inTransition enrollment be mandatory for all transitioning SMs receiving mental health treatment. In October 2015, DoD mandated that all SMs who had seen a mental health provider within a year prior to separation be automatically enrolled in inTransition.

The inTransition program is confidential and available 24 hours a day, seven days a week.

At the end of this session attendees will be able to:

- Identify three challenges with military transition that impact continuity of care for service members.
- Describe how mental health care providers can access and use inTransition program to assist service members to ensure continuity of care across transitions.
Describe three ways how inTransition program can assist and support SMs during any phases of transition.

10:30 am -- 11:00 am
National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care in the Medical Community
CAPT Samuel Wu, PharmD, USPHS, Public Health Advisor, Department of Health and Human Services, Office of the Secretary, Office of Minority Health

According to the 2008 National Ambulatory Medical Care Survey, approximately 84 percent of visits to a primary care delivery site occurred in physician offices, 11 percent in hospital outpatient departments, and five percent in community health centers. Nearly three-quarters of all ambulatory care visits took place at practices with five or fewer physicians. These physicians and other healthcare professionals are the backbone in providing critical medical services to the communities and are part of the national health care provider safety net. This presentation describes the development of a toolkit that provides resources health care providers to increase their awareness of the National CLAS Standards and to help them adopt and integrate these standards into their clinical practice as part of the quality improvement and practice transformation initiative.

At the end of this session attendees will be able to:

- Provide an overview of the National CLAS Standards.
- Describe the toolkit content.
- Explain the development process of the toolkit.

1:45 pm -- 2:15 pm
Mitigating Suicide Risk for Patients Completing Intensive PTSD Treatment
CAPT Rick Schobitz, Ph.D., USPHS, Chief, IOP, Brooke Army Medical Center; Gerry Grace, Ph.D., Deputy Chief, IOP, Brooke Army Medical Center

The Trauma-Focused Intensive Outpatient Program (TF-IOP) at Brooke Army Medical Center (BAMC) serves patients with PTSD who are often at high risk who need care beyond that offered in traditional outpatient but do not require inpatient or residential care. Due the severity of their symptoms suicidal ideation is very common among participants in the program. The program consists of a 6-week closed cohort and treatment follows a model based on Prolonged Exposure (PE) and Acceptance and Commitment Therapy (ACT). The program has graduated approximately 200 service members with an average reduction of symptoms seen at greater than 20 points on both the Posttraumatic Checklist for DSM-5 (PCL-5) and the Posttraumatic Diagnostic Scale for DSM-5 (PDS-5). This reduction is twice the level described as clinically significant in the literature.

One challenge that the program has faced is the management of patient care during periods split by holidays. Access to care and productivity preclude the program from shutting down during the holiday season and restricting patients from being able to take time to spend with families during the holidays is also problematic. A concern of the program’s staff has been how to manage patients with suicidal ideation which can be triggered during PTSD care while allowing them time away for the holidays. The BAMC TF-IOP conducted a performance improvement project consisting of two models of treatment
that aimed at adding flexibility in care and also mitigating risk of suicide. This presentation will explore these models, present outcomes, and discuss lessons learned.

At the end of this session attendees will be able to:

- Describe risks associated with intensive PTSD treatment.
- Evaluate the effectiveness of this pilot program in terms of PTSD care and suicide risk mitigation.
- Describe the steps taken by the program to mitigate risk of suicide during the holidays.

2:15 pm -- 2:45 pm

**Increase Access to Quality Behavioral Health Care through Utilization of Interprofessional Education and Collaborative Team-Based Care**

LCDR Sara Azimi-Bolourian, PhD, MBA, MS, USPHS, Public Health Analyst, Health Resources and Services Administration; LCDR Andrea Battle, PhD, USPHS, Public Health Analyst, Health Resources and Services Administration

The Health Resources and Services Administration (HRSA), the Bureau of Health Workforce (BHW), through its Nursing and Public Health programs, utilizes the Interprofessional Collaborative Practice (IPCP) model of care to integrate behavioral health and primary care. These programs increase access to quality behavioral health care, inform the fields of interprofessional education and collaborative team-based care, advance methodology and evaluation science, and improve patient and community health outcomes. Preparing diverse professionals to work together in teams to deliver high quality, efficient, collaborative care is widely recognized as an effective means to improve health outcomes. As such, the programs’ overarching goals include: 1) identifying innovative collaborations with key stakeholders in planning, designing and implementing interprofessional training sites, 2) focusing on integration of primary care with prevention and treatment for behavioral health, 3) developing the capacity to assess the impact of the integrated model, and 4) increasing access to quality behavioral health care. These goals provide a framework to inform the field of interprofessional education and collaborative team-based care, move forward methodology and evaluation science, and ultimately improve patient, family and community health outcomes. This is in alignment with the BHW’s mission to improve the health of underserved and vulnerable populations by advancing the competencies of health workforce and connecting skilled professionals to communities in need, with a specific focus on the Nursing, Behavioral Health, and Public Health workforce, increasing access to quality services, and improving health equity.

At the end of this session attendees will be able to:

- Describe the Interprofessional Collaborative Practice (IPCP) model that integrates behavioral health into primary care to increase access to behavioral health services.
- Explain HRSA’s efforts to prepare diverse professionals to work together in teams to deliver high quality, efficient, collaborative care.
- Apply the principle of HRSA’s programs to their organization’s efforts to integrate behavioral health and primary care.

2:45 pm – 3:15 pm

**The Zero Suicide Initiative: One Tribe’s Journey toward Transforming Delivery of Mental Health Care**

LCDR Sharyl Trail, PsyD, USPHS, Supervisory Psychologist, Oneida Comprehensive Health Division, Bemidji Area, Indian Health Service
Zero Suicide is a key concept of the 2012 National Strategy for Suicide Prevention, a priority of the National Action Alliance for Suicide Prevention. The foundational belief of Zero Suicide is that suicide deaths for individuals under care within health and behavioral health systems are preventable. This presentation will highlight one tribe’s participation in the Zero Suicide Academy and adoption of the Zero Suicide Model, including how this model improves screening, detection, and treatment of patients that present to both the medical and behavioral health departments with depression and suicide risk factors. The Oneida Nation Comprehensive Health Division is tribally run and comprised of Medical, Dental Pharmacy, Behavioral Health, Vision, Employee Health, Health Promotion, Environment Health, Skilled Nursing Facility and Purchased and Referred Care. Oneida Comprehensive Health employs 343 staff and served 4,960 individual patients with 64,995 individual visits in 2016. Near half of all patients seen in Primary Care were also seen at Behavioral Health. With vision, mission, and core values as guiding principles, the goal of the Oneida Nation Zero Suicide Initiative is to create a healthy and empowered community through providing culturally-based, trauma-informed Zero Suicide treatment and prevention across the healthcare system. Our objectives are to (1) Increase leadership commitment and support for Zero Suicide Initiative; (2) Train healthcare employees and community partners on culturally appropriate evidence-based treatment (3) Improve access to care through the Suicide Care Management Plan and (4) increase sustainability through development of resolutions, standing committees, and Policies and Procedures.

At the end of this session attendees will be able to:

- Identify the Zero Suicide 7 essential elements of suicide care utilizing the Zero Suicide Toolkit.
- Identify multiple workforce development trainings on topics such as trauma informed care; motivational interviewing; Primary Care mental health screening tools; clinician self-care and secondary trauma.
- Apply the Zero Suicide model at other Tribal clinics with a focus on integrating Primary Care Integration models and National Culturally and Linguistically Appropriate Services (CLAS) Standards.

3:15 pm – 3:45 pm
**Interagency Evaluation of a Marine And Marine Veteran Suicide Cluster**
CAPT Meena Vythilingam, M.B.B.S, M.D., USPHS, Chief Strategy Officer, National Capital Region Medical Directorate, Department of Defense

**Background:** Two Active duty Marines and 12 veterans from a high risk Marine battalion died by suicide after returning from an eight-month deployment to Afghanistan in 2008. Without access to Marine Corps or Department of Veterans Affairs (VA) data, articles in the popular press stated that the deaths were a suicide cluster due to exposure to severe combat and contagion. The Marine Corps led an interagency investigation to evaluate if the Marine deaths constituted a suicide cluster, determine potential causes of deaths and develop a plan to prevent further suicides.

**Methods:** An interagency, multidisciplinary evaluation was conducted in collaboration with 78 staff from nine Federal Agencies & 14 Counties. Medical, non-medical, personnel, legal, police, surveillance and postmortem data were collected and analyzed. A suicide rate was calculated for this battalion and the comparison group. A cradle to grave review of modifiable suicide risk factors was conducted across the phases of a Marine’s life.
**Findings:** The suicide rate in Marines & Veterans from this specific battalion was ~4 times higher than the suicide rate in a comparison group of Marines & Veterans. A cradle to grave review of the 15 Marines and Veterans who died by suicide revealed several missed opportunities for intervention at the individual, family and community level.

**Discussion:** Findings from this rapid epidemiological response to Marine suicides helped design a suicide prevention outreach program to prevent further suicides in this battalion and other similar high-risk units. Results also informed Marine Corps and VA policy and programs to prevent suicides in other high-risk groups.

At the end of this session attendees will be able to:

- Define a suicide cluster.
- Explain the contributions of interpersonal issues, alcohol use, and access to weapons to suicide.
- Describe modifiable risk factors for suicide.

3:45 pm -- 4:15 pm

**The Life Course of Homeless Female Veterans: A Qualitative Study**

LCDR Stephanie Felder, MSW, LCSW, LCAS-A, USPHS, Public Health Analyst, Health Resources and Services Administration

Homelessness among U.S. veterans is a significant problem especially among female veterans, the fastest growing subset. The number of homeless female veterans increased by 135% between 2006 and 2016 (HUD, 2016). According to The VA National Center on Homelessness Among Veterans, the number of women accessing VA specialized homeless programs or with a homeless identification has tripled from 11,016 in FY 2010 to 36,443 in FY 2015 (2016, p. 6). This exploratory qualitative study examined the pathway into homelessness among female veterans. Participants provided narratives of their childhood, adolescence, young adulthood, adulthood, military service, and the transition from military service to veteran status, and homeless experiences. Themes of loss, unresolved grief, adverse childhood experiences, service access, sense of agency, proud moments, and resilience emerged and are discussed in relation to the five core principles and concepts of Life Course Perspective.

At the end of this session attendees will be able to:

- Describe the life course of the homeless female veteran, drawing on their voices and experiences as described in their own words as viewed through Life Course Perspective.
- Identify innovative solutions and strategies to prevent and end homelessness among female veterans.
- Identify female veterans’ pathways into homelessness and their unique needs.

**Track 6: Prevention, Health Promotion, and Personal Factors**

*Location: Colonnade*