2014 USPHS Scientific and Training Symposium
Preliminary Scientific Program Agenda

Tuesday, June 10

7:00 pm – 10:00 pm  Anchor & Caduceus Dinner (priced separately)

8:00 pm – 9:00 pm  C. Everett Koop Memorial Lecture

Continuing the Legacy of C. Everett Koop
Speaker: RADM Fitzhugh Mullan, MD, USPHS (Ret), Professor of Pediatrics, George Washington University

To think about the future of the Commissioned Corps of the United States Public Health Service, it is important to understand its past. RADM Mullan will review key junctures in the 125 year history of the Commissioned Corps including the tenure of C. Everett Koop. He will examine the emergence of the Public Health Service from the Marine Hospital Service, the engagement with state and local public health, the growth of federal public health in the 1950-1970 period set against the “out placement” of Medicare and Medicaid and the removal of the Surgeon General from the line of command. He will touch on the role of the Surgeon General in the 47 years since and then focus on why the PHS remains a bridge between public health and medical care and is key to the future of health and health care in the United States.

At the end of the session, attendees will be able to: 1. Identify the broad outlines of the history of the US Public Health Service. 2. Describe the changes in federal public health that took place in the 1960s and their implications for health and health care in the United States. 3. Appreciate the challenge faced by subsequent Surgeons General and by the Commissioned Corps. 4. Describe the opportunities that lie ahead for the USPHS in bridging the public health – medical care gap that exists in the US -- and the barriers that will stand in the way of playing this historical role for health in America.

Wednesday, June 11

9:15 am – 10:15 am

Welcoming Remarks

Opening Keynote: Luther Terry Lecture
Speaker: Dr. Arthur Kellerman, MD, Edward Herbert School of Medicine, Uniformed Services, University of the Health Sciences

In the 50 years since Dr. Luther Terry released the Surgeon General's Report on Smoking and Health, the public's view of smoking, and public policy towards tobacco
have dramatically changed. As a result, smoking rates have been cut by more than half, and millions of people have been spared the ravages of tobacco related diseases. This public health triumph, and others like it, were succinctly described in a two landmark MMWR reports entitled “Ten Great Public Health Achievements -- United States, 1900-1999” and “Ten Great Public Health Achievements -- United States, 2001—2010.” The U.S. Public Health Service and its allies can be justifiably proud of these accomplished. Unfortunately, although public health has won numerous battles, there are ominous signs that it may be losing the war. The ongoing debates over how to reduce healthcare spending are almost entirely focused on healthcare finance and delivery; public health is rarely mentioned. Natural threats, such as global climate change and emerging microbial resistance threaten to undo a century of progress. The very foundations on which public health is based are being undermined by public complacency, official indifference, industry pushback and an increasingly active anti-science movement. How we meet these challenges will not only determine the future of public health, but the fate of millions.

At the end of the session, attendees will be able to: 1. List several notable achievements in public health since Dr. Terry’s report on Smoking and Health was released in 1964. 2. Identify five new threats to public health that have emerged over the same period of time. 3. Describe how these threats, if unchecked, could undo a century of progress in the control of communicable and non-communicable diseases. 4. Consider how a reenergized approach to public health; one that stresses the value of effective leadership and draws on the best of behavioral science, marketing and communications can inspire communities, motivate policymakers, and convince employers to defend and advance the public’s health.

Scientific Track Sessions
*From 10:30 am to 4:45 pm attendees can choose among five concurrent track sessions. Details for each track are listed below.*

**Track 1: Emergency Preparedness**

10:30 am 12:00 pm

**Session 1: Chemical Releases**
The opening 90-minute session will focus on issues, challenges and preparedness related to chemical weapons, chemical and biological attacks and releases and other chemical incidents.

**Chemical and Biological Release (CB) Attacks, and the Psychological Effects of Bioterror**
*Speaker: LCDR Margaret Hale, PA, USPHS, Bureau of Prisons, Federal Medical Center, Butner*

This session will give a brief overview of the history of CBR attacks in the United States, address the psychological effects of bioterror, and demonstrate how a good official
response in event of a CBR attack, or other natural/manmade incident, can prevent
mass panic.

At the end of this session, participants will be able to: 1. Summarize a brief history of
CBR attacks, and near CBR attacks, in the United States. 2. Describe the psychological
effects of bioterror attacks. 3. Demonstrate how honesty from authorities during an
incident can prevent mass panic.

**Chemical Weapons Elimination in the U.S. and Public Health**

*Speaker: LCDR Gino Begliutti, MPH, CIH, CHMM, USPHS, Deputy Branch Chief,
Environmental Public Health Readiness Branch, Chemical Weapons Elimination
Program, Division of Emergency and Environmental Health Services (DEEHS), National
Center for Environmental Health (NCEH), Centers for Disease Control and Prevention
(CDC)*

This session will examine the United States Department of Defense’s (DoD) continuing
efforts to destroy the aging U.S. Army stockpile of chemical weapons. Demilitarization
facilities are built at the original stockpile sites across the United States to conduct the
destruction. There will be a total of nine facilities built to accomplish this Stockpile
destruction mission and DoD will have a legacy mission to deal with recovery and
destruction of future discovered Non-stockpile material across the U.S. The session will
highlight the different stockpiles, the different technologies used to complete these
missions, and the successes of the Chemical Stockpile Emergency Preparedness
Program (CSEPP). In the communities surrounding the demilitarization facilities the
U.S. Army, FEMA and the CDC have developed the Chemical Stockpile Emergency
Preparedness Program (CSEPP). CSEPP is U.S. Army funded, FEMA organized, and
operated by state and local agencies. The CDC assisted during the original program
development and has maintained a subject matter expert/liaison role in each CSEPP
community. CSEPP is a unique chemical emergency preparedness program with
extensive federal government funding, support and oversight. While typical communities
have little federal government support and different hazards, the CSEPP has generated
extensive knowledge in chemical emergency preparedness that can be used a model
by communities throughout the U.S. to enhance public health preparedness for
chemical events.

At the end of this session, participants will be able to: 1. Describe the U.S. DoD effort to
destroy the aging U.S. chemical weapons stockpile. 2. Summarize CSEPP and navigate
to CSEPP and the CDC website to obtain information 3. Analyze CSEPP tools that may
be used in communities at risk to hazardous chemicals.

**Public Health Impact of Acute Chemical Releases in Schools**

*Speaker: LT Ayana Anderson, MPH, USPHS, Public Health Analyst, Agency for Toxic
Substances and Disease Registry*

This session will address the strategic direction of Healthy and Safe Community
Environments, which includes schools under the National Prevention Strategy. Schools
have a responsibility to provide a healthy learning environment for children. However, the school environment is not always safe, as chemical incidents can occur, resulting in injury and disruption of the learning environment. Data from 14 participating states in ATSDR’s acute chemical release surveillance system from 2002-2011 showed that of the 68,138 acute chemical release incidents that occurred, 663 (1 percent) occurred in schools. Although this percentage may appear minor, there was a significant public health impact from these incidents. Approximately 32.4 percent of these incidents resulted in 1,369 injured persons, and 47.5 percent involved evacuations. Mercury was the most commonly reported chemical involved in school evacuations. The average number of people evacuated was 301, ranging from 2-3000 evacuees per incident. The average duration of these evacuations was 23 hours. Children are more vulnerable to the harmful effects of chemical exposure than adults for many reasons, thus underscoring the need to address the issue of chemical releases in schools. Due to the public health impact and possibility of prevention, this session will focus on mercury releases (176, 26.5 percent), cleaning product releases (88, 13.3 percent), and releases that occur in chemistry labs (38, 5.7 percent).

At the end of this session, participants will be able to: 1. Identify priority areas regarding acute chemical releases occurring in schools. 2. Describe the public health impact of acute chemical releases occurring in schools. 3. Identify strategies to prevent/mitigate adverse outcomes associated with school releases

Session II: Assets and Assessments--Keys to National Readiness
This session will examine training programs, assessments and other resources being developed to help ensure national readiness for emergencies and disasters.

1:30 pm - 3:00 pm

Center for Disease Control and Prevention’s (CDC) Responder Workforce:
Addressing Preparedness Learning Needs
Speakers: Ms. Sylvia Trigoso, MPH, Associate Service Fellow, Learning Office, Center for Disease Control and Prevention, Office of Public Health Preparedness and Response and CAPT Gail Williams, MPH, CHES, USPHS, Senior Health Education Specialist, Centers for Disease Control and Prevention, Office of Preparedness and Emergency Response- Learning Office

This session will examine how preparing for public health emergencies is a challenge and requires investments in responder training at federal, state, tribal and local levels. The training systems that produce a competent and prepared public health responder workforce must be continuously evaluated and informed by emerging issues. Thus, the CDC Office of Public Health Preparedness and Response (OPHPR) conducted a responder needs assessment (RNA) in 2013 for the purpose of identifying perceived preparedness and response training needs among the CDC responder workforce. The current training system serves more than 2000 individuals who have or might have a response role at CDC or in field deployments. The presentation will summarize the importance of getting feedback from sub-groups of responders and how the feedback is
being translated into a collaborative action which addresses current and future requirements. This work aligns with the National Health Security Strategy, Strategic Objective 2. Develop and maintain the workforce needed for National Health Security.

At the end of this session, participants will be able to: 1. Explain the learning needs of the CDC Responder Workforce 2. Identify the influences on emerging learning requirements 3. Describe CDC’s next steps to support responder learning opportunities

Development of the National Health Security Preparedness Index
Speaker: CDR Yoon Miller, MS, USPHS, National Program Manager, National Health Security Preparedness Index, Centers for Disease Control and Prevention

This session will look at how the Association of State and Territorial Health Officials (ASTHO) collaborated with the Centers for Disease Control and Prevention through a cooperative agreement to lead development of the National Health Security Preparedness Index (NHSP). The Index provides measures of health emergency preparedness, allows communities to track their preparedness levels, and identifies useful practices that can be shared across jurisdictions. The NHSP project team involved over 75 preparedness experts including representatives from government, the private sector, academia, and other groups. The project workgroups include expertise in many areas of preparedness such as emergency planning, laboratory, communication, measurement theory, and evaluation. The NHSP project team actively sought involvement from a broad range of stakeholders throughout the development of the Index. Stakeholders included those who will provide data to calculate the Index and those who will make policy decisions based on the Index data. This session will provide details on the first version of the NHSP (released in December 2013) and discuss the development and stakeholder engagement process, as well as future plans for continued Index development. It will also address how the first-year Index version fits into the long-term goals of this multi-year project. Participants will be engaged for feedback and commentary on the development and future direction of the Index.

At the end of this session, participants will be able to: 1. Describe the rationale for the NHSP, and its intended uses 2. Interpret the NHSP results, and apply it to their own community 3. Explain the development process for the NHSP, and future plans for improvement.

Healing in Times of Chaos: Federal Disaster Resources
Speakers: LT Stephanie Felder, PhD Candidate, USPHS, Center for Mental Health Services, Federal Emergency Management Agency Crisis Counseling Program and CDR Jamie Seligman, MSW, USPHS, Project Officer, Substance Abuse and Mental Health Services Administration

This session will review the resources that the Substance Abuse and Mental Health Services Administration (SAMHSA) offers the nation to assist in the psychological recovery process. Furthermore, this session will examine disaster behavioral health from a trauma theory perspective and address high-risk, special populations during
disasters. Over the past two decades, there has been a substantial increase in the number of devastating natural and man-made disasters in the US. These disasters have taken an economic and psychological toll on the affected communities; however, the death toll for these events has decreased. Despite our ability to measure economic damages, society is challenged when attempting to calculate the impact that disasters have on psychological health. Trauma theory can provide a framework to analyze disaster reactions and assess the need for appropriate interventions and resources for disaster response. Trauma theory asserts that there are psychological, physiological, and social consequences that occur when a person experiences a traumatic event. It is essential to provide support services and resources to both those who are resilient and those that may need extra help with coping with the aftermath of a disaster.

At the end of this session, participants will be able to: 1. Describe the symptoms of disaster-related emotional distress 2. Demonstrate how Federal and local resources can be maximized to respond 3. Evaluate how trauma theory can be utilized as a framework to analyze DBH.

Overview of the Division of the Strategic National Stockpile

Speaker: LT Avi Stein, USPHS, Member, Division of the Strategic National Stockpile, Response Branch, Current Operations Team

This session will present an overview of the Division of the Strategic National Stockpile (DSNS). The Division of the Strategic National Stockpile, initially known as the National Pharmaceutical Stockpile until the implementation of the Homeland Security Act of 2002, is operated at the Centers for Disease Control and Prevention. The DSNS serves as a national repository of antibiotics, chemical antidotes, antitoxins, life-support medications, IV administration, airway maintenance supplies, and medical/surgical items. The SNS is designed to supplement and re-supply state and local public health agencies in the event of a national emergency anywhere and at anytime within the U.S. or its territories. The session will highlight several capabilities of the DSNS including 12-hour Push Packages, Managed Inventory, and the Federal Medical Stations. The session will also highlight the multiple deployment teams within the DSNS including Stockpile Services Access Group (SSAG), Receive Stage and Store Task Force (RSS TF), and the Federal Medical Station Strike Team (FMS-ST). The history and legislative authorities, legal authority for deployment of materiel, and past deployments of DSNS will be discussed as well.

At the end of this session, participants will be able to: 1. Describe the history and legislative authority for the establishment of the DSNS. 2. identify components of the DSNS. 3. Identify deployment models for DSNS materiel and/or deployment personnel during a crisis.
Session 3: Deployment

This session will look at lessons learned from recent U.S. Public Health Service deployments as well as broader issues related to deployment.

3:15 pm – 4:45 pm

Commissioned Corps Hospital Assistance Team’s (CCHAT) Mission to Saipan

Speaker: RADM Newton Kendig, MD, USPHS, Assistant Director of the Health Services Division, Federal Bureau of Prisons

This session will examine how the U.S. Public Health Service Commissioned Corps embarked on a mission to provide clinical and technical assistance to the Commonwealth Health Center in Saipan, Northern Mariana Islands. This occurred through three distinct deployments with the teams comprised of physicians, pharmacists, medical technologists, nurses, engineers and administrators from several agencies across the federal government. Working in conjunction with the government of CNMI and the Commonwealth Healthcare Corporation, the teams sought to provide clinical and technical expertise and support for the Commonwealth Health Center, which in October 2012 had failed the Centers for Medicare and Medicaid Conditions of Participation survey and risked decertification. The main mission of the deployment was to stabilize the hospital’s critical areas, develop a plan of action to address the deficiencies cited in the survey, monitor and assess the progress of the Hospital in implementation of the plan of correction and assist in compliance with CMS Conditions of Participation.

At the end of this session, participants will be able to: 1. Summarize the mission of CCHAT. 2. Describe the three different deployments and their unique nature of officer involvement. 3. Describe officer characteristics that were needed to accomplish a successful mission.

Navy Yard Shooting: Collaborative Response via Navy/Public Health

Speakers: CAPT Kimberly Deffinbaugh, BSN, MPH, USPHS, Deputy Director of Employee Assistance, Work Life Services Division of Federal Occupational Health

This session will provide insight across Public Health Service professions, as to how a critical incident can affect the workplace as well as an individual, therefore, affecting an agency’s ability to achieve its mission. We will provide the opportunity for gaining a perspective on the complexity of post-traumatic stress disorder (PTSD) as a result of workplace violence, and how leadership can set the tone for resiliency. We will provide a case study of the response at the Navy Yard, which was a joint effort between FOH and US Navy SPRINT as a result of the mass shooting, which will illustrate how a critical incident response is carried out in the federal sector.

At the end of this session, participants will be able to: 1. Define a critical incident and workplace violence, and identify key components. 2. Summarize how critical incident
response is handled in federal sector and key stages 3. Identify the affects of workplace violence/PTSD, and apply understanding of resiliency.

The NHPP: Impact on the Nation and Deployment Teams
Speakers: CDR Kenneth Monahan, MHA, USPHS, Office of the Assistant Secretary for Preparedness and Response

This session will highlight the work that the NHPP conducts to ensure our nation’s healthcare infrastructure is prepared for natural and/or man-made disasters. In particular, this presentation will focus on tying in the relationship between the various deployment teams and the local responders; this will greatly enhance the knowledge-base of our deployment teams. The National Healthcare Preparedness Program (NHPP) provides leadership and funding through grants and cooperative agreements to States, territories, and eligible municipalities to improve surge capacity and enhance community and hospital preparedness for public health emergencies. In July 2012, states, territories, and large metropolitan areas received HPP grants totaling $332 million to help hospitals and other health care organizations strengthen the medical surge capability across the nation.

At the end of this session, participants will be able to: 1. Demonstrate an understanding of the NHPP and its relationship with the States 2. Differentiate DCCPR deployment teams. 3. Describe collaboration between RECS and FOs
Track 2: Prevention

10:30 am – 12:00 pm

Session 1: Innovative Efforts to Address Preventable Diseases

This session will provide an overview of three programs seeking in different ways to address significant preventable illnesses and diseases.

Dengue: Old Disease, New Challenge
Speaker: LCDR Qiao Bobo, PhD, USPHS, Inspection and Review Officer, Center for Biologics Evaluation and Research (CBER), Food and Drug Administration

This session will describe the dengue fever threat to public health, the cause and the potential solutions to stop the spread of the disease. Dengue fever is the fastest growing mosquito-borne disease, affecting up to 100 million people each year across the world, and continuing to grow both in prevalence and severity. There are approximately 25,000 fatalities each year and severe cases require hospitalization and constant monitoring. Dengue is caused by any one of four related viruses transmitted by mosquitoes. Existing methods of controlling the dengue mosquitoes, which include spraying or fogging using chemical pesticides, have failed to stop the spread of the disease. Although there is neither specific medication nor vaccine for dengue, scientists, researchers, biotech and biopharmaceutical companies are working tirelessly looking for solutions such as vaccines and mosquito control. PHS officers are undoubtedly already playing a part in addressing this challenge, which is becoming a U.S. public health issue. However, we can also play an important role in raising the profile of this devastating emerging infectious disease and helping to mobilize an appropriate response. I will discuss the pros and cons of various approaches and consider the possible synergy of utilizing different approaches in conjunction with one another to enhance the effectiveness of dengue control.

At the end of this session, participants will be able to: 1. Summarize the threat to public health from dengue. 2. Explain the various control methods and benefits of applying multiple approaches. 3. Describe the role of USPHS officers in raising awareness of this challenge.

FDA Regulatory Authority to Reduce the Adverse Impact of Tobacco Speaker: RADM David Ashley, PhD, USPHS, Director, Office of Science, Center for Tobacco Products (CTP), Food and Drug Administration

This session will discuss renewed regulatory efforts by the Food and Drug Administration (FDA) to address health issues associated with tobacco. Smoking remains the leading preventable cause of death in the United States resulting in more than 440,000 deaths per year. Congress gave the FDA comprehensive federal regulatory authority over tobacco products when it passed the Family Smoking Prevention and Tobacco Control Act (TCA) which was signed into law by President Obama on June 22, 2009. The TCA provides FDA important tools to carry out its
mission including understanding the regulated products; restricting product changes to protect public health; prohibiting modified risk claims that state/imply reduced risk without an order; restricting marketing and distribution to protect public health; decreasing the harms of tobacco products; ensuring industry compliance with FDA regulation through education, inspections, and enforcement; educating the public about FDA's regulatory actions; expanding the science base for regulatory action and evaluation. The TCA established a new standard for FDA to regulate tobacco products according to their impact on overall population health. This session will discuss how the Center for Tobacco Products of the FDA is using its authority to improve public health by reducing the death and disease which results from tobacco use.

At the end of this session, participants will be able to: 1. Describe FDA's regulatory authorities related to tobacco products. 2. Explain how FDA is acting to reduce the death and disease from tobacco use. 3. Describe the broad expertise needed to address this public health objective.

**PRC Program: Applied Public Health Prevention Research**

*Speaker: CAPT Mehran Massoudi, MPH, PhD, USPHS, Branch Chief, Applied Research and Translation Branch, Director. Prevention Research Centers (PRC) Program, Centers for Disease Control and Prevention*

This session will look at the work of Prevention Research Centers (PRC). The National Prevention Strategy outlines the importance of disease prevention through active community engagement. The Centers for Disease Control and Prevention funds centers with schools of public health (PH) or medicine with a preventive medicine residency. The PRCs are a network of academic centers that conduct applied chronic disease prevention research in collaboration with local and state health departments and communities. PRCs share a goal of addressing behaviors and environmental factors contributing to chronic diseases. Each PRC conducts at least one core research project with an under-served population that has a large burden of disease and disability and also works with partners on special interest projects and projects funded by other sources. As a result, PRCs contribute public health findings from hundreds of projects each year. PRC research outputs are evaluated annually through interview, document, and website data collection. PRCs are projected to reach nearly 30 million people in 103 communities. PRCs are committed to conducting prevention research and are leaders in translating research results into public health practice. Research from PRCs involves academic researchers, public health agencies and community members finding innovative ways to promote health and prevent disease; they work together to design, test, and disseminate strategies to enhance collaboration between public health and healthcare. PRCs are a public health resource that can offer results of interest to officers in accomplishing our public health mission.

At the end of this session, participants will be able to: 1. State role of PRCs to promote evidence-based public health strategies. 2. Describe how PRC utilize active community engagement to prevent chronic diseases. 3. Describe how PRC research findings help accomplish PHS mission.
1:30 pm - 3:00 pm

Session 2: Healthy Lifestyles
This session will look at programs designed to encourage health lifestyles in individuals and communities.

Educational Intervention to Increase Detection of Metabolic Syndrome
Speaker: Dr. Tamatha Arms, DNP, PMHNP-BC, NP-C, Assistant Professor, The University of North Carolina Wilmington

This session will examine the prevalence of metabolic syndrome and associated illnesses, which is almost double in persons with mental illness than in the general public. An educational intervention on metabolic syndrome was provided to mental health counselors who performed intake assessments on patients newly admitted at two outpatient mental health facilities. The study measured mastery of metabolic syndrome content following the educational intervention using a chart audit on new admissions to measure changes in clinician behavior. Prior to the intervention, neither facility screened for metabolic syndrome or referred patients with a BMI >25 for medical evaluation. A paired t-test showed no significant difference in the educational pre/posttest scores; however, following the intervention, 53/132 (40 percent) had a Body Mass Index (BMI) >25 and 47/53 (89 percent) were referred to a Primary Care Provider (PCP) for medical evaluation. The findings suggest that it is helpful to inform mental health counselors about metabolic syndrome and associated illnesses.

At the end of this session, participants will be able to: 1. State criteria used to diagnosis metabolic syndrome. 2. Identify reasons for increased prevalence of metabolic syndrome in persons with mental health illnesses 3. Describe how collaborative efforts between disciplines can potentially address these issues.

Get Healthy, Healthy Diet: Challenges of Remaining Fit and Healthy
Speaker: LCDR Sara Anderson, MPH, USPHS, Food and Drug Administration

This session will provide an overview for officers regarding the challenges of Remaining Fit and Healthy in an Obesogenic Environment. It will be broken into three sections including: (1) Epidemic of Obesity and its Consequences: An overview of the current epidemic of Obesity in the United States as well as it consequences on personnel and public health. (2) Obesogenic Built Environment and our Health: Highlighting and demonstrating the relationship and concept of “obesogenic-built environment” on individual health. (3) Living a healthier life: includes teachings and resources for officers in living a healthier life and interventions they can do in their workplace and environment.

At the end of this session, participants will be able to: 1. Explain Epidemic of Obesity and its Consequences 2. Describe Obesogenic Built- Environment and our Health 3. Describe Living a Healthier Life
Leading the Way to Wellness: One Community at a Time
Speaker: CDR Michelle Brown-Stephenson, BSN, MS, MLS, CHES, USPHS, South Central Regional Nurse Consultant for the Federal Bureau of Prisons

In this presentation participants will gain a working knowledge of how one community is well on its way to wellness. In 1997, Health Options & Alternatives, Inc. began its mission of alleviating knowledge deficits in healthcare by improving health literacy. Consumers are empowered through education to make healthier lifestyle choices using evidence-based research and standards to both treat and prevent prevalent diseases. Through a network of multidisciplinary resources consumers and health care providers have access to health options and alternatives that improve health and also quality of life. This presentation will not only provide participants with a best practice but also a working model that can be implemented in their community.

At the end of this session, participants will be able to: 1. Assess relevant/most prevalent health issues of the community. 2. Describe proven model to resolve the health issues. 3. Present a modifiable checklist to duplicate/implement in the community

Session 3: Focusing on Specific Populations
This session will look at prevention strategies applied to targeted populations.

3:15 pm - 4:45 pm

Dental Therapists as Part of a Dental Prevention Strategy
Speakers: Dr. Sarah Shoffstall-Cone, DDS, MPH, DENTEX Clinical Site Director, Alaska Native Tribal Health Consortium and LCDR Mary Williard, DDS, USPHS, Director, Department of Oral Health Promotion, Alaska Native Tribal Health Consortium

This session will address why the Alaska Area Tribal Health Organizations became the first in the United States to introduce Dental Health Aide Therapists (DHATs) to the dental team. The presentation will begin by looking at the history of dental caries in the AI/AK native population and the collaborative efforts that lead to the development innovative new dental providers. An overview will be given of the educational requirements for DHATs and the scope of services that they are able to provide. This session will also review the progress that DHATs have made in improving patient satisfaction, providing culturally competent, safe and appropriate care all while saving costs to the healthcare delivery system. Additionally the speaker will touch on outcomes that have nothing to do with teeth, but everything to do with improving the circumstances of the small communities in which DHAT are employed, such as creation of jobs and economic opportunities. The session will provide an overview of how the creative thinking by Alaska’s Tribal Health Organizations has received national attention. The presentation will culminate with information about how DHAT might be used in other settings to provide community-based preventive and clinical services. There will be a discussion of the work already being done in other states to pave the way for similar providers to be legally allowed to practice in places other than the Alaska Tribal Health System.
At the end of this session, participants will be able to: 1. Describe the access to dental care issues faced by Alaska Native people. 2. Identify how dental therapists can provide community-based prevention. 3. Identify other areas where these practices could be applied.

**Diabetes Self-Management Education as Key to Prevention**  
*Speaker: Mrs. Mary Nicole John, RN, Student*

This session will provide a brief introduction on diabetes and complications that can arise. The session also will cover Diabetes self-management education (DSME) programs, the benefits, and the structure of these programs. The presenter will offer ideas for integrating programs into the clinical practice setting, with group education for patients and address specific issues that arise in clinical practice that prevent referrals.

At the end of this session, participants will be able to: 1. Define what DSME is and the benefits for patients with diabetes. 2. Use this information to better serve their patients and integrate into practice 3. Determine when it is appropriate to refer patients to DSME programs.

**Partner Notification to Improve Detection and Care of Gonorrhea**  
*Speakers: LT Eleanor Fleming, DDS, PhD, USPHS, Epidemic Intelligence Service Officer, Office of Health Equity, National Center for HIV/AIDS*

This session will examine how patterns of notifying and treating partners of persons with gonorrhea differ by partner notification approach (PN). In 2011, 321,849 cases of gonorrhea were reported in the United States. PN is critical for gonorrhea control: initiated through public health professionals (provider referral), patients (patient referral), or patient-delivered partner therapy (PDPT). For provider referral estimates, researchers obtained 2010-2011 referral data for patients seen in STD clinics in 3 states. From the published literature (2005-2012), researchers extracted 10 estimates of patient referral data from 7 studies and 5 estimates of PDPT data from 5 studies. The researchers calculated the proportion of partners identified who were notified and who were treated, calculating notification and treatment ratios for each approach. With provider referral, 21 percent of partners named by patients were notified and 19 percent were treated. With patient referral, 56 percent were notified and 34 percent were treated. With PDPT, 57 percent were notified and 46 percent were treated. Per 100 patients seen in the clinic, 88 percent of those notified partners via provider referral; 64 percent of those notified with patient referral; 81 percent of those notified and treated with PDPT. Higher proportions of partners were treated through patient-based methods, but the highest proportion treated among those notified in provider referral. Scalable and sustainable mix of PN methods is needed.

At the end of this session, participants will be able to: 1. Compare partner notification methods. 2. Interpret a treatment and notification cascade. 3. Determine the best mix of partner notifications to improve linkage to care.
Understanding Native American and Alaskan Native Suicide

Speakers: CDR Julie Chodacki, PhD, USPHS, Chief, Comprehensive Airman Fitness, Air Mobility Command, Office of the Surgeon General

This session will explore suicide in Native American populations through the lens of community connectedness. Many conceptual models of suicide argue that community connectedness is the primary risk factor for suicide; lack of social ties makes one especially vulnerable to suicide. Indigenous populations that have been subjected to colonization have severe disruptions in connectedness. Thomas Joiner proposed what is the most researched theory of why people die by suicide. He argues that the acquired capability toward lethal self-injury is an overlooked and necessary element in the suicide equation. Applying social cognitive theory, I shall propose that mainstream American society's moral disengagement from the Native American experience leads to increased acquired capability for suicide among Native Americans. Native Americans are put in a bind: identifying with their sub-culture essentially dehumanizes them in the eyes of larger American society; on the other hand, identifying with mainstream American culture disengages them from their subculture. Both have the potential to raise suicidality.

At the end of this session, participants will be able to: 1. Describe Joiner's theory of suicide. 2. Identify Native American risk and protective factors for suicide. 3. Analyze how society's moral disengagement plays a role in increasing suicide risk.
Track 3: Clinical Services

10:30 am – 12:00 pm

Session 1: Behavioral Health
This opening session will examine clinical services addressing behavioral health issues.

Assessment and Management of Patients at Risk for Suicide
Speakers: CDR Meena Vythilingam, MD, USPHS, Deputy Director, Deployment Health Clinical Center

This session will examine completed and attempted suicide, which is a significant and persistent public health problem. The Centers for Disease Control and Prevention (CDC) estimates that veterans account for approximately 20 percent of the deaths from suicide in the United States. The 2013 based Veterans Affairs/Department of Defense Clinical Practice Guidelines (CPG) for the assessment and management of patients at risk for suicide will be reviewed in this session. Risk and protective factors for suicide, assessment and determination of suicide risk, treatment Interventions and safety planning and monitoring of patients at risk for suicide will be reviewed in detail.

At the end of this session, participants will be able to: 1. Apply evidence-based practices to assess suicide risk. 2. Use safety planning in patients at high risk for suicide. 3. Manage patients at high risk for suicide

Behavioral Health Guidelines for Treating Lesbian, Gay and Bisexual (LGB) Service Members
Speaker: Randy Georgemiller, PhD, Medical Evaluation Board and Outpatient Behavioral Health Service at Eisenhower Army Medical Center

This session will update providers on current treatment guidelines and affirmative strategies for more effectively addressing LGB Service Members’ Behavioral Health needs. Based on a longstanding consensus of all major Behavioral Health professional organizations, resolutions and treatment guidelines have been adopted recognizing a non-pathological stance toward normal variations of human sexual orientation. Social science research has also identified that LGB persons are more likely to suffer from emotional distress and behavioral problems as a result of societal prejudice and stigma. With the repeal of 10 USC 654 and its implementing regulations (legislation commonly known as “Don’t Ask, Don’t Tell”) service members are more likely to present for behavioral health services.

At the end of this session, participants will be able to: 1. Define sexual orientation. 2. List the five components of affirmative psychotherapy utilized with LGB patients 3. Cite five factors related to the repeal of "Don't Ask Don't Tell".

Military Behavioral Health Specialists: Increasing Access to Care
Speakers: CAPT Jennifer Iveland, MA, USPHS, Clinical Psychology Intern, Brooke
Army Medical Center; CAPT Thomas Patterson, PsyD, USPHS, Staff Psychologist Brooke Army Medical Center; and CDR Richard Schobitz, PhD, USPHS, Chief of Training and Research and Director of the Clinical Psychology Residency program, Brooke Army Medical Center

This training will address the gap in knowledge about how enlisted military behavioral health specialists are trained, how they can best be utilized in both garrison and deployed environments, and how licensed professionals can provide supervision to them and foster professional development. An overview of the didactic training behavioral health specialists receive at Fort Sam Houston will be presented and the skills they must demonstrate to graduate from Advanced Individual Training will be reviewed. The practicum training opportunities available to behavioral health specialists at Brooke Army Medical Center will also be discussed. Special emphasis will be placed on helping licensed providers identify ways in which they can best mentor behavioral health specialists to foster growth and utilize their skills most effectively.

At the end of this session, participants will be able to: 1. Describe the primary responsibilities of an enlisted behavioral specialist. 2. Identify skills behavioral health specialists must demonstrate in training. 3. Identify ways providers can best mentor behavioral health specialists.

1:30 pm – 3:00 pm

Session 2: Expanding Your Toolkit: Opportunities to Develop Useful Skillsets

This session will explore ways that clinical care providers can improve their performance by taking advantage of opportunities to enhance their clinical and non-clinical skills.

Achieving Excellence: Leadership in a Clinical Setting

Speakers: CDR Jamal Gwathney, MD, MPH, USPHS, Clinical Director, Federal Bureau of Prisons and LCDR Melanie Paredes RN, USPHS, Assistant Health Service Administrator, Bureau of Prisons

This session will educate healthcare providers from a variety of disciplines on the importance of clinical leadership and how to implement that leadership within their healthcare organization. Many clinicians feel a constant pressure to meet their basic clinical commitments and patient workloads, preventing clinicians from taking up opportunities to become involved in leadership. Clinical leadership is an integral part of not only creating a cohesive unit but also improving adherence to policies/procedures and clinical practice guidelines, as well as improving clinical outcomes. Leadership increases confidence in clinicians and empowers team members to seek challenging opportunities to increase professional growth. The development of future leaders is dependent on whether our practice environment is supportive and contains strong leadership which will identify the leadership abilities of their team. This session will
describe key factors in strong clinical leadership, describe how to implement leadership techniques, and ways to measure leadership outcomes in a clinical setting.

At the end of this session, participants will be able to: 1. List important factors that are key to clinical leadership. 2. Describe examples of clinical leadership implementation strategies. 3. Describe potential outcomes to measure the success of leadership intervention.

Post-War to Prison: Continuing Clinical Skills in the Future
Speakers: CAPT George Durgin, MS, USPHS, Commissioned Corps Liaison, Federal Bureau of Prisons and CAPT Stephen Spaulding, USPHS, Warden Federal Bureau of Prisons

This session will explore how, with over 1,600 healthcare providers within the Bureau of Prisons there are opportunities as a civilian provider or a USPHS officer within 119 institutions in the United States and territories for clinicians to serve vulnerable populations that are now confined within the BOP. Working for the BOP provides a unique opportunity to provide a full range of healthcare skills to deliver medically necessary healthcare to inmates effectively in accordance with proven standards of care without compromising public safety concerns inherent to the Bureau’s overall mission. BOP healthcare opportunities and experiences will be explored with BOP staff to gain an understanding on how you can continue in civil or Uniformed Service with the BOP following a military career.

At the end of this session, participants will be able to: 1. Describe the clinical settings of the Federal Bureau of Prisons 2. Explain how providers are selected in the Federal Bureau of Prisons 3. Identify examples of healthcare provided to inmate patients within the BOP.

Provision of Culturally Competent Care
Speaker: Mrs. Nicole John, RN, BSN, BS, Duke University School of Nursing

This session will open with the question “What does cultural competence mean to you in relation to providing care to ethnic diverse populations?” The presenter will provide an overview of culturally competent care; introduce and define cultural competence; give background information on ethnic minority populations, disparities in health care, and rates of disease in the United States; present statistical data on positive outcomes that result from culturally competent care; and provide different culturally competent models and training programs. This will provide a base that attendees can draw from when integrating culturally competent care into future practice. Such models will be the CARE model, the Providers Guide to Quality and Culture, the National CLAS Standards, and other models deemed pertinent. Finally a dialogue will be established for input from attendees on what culturally competent care means to them, reaching out to all ethnic backgrounds in audience. With a base of knowledge on culturally competent care and knowledge attendees will leave with an enhanced competence and understanding of the
significance of providing culturally competent care. With this new and reinforced cultural awareness clinical and public health outcomes can only improve.

At the end of this session, participants will be able to: 1. Explain the meaning of cultural competence and how to provide that level of care. 2. Identify the outcomes that result from provision of culturally competent care. 3. Integrate culturally competent care into practice for ethnically diverse populations.

3:15 pm – 4:45 pm

**Session 3: Addressing Specific Clinical Issues**

*This session will examine new research and programs aimed at addressing specific clinical issues faced by health-care providers.*

**Implementation of an Interdisciplinary Chronic Pain Service**

*Speaker: LT Keith Warshany, PharmD, PhC, BCPS, USPHS, Northern Navajo Medical Center Chronic Pain Management Clinic*

This presentation will elaborate upon the epidemiology of prescription drug misuse and describe how an interdisciplinary pharmacist-run clinic has simultaneously addressed the issues of chronic pain and prescription drug misuse at Northern Navajo Medical Center (IHS, Shiprock NM). The presentation will offer a template for health care providers who may be trying to establish their own clinical specialty service for pain management. It will detail the use and respective limitations of screening tools that may offer a degree of objective assessment in patients with chronic non-cancer pain.

At the end of this session, participants will be able to: 1. Identify patients at highest risk for prescription drug overdose. 2. Describe an interdisciplinary model for an ambulatory pain management service. 3. Apply screening tools that may be of utility in the context of pain management.

**Translating Evidence-Based Pediatric Obesity Care into Practice**

*Speaker: Melissa Baker, MPH, Community Corrections Manager, Buncombe County Department of Health*

This session will describe the WNC Pediatric Care Collaborative, a physician-led collaborative model where primary care physicians, specialists, insurance payors and community public health work together to translate evidence-based care for Pediatric Obesity. Collaborative leadership is provided by: Mountain Area Health Education Center, Community Care of WNC, Buncombe County Health Department, and Pediatrician Calvin Tomkins. With physician champions, evidence-based obesity guidelines, practice work-flow, team-based care, quality measures, and billing were combined into a protocol. Strategies to increase practice implementation include: aligning with MU/PCMH criteria; training providers on health literacy; building skills in motivational interviewing. Presenters will highlight the mission & vision of the Collaborative, the obesity workflow for practice implementation, evaluation methods,
and healthy weight screening tool. They will discuss lessons learned while supporting 15 primary care practices: challenges working with multiple EHR systems, readiness for clinical transformation, aligning with clinical quality criteria, communication with families, and limited referral sources. The WNC Pediatric Care Collaborative model translates knowledge into practice by developing evidence-based interventions that improve the quality of clinical care for pediatric patients.

At the end of this session, participants will be able to: 1. Describe the key elements of the program. 2. Identify a strategic approach to engage and align medical practices with communities. 3. Use the collaborative methods for evaluating implementation of quality care.

**Treatment and Risk Factors for Rocky Mountain Spotted Fever (RMSF)**

*Speaker: CDR Dwight Humpherys, DO, USPHS, Indian Health Services*

This presentation will present evidence that shows how early treatment with Doxycycline can be life-saving to a patient with RMSF and will also show what are some of the most frequent physical and laboratory findings of RMSF. This information has important practice changing guidelines for any provider working in the Southwest where, since 2002, researchers have discovered a different and more virulent strain of this disease not before known in the United States. This research shows that early findings, occurring in the first three days of illness, were significantly more common in fatal cases than survivors. These findings are: abdominal pain, anorexia, nausea, vomiting, diarrhea and hepatosplenomegaly. Rash occurred later in fatal cases (day 5.5) then survivors (day 2). Patients with a history of alcohol abuse or chronic lung disease were at greater risk of a fatal outcome. However, on a multivariate analysis, neither abdominal symptoms nor medical history remained significant because only delayed treatment with doxycycline was associated with a fatal outcome. Classic findings of RMSF such as thrombocytopenia, hyponatremia and petechial rash were often detected late in disease progression. Fatal cases were treated on median day 7 of symptoms and survivors treated on day 3 of symptoms- thus justifying early treatment with Doxycycline. The risk for hospitalization and fatal outcome increased with each day’s delay in treatment.

At the end of this session, participants will be able to: 1. Describe three laboratory findings that are common in patients with RMSF. 2. Explain what physical findings are present with many patients with RMSF. 3. Explain the role of Doxycycline in treating RMSF.
Track 4: Pharmacy

10:30 am – 12:00 pm

Session 1: Medications
This session will examine issues, challenges and opportunities in the handling of medications.

Exposures to Drugs in Pharmacies, Clinics, and Other Settings
Speaker: LCDR Kenneth Fent, MS, PhD, USPHS, Senior Industrial Hygienist, National Institute for Occupational Safety and Health

This session will look at issues surrounding drug exposure. In 2012, 4.6 billion prescriptions were filled in the United States. These prescriptions included one of more than 10,000 pharmaceuticals currently in use. Many pharmaceutical manufacturers take measures to protect their employees from being exposed to drugs at levels above internally set hazard control bands or occupational exposure limits. However, manufacturing of pharmaceuticals is just the first step in the lifecycle of a drug. Other steps include the distribution, dispensing, administration, and excretion (or disposal) of a drug. Potential health impacts from exposure to drugs depends on a variety of factors including the exposure levels, absorption routes, vulnerability of the exposed population, and potency, toxicity, and interaction of the drugs. The potential for unintended human exposure exists during each of these stages in the lifecycle. In this session, the presenters will discuss recent studies and health hazard evaluations concerning occupational exposures to pharmaceuticals, antineoplastic, and other hazardous drugs at pharmacies, clinics, and other settings. The presenters will summarize the exposure assessment results, discuss the potential health implications from these exposures, and highlight the measures that can be taken in indirect and direct patient care settings to minimize or prevent occupational exposures to pharmaceuticals.

At the end of this session, participants will be able to: 1. Explain the lifecycle of a pharmaceutical as it relates to human exposure. 2. List ways employees could be exposed to drugs and related health effects. 3. Describe measures that can be taken to minimize pharmaceutical exposures.

Medication Therapy Management (MTM) in Medicare and the Affordable Care Act
Speakers: LCDR Jerry Zee, PharmD, USPHS, Regional Pharmacist Center for Medicare and Medicaid Services

This session will expand the understanding of a professional’s knowledge and practice in Medication Therapy Management (MTM) which is not just within the framework of the pharmacy profession, but the overall healthcare delivery model in the 21st century. After attending this educational program, a professional will comprehend the impact that MTM already has on the patient population and what it means in the future in terms of optimization of health-system performance with better health, better care, and lower costs.
At the end of this session, participants will be able to: 1. Distinguish what evidence-based pharmaceutical care means in the Medicare program. 2. Analyze the impact on Medicare beneficiaries since MTM has been enacted. 3. Describe how MTMs are making an impact within the Affordable Care Act via ACOs.

Reducing Medication Errors Using a Human Factors Approach
Speakers: LT LeAnn Poole, PharmD, USPHS, Centers for Medicare and Medicaid Services

This session will examine how national statistics indicate that more than 1.5 million preventable medication-related adverse events occur each year in the US, with costs of more than $177 billion annually for associated care. Several studies document error rates at Outpatient and Ambulatory Pharmacies between 3.23 percent and 12.5 percent. Opportunities for errors are often a result of latent conditions such as noise, lighting, interruptions and distractions, and volume of prescriptions filled per hour, all of which are inevitable within the system. Human factors engineering (HFE) is the discipline that takes into account human strengths and limitations in the design of interactive systems that involve people, tools and technology, and work environments to ensure safety, effectiveness, and ease of use. It attempts to identify and address issues as it relates to a particular activity in terms of its component tasks, and then assesses the physical demands, skill demands, mental workload, team dynamics, aspects of the work environment (e.g., adequate lighting, limited noise, or other distractions), and device design required to complete the task optimally. This session will review current research data to support the application of HFE to pharmacy settings to minimize interruptions and distractions in an effort to reduce medication errors.

At the end of this session, participants will be able to: 1. Summarize the incidence of medication errors in the United States and impact to public health. 2. Describe Human Factors Engineering and its application in various settings. 3. Evaluate application of HFE to a pharmacy setting and the impact to patient safety.

1:30 pm – 3:00 pm

Session 3: Addressing Specific Healthcare Challenges
This session will examine pharmaceutical interventions related to three specific healthcare challenges: diabetes, the use of nutrition supplements and HIV/AIDS.

Diabetes Medications: A Quick Overview
Speaker: LCDR Tamy Leung, PharmD, USPHS, Tuba City Regional Health Care Corp

This session will give a summary of the latest American Diabetes Association guideline on the treatment of diabetes. It will identify the various classes of drugs that are available for treatment and engage health providers to select the most appropriate ones for their patients. Additionally, the session will discuss the new drugs that are currently under development for the treatment of diabetes.
At the end of this session, participants will be able to: 1. Define the American Diabetes Association treatment guideline for diabetes. 2. Determine the most appropriate treatment for a patient with diabetes 3. Identify the new drugs that are being researched for diabetes treatment.

**Dietary Supplement Use: A Risky Business**  
*Speaker: LCDR Kevin Chatham-Stephens, MD, MPH, USPHS, EIS Officer, Centers for Disease Control and Prevention*

This session will highlight potential adverse health effects associated with dietary supplement use and describe the current regulatory process for these products. In 2013, Centers for Disease Control and Prevention (CDC) responded to 2 outbreaks related to nutritional supplements. The first outbreak resulted from adulteration of multiple vitamins with anabolic-androgenic steroids (AASs). A cohort study identified 137 cases; median patient age was 50 (range: 11-79) years; 72 percent were female. Exposure was significantly associated with adverse health outcomes, including liver injury (RR: 7.7; CI: 1.1 55.7), hair loss (RR: 12.2; CI: 1.7 87.0), and hot flashes (RR: 4.24; CI: 1.4 13.1). In the second outbreak, exposure to a dietary supplement resulted in herbal-induced liver injury in 72 cases; median patient age was 35 (range 16-67) years and 55 percent were female. Commonly reported symptoms included dark urine, jaundice, and fatigue. Of case-patients identified, 29 (40 percent) were hospitalized, 3 (4 percent) received liver transplants and 1 (1 percent) died. Fifty-one (82 percent) of patients reported exposure to a common dietary supplement.

At the end of this session, participants will be able to: 1. Explain the range of adverse health effects associated with dietary supplements. 2. Describe the regulatory process for dietary supplements. 3. Identify resources available to public health and medical providers.

**Trials and Triumphs HIV Pharmacy Clinic Program**  
*Speaker: CDR Robert Macky, PharmD, NCPS, USPHS, HIV Clinical Pharmacist, Bureau of Prisons*

This session will review the revised Center for Disease Control and Prevention’s (CDC) goals of HIV treatment; discuss the definition and impact of a collaborative pharmacist practice on HIV patient care; review what providers and other members of the medical professions should expect from a HIV clinical pharmacist in terms scope and responsibility; and demonstrate how an HIV Advanced Pharmacy Program was justified, promoted and sustained.

At the end of this session, participants will be able to: 1. Apply Information from national guidelines for HIV treatment. 2. Manage Chronic care needs of HIV patients more efficiently. 3. Utilize Clinical Pharmacists as part of a treatment team approach.
Session 3: Unique Pharmaceutical Challenges and Opportunities

This session will look at approaches to three unique issues in the pharmaceutical world.

A Unique Perspective on Delivering Sedation
Speakers: LT David Good, II, Certified Registered Nurse Anesthetist, USPHS, Alaska Native Medical Center

This session will discuss the specifics related to a process for delivering sedation. It will also discuss the results of a retrospective program evaluation that took place in January 2014. The evaluation’s purpose was to determine whether Nurse Administered Propofol (NAP) for sedation during endoscopic procedures has produced a measurable difference in safety, cost, and sedation quality for patients 18-70 years old who aren’t pregnant or incarcerated. The quality of sedation will be measured by comparing staff surveys taken between April 2011 - September 2011 prior to the initiative, to surveys taken between April 2012 and September 2012 after the initiative. The sedation survey tool contains a 5-point Likert scale question measuring overall quality of sedation. Patient safety and cost savings will be measured by comparing anesthesia intervention rates, adverse outcomes, and Post Anesthesia Care Unit (PACU) admissions following sedation before and after the initiative.

At the end of this session, participants will be able to: 1. Demonstrate an understanding of the challenges associated with drug shortages in this environment. 2. Describe the process improvement project, involving a multifaceted training program. 3. Describe the results of a retrospective program evaluation.

How an Antidote Becomes a Poison
Speaker: LCDR Anastasia Shields, PharmD, USPHS, Pharmacist, Indian Health Service

This session will examine toxin antidotes and potential complications. The role of chronic disease state management and treatment of acute illness is well-established and justified in the daily practice of pharmacy. However, caring for patients when they become toxic from a medication or substance either purposefully or accidently can sometimes involve complications and medications that are not seen in everyday practice or reviewed on a consistent basis. Antidotes used to treat some of the common toxidromes are often perceived safe due to their classification as antidotes and complications from their use as well as caution and appropriate administration may be a gray area in certain pharmacy practice settings. This lecture reviews a few common antidotes and some of the more common complications that may present themselves as well as how to manage these complications and or prevent them from occurring.

At the end of this session, participants will be able to: 1. Analyze a few common antidotes, mechanism of action and potential for harm. 2. Apply appropriate use of antidotes. 3. Manage the pharmacological effect of antidotes.
Role of New Drug Development to Fight against the Rare Disease

Speaker: CDR Haksong Jin, PharmD, USPHS, Senior Research Pharmacist, National Institutes of Health

This session will examine rare diseases and the efforts that the Department of Health and Human Services (HHS) is making to taking care of them. Individual care is in trend and some medicines are produced only for one patient. Cysteamine eye drops and copper histidinate are good examples of rare diseases. Serum eye drops and cancer vaccines are examples of individual care.

At the end of this session, participants will be able to: 1. Distinguish the rare disease. 2. Formulate the new agents for the clinical studies. 3. Apply to the patients with individual care.
Track 5: Innovation

10:30 am – 12:00 pm

Session 1: Innovation to Address Specific Challenges and Opportunities
*This opening session will look at innovative efforts to address specific challenges and opportunities in the public health field including citizen science, global health security threats and workplace violence.*

Citizen Science and Emerging Technologies
*Speaker: Ms. Amanda Kaufman, MSPH, Environmental Health Fellow, Environmental Protection Agency*

This session will discuss challenges and opportunities associated with citizen science and how emerging technologies can support citizen science activities. In addition, the session will provide an overview of low-cost environmental monitors and sensors and introduce the Citizen Science Tool Box, a suite of recommendations and technical guidance materials to assist with citizen science monitoring campaigns. There exists a strong desire by the general public to collect environmental data of importance to their family or community. This desire is driven by a wide variety of goals including concerns citizens have about known or perceived local pollution sources. Low-cost environmental sensors and monitors have recently been introduced into the public domain, giving residents the opportunity to collect environmental data for their own use. The Citizen Science Tool Box will provide guidance and instructions to citizens to allow them to effectively collect environmental data. This includes a list of devices with known performance characteristics, sampling methodologies, generalized calibration/validation approaches, measurement method suggestions, data interpretation guidelines, and education and outreach. The ultimate goal of the Tool Box is environmental awareness of local pollution levels through citizen-based environmental monitoring.

At the end of this session, participants will be able to: 1. Explain application of low-cost environmental monitors for citizen-based monitoring. 2. Describe how the Tool Box can assist citizens in collection & interpretation of data. 3. Identify examples of low-cost air sensors and understand their applications.

Combatant Commands: The Path Forward for Department of Health and Human Services (HHS) and Department of Defense (DoD) Engagements
*Speakers: LCDR Matthew Johns, USPHS, U.S. Pacific Command Surgeon’s Office and CAPT Michael Schmoyer, PhD, MSEd, USPHS, HHS Liaison Officer, Southern Command, Department of Defense*

This session will examine how, in January 2014, the President announced a whole-of-government Global Health Security Initiative (GHSI) that requires HHS, DoD, and other USG partners to collaborate on strengthening their work together to protect the nation from global health security threats. GHSI describes the importance of aligning strategies...
inter-departmentally and perhaps nowhere is that done more effectively than at DoD's large geographic combatant commands (CCMDs). This presentation will describe current/past/projected successes that have already been demonstrated by collaboration between HHS and DoD and aligning with GHSI. Presenters reflect their daily work in an interagency environment comprising more than 30 different USG agencies working together to address multi-million dollar initiatives in their three respective geographic regions (NORTHCOM, SOUTHCOM, and PACOM). The presentation will provide a dialogue on where DoD public health-related doctrine aligns with HHS goals and specific examples of how current work strengthens GHSI in a variety of sectors (e.g., disease surveillance, preventing infectious diseases, preparing/responding to public health emergencies and disasters, and strengthening adherence to international health standards via multiagency engagement. USG strategies discussed will include: -GHSI -The President's Emergency Plan For AIDS Relief (PEPFAR) -The President's Malaria Initiative (PMI) -The President's Global Health Initiative (GHI)

At the end of this session, participants will be able to: 1. Describe how HHS & DoD partnerships support the Global Health Security initiative 2. List specific sustainable engagements that HHS & DoD have undertaken internationally. 3. Explain common interagency coordination pitfalls and associated solutions.

1:30 pm – 3:30 pm

Session 2: Fostering Innovation
This session will look at programs underway to foster and encourage innovation in public health.

Creating a Culture of Innovation in Local Public Health
Speakers: Dr. Colleen Bridger, MPH, Orange County Public Health Director and Mr. Michael Fliss, MSW, Health Informatics Manager, Orange County Public Health

This session will help public health professionals working in organizations providing direct clinical services and / or population health surveillance and interventions (LHDs, FQHCs, etc.) learn methods to create a culture of innovation at their organization for the purpose of improving public health. Presenters from the Orange County Health Department will drill down into two specific vehicles for innovation (Local Health Department Innovation Grants and local data partnerships/dashboards) and their consequences for improved public health at the local level.

At the end of this session, participants will be able to: 1. Describe multiple aspects of creating a culture of innovation in local public health. 2. Evaluate two specific examples of innovation in local public health (LPH). 3. Describe how to create population health data in partnership with LPH.
The Center for Medicare and Medicaid Innovation at CMS
Speakers: CDR Frances Jensen, MD, USPHS, Centers for Medicare and Medicaid Services

This session will: explain the goals, strategy, organization and operations of CMMI in the context of CMS and HHS; describe some of the models, including Accountable Care Organizations, the Comprehensive Primary Care Initiative, the Health Care Innovation Awards and the State Innovations Model, that have been launched by CMMI across the country, with a particular emphasis on those that include public health and delivery transformation; report some key findings, challenges, and lessons learned from the models and their participants; provide the opportunity for participants to discuss their ideas about how to improve healthcare delivery; help attendees discover how they can learn more about health reform initiatives that they can potentially implement in their agencies and in their own work that support the USPHS mission.

At the end of this session, participants will be able to: 1. Describe the purpose of CMMI and how it is accelerating health reform. 2. Explain some of the new models for healthcare delivery and payment. 3. Use several of the lessons learned from CMMI in their own work.

USPHS in Innovative Health Policy and Strategy
Speaker: CAPT Paul Reed, MD, USPHS, Director, Federal Health Futures Initiative

This session will elaborate on the relevance of the Federal Health Futures Initiative to the national and federal paradigm shift from a focus of healthcare delivery to one of health. A discussion of the history of the initiative, to date, will lead in to an interactive dialogue on the national strategic imperative of health for the Nation and the predominant role the US Public Health Service has amongst governmental and nongovernmental partners. The futures-based themes/imperatives of network leadership, accurate communication, innovation and wisdom generation, as well as personal responsibility will be highlighted and form a backdrop to the explanation and conversation about USPHS engagement. Aligning the future strategy of the USPHS against those of federal partners and national propositions such as the National Prevention Strategy, the National Quality Strategy, and the Global Health Initiative will be prominent in this presentation. Ultimately, attendees will have a better understanding of futures-based thinking, the impact on a national dialogue and the important role that the USPHS plays in strategically and operationally applying its capabilities to further the agenda on health not healthcare in the context of a national strategic imperative for health and our organization’s own future strategy. Senior USPHS leadership will participate in an interactive discussion with attendees.

At the end of this session, participants will be able to: 1. Define the current impact of the federal health futures initiative. 2. Identify partners and central themes in health futures strategy. 3. Define the role of the USPHS at levels from the individual officer to headquarters.
3:15 pm – 4:45 pm

Session 3: Innovative Public Health Strategies in Selected Communities
This session will look at innovative programs being piloted at the community level.

Integrative Holistic Medicine: An Optimal Healing Environment
Speaker: CAPT George Ceremuga, MD, USPHS, Chief, Integrative Holistic Medicine, Ft. Belvoir Community Hospital

This session will integrate the care that healing organizations provide across the continuum of care based on the patient and family priorities. Integrative medical care incorporates the best evidence-based healing oriented practices and life-style changes, with conventional medical approaches to ameliorate disease and alleviate suffering. Combining the best of western medicine with complementary and alternative medicine to create a center of health and well-being takes organizational commitment and hard work. Done well, the pay-off is a healthier, more vibrant and resilient community/nation

At the end of this session, participants will be able to: 1. Demonstrate an understanding of Integrative Holistic Medicine 2. Apply the principles of an Optimal Healing Environment. 3. Encourage dialogue regarding health, well-being and healing.

Building Partnerships on Tribally-Built Health Care Facilities
Speakers: CAPT Kelly Leseman, PE, MS, USPHS, Health Facility Engineer, Indian Health Services

This session will demonstrate how Indian Self-Determination can successfully work. Two hospitals were recently completed in Barrow and Nome Alaska. Construction was managed and/or procured through PL 93-638 Title V agreements between the Tribe and IHS. In addition, four new health centers were also completed through the IHS Joint Venture Construction Project (JVCP) Program. The Arctic Slope Native Association completed both design and construction of a $152-Million hospital in Barrow. The $172-Million Nome hospital was constructed with a federally procured contract and project/construction-management services provided by the Norton Sound Health Corporation. Barrow is the only IHS hospital to be fully constructed by a Tribe and these agreements are the largest Title V construction agreements in IHS history. Alaskan Tribes were also the recipient of four JVCP projects which, is a unique IHS program where a Tribe agrees to build a health facility according to IHS program requirements and design standards, and the IHS agrees to lease and staff the new facility. Both the PL 93-638 Title V agreements and the joint venture projects all presented unprecedented and unique challenges that fostered a close working relationship between the IHS and Tribes. The successful completion of these projects will bring nearly $100 Million in new annual health care dollars to serve the Alaskan Natives in some very remote and underserved parts of the State.

At the end of this session, participants will be able to: 1. Demonstrate how Indian Self Determination can work on large IHS Health Care Facilities 2. Demonstrate how IHS
can be flexible to meet Tribal needs. 3. describe 6 new Hospitals/Health Care Facilities that were constructed in Alaska by Tribes

**Mr. Shaky and the PHS Backpack: Daycare Disaster Preparedness**
*Speakers: LCDR Cassidy Brown, RN, BSN, MSHS, USPHS, Health Services Administrator, Federal Bureau of Prisons; CDR Christopher McGee, LCSW, USPHS; Forensic Social Worker, Federal Bureau of Prisons and CDR Selena Ready, PharmD, USPHS, Safety Evaluator, Food and Drug Administration*

This presentation will describe a public health initiative that educated and provided disaster preparedness for Kentucky Region 1 Child Care Centers. The officers of the USPHS Services Access Team 3 (SAT-3) participated in the National Disaster Medical System National Level Event (NLE) in Paducah, Kentucky. This team demonstrated public health innovation and progress when it partnered with the local community and created educational earthquake preparedness videos, as well as, developed a portable disaster tool kit/backpack with instructional video included for all State of Kentucky Region 1 child care centers. The impact of this one-week field training was greater than 7000 children were assisted with emergency preparedness. The Region 1 child care center coordinator implemented the educational program to ensure that both children and staff viewed the video and used the disaster backpack in the child care centers. Thus, SAT-3's ingenuity and creativity provided an opportunity to promote, protect, and advance the safety and health of the population of the State of Kentucky.

At the end of this session, participants will be able to: 1. Identify the gaps in earthquake emergency response planning of child care centers. 2. Formulate goals to educate regarding overall emergency response planning. 3. Use the SAT-3 educational program for local and regional child care centers.

**Supporting the Surgeon General's Walking Initiative in Prison**
*Speakers: LCDR Misty Rios, FNP, USPHS, Family Nurse Practitioner, Federal Bureau of Prisons and LCDR Tara Ross, RN, USPHS, Federal Bureau of Prisons*

This session will examine the Surgeon General's Walking Initiative which charges individuals, families and communities to create a healthier nation by promoting active lifestyles. The Federal Bureau of Prisons (BOP) currently has 219,357 incarcerated inmates. Recent research suggests chronic conditions are more prevalent in prisons than the outside world. Nearly 39 percent of federal inmates have at least one chronic condition. A leading cause is the high prevalence (47 percent) of obesity. As a result correctional systems are increasingly feeling the impact of these growing concerns. Circumstances before, during and after incarceration increase the risk for poor health outcomes. Better managing inmate health conditions is crucial for community health since nearly 30 percent of Federal inmates will be released within the next 10 years. Prisons need to become more involved in health improvement efforts to prepare inmates for reintegration back into communities. The BOP currently employees 38,507 Federal employees. Research shows prison employees have increased use of coffee, cigarettes, alcohol, are at risk for unbalanced nutrition (fast-food in shift work) and
insufficient exercise. Connections need to be established between work in prisons and the health situation of staff. Prison employees represent a model for the inmates. Creating a steady, comprehensive and multidisciplinary health promotion process will evolve the idea of health promotion in prisons from idea to action.

At the end of this session, participants will be able to: 1. Identify risk factors for poor health outcomes in the inmate population. 2. Apply walking as a way to increase active living among inmate population. 3. Identify opportunities & actions to take to improve health promotion.
5:00 pm – 6:00 pm

**Wednesday Closing Keynote**

*Speaker: William Lanier, MD, Professor of Anesthesiology, Mayo Clinic Proceedings, Mayo Clinic*

As Editor-in-Chief of the journal Mayo Clinic Proceedings, Dr. Bill Lanier will share his expert perspective and advice with attendees. He will describe the importance of sharing medical information to improve the public’s health. Officers in the Public Health Service Commissioned Corps and their civilian partners in local, state, and tribal health departments have a great deal of research findings and practice experience to share with the public. Dr. Lanier will address why attendees should publish and how the process happens.

At the end of the session, attendees will be able to: 1. Describe the public’s expectations for medical information. 2. Identify the methods physicians, scientists, and journals use to optimize the quality of medical information. 3. Develop realistic expectations for the strengths and weaknesses of conclusions based on scientific research. 4. Discuss the challenges— to authors, journalists, and others—in communicating new medical information to the public.
Thursday, June 12

5:00 pm – 6:00 pm

Closing Keynote
Speaker: RADM Boris Lushniak, USPHS, MD, MPH, Acting Surgeon General of the U.S. Public Health Service Commissioned Corps

RADM Lushniak serves as the Acting Surgeon General of the United States. The session will highlight his vision of how officers in the USPHS Commissioned Corps will collaborate with local, state, federal, and tribal partners to improve public health in communities large and small. He will also touch upon issues of parity between the Commissioned Corps and sister services, emphasizing the USPHS Commissioned Corps’s unique mission to “protect, promote, and advance the health and safety of our Nation.”

At the end of this session, participants will be able to: 1. Articulate the Acting Surgeon General’s vision for the future of the Corps’ role in public health. 2. Consider new ways to partner with organizations outside of the USPHS Commissioned Corps. 3. Identify areas of improvement in the national, state and local public health systems.