



Words of Wellness

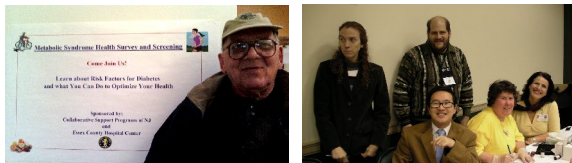


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HIGHLIGHTS OF WELLNESS AND RECOVERY CONFERENCE

Wellness is Possible!, our annual wellness and recovery conference, will take place on Thursday March 19th and Friday, March 20th. The full conference brochure and registration form are available by accessing the current “wellness calendar” link at the bottom right-hand corner of www.cspnj.org. This year’s conference has relocated to the Pines Manor in Edison, New Jersey. The price is \$60 per person per day¹. As in the past, we expect various agencies, self-help centers, and self-help groups to be able to offer scholarships and transportation assistance.

The latest breakout session to be added to the conference schedule is Asset Building Practices for People with Disabilities and Special Needs to Increase Wellness and Recovery, Attendees may register for this workshop a, to be offered in the third session on Friday, as #2C7. In this session, presenters Peter Stahl and Zoraida Reyes will share their vision and victories of asset-building practices for people with special needs/disabilities. Participants will learn effective practices used in assisting such individuals in regards to money management despite severely limited incomes.



HEALTH SCREENING HELPED RAISE AWARENESS

For nearly a quarter of a century, the annual COM-HCO² conference has been a major event in New Jersey’s mental health self-help community, bringing together people involved in mental health self-help centers and groups from around the state for education and socialization. Like our own Wellness and Recovery Conference, current patients from New

Jersey’s state psychiatric hospitals are also an important and visible presence.

In an innovative project this year, CSPNJ and Essex County Hospital Center collaborated to conduct a health screening during the period at the conference. The screening was intended to serve several purposes:

1. To identify people who might be at risk of having diabetes, but who do not have a diagnosis. We did this primarily by computing people’s body mass index (BMI). BMI, calculated by a formula based on height and weight, is one of several predictors of Type II Diabetes.
2. To find out if it were likely that the identified individuals did have diabetes or a related “pre-diabetic” condition. We did this by means of a piece of equipment known as an A1Cnow testing system.³ Unlike typical portable blood glucose testing systems, which measure the level of sugar in a person’s bloodstream at the time of testing, glycolated hemoglobin (A1C) testing provides a reliable estimate of the average blood sugar level a person had over the past 2-3 months. People with diabetes and their physicians rely on A1C measures to determine the effectiveness of their diabetes treatment. In a screening setting, the A1C measure can provide a more reliable indicator than a blood sugar level. We did, in fact, identify a few people who had significantly elevated A1C measures, and helped them work through the means to plan getting prompt medical attention.
3. To provide people who were deemed most likely to have diabetes with information that would allow them to choose and seek the medical care they would need. We did this with a combination of one-on-one conversations and a “Special Edition” of this newsletter aimed at people who have just learned that they likely have diabetes or are pre-diabetic⁴.
4. To gather some health indicator data about people in our mental health community. We did this with a health history questionnaire, along with gathering

³ www.a1cnow.com.

⁴ Several of the articles in this newsletter issue relating to diabetes and primary healthcare access were originally written for the “special issue.”

¹ For registrations received on or before February 24, 2009

² New Jersey Coalition of Mental Health Consumer Organizations

personal height, blood pressure, and waist measurement.

5. To help people get information about the status of their health. We did this by giving people written feedback of their weight, waist measurement, and blood pressure.
6. To show to a few “naysayers” that members of our mental health community were indeed interested in determining their health risks. We feel that we accomplished this last objective.

Confidentiality considerations prevent us from showing a picture of the screening “in full swing,”⁵ but it was truly inspiring to see the large conference room filled with people lining up for surveys, blood pressure tests, blood tests, etc. Several of us were inspired to work on getting health screenings going at COMHCO and other similar events and settings in the future. We have already conducted a similar center at the Freehold Self-Help Center, and expect to be working on diabetes and other screenings throughout the mental health community.

Remember:

- Free subscriptions and content submissions by e-mailing nleditor@cspnj.org
- Back issues and index at www.cspnj.org/services/wrinstitute/newsletters.html
- Latest Calendar Edition by following the link at the bottom right-hand corner of www.cspnj.org.

DIABETES – ONE MAN’S STORY

“You have diabetes.” This statement in 1997 from my primary doctor/internist should not have come as much of a surprise. Like many Americans, I had gained a good amount of middle body weight; caused in part by lack of exercise and a diet too high in fats and simple carbohydrates. I had also gone through a period of several years of having no primary doctor, and of no healthcare other than dentist visits (it might have gone on longer, except that the women in my life urged me to see a doc for a respiratory infection, and I liked the man, so I decided to let him assist me in trying to get my health under control).

Over the next few years, I learned that the diabetes, which had advanced for several years before diagnosis, had caused damage in a few key areas, such as:

- My eyes. I had “diabetic retinopathy,” meaning that the high blood sugars led to bleeding inside my eyes, which could have led directly to blindness. I went through several surgeries (laser and open) to deal with this, and still suffer from unavoidable aftereffects of the treatment (cataract and reduced night vision).
- My kidneys. I had developed “diabetic nephropathy.” Untreated, this could have led quickly to the need to be on dialysis. This condition has reversed itself through getting my blood sugars under control, and through medication to deal with the nephropathy.

- My muscles. “Frozen Shoulder,” or adhesive capsulitis, is a condition which occurs in diabetes that results in extreme discomfort in muscle motion, and reduced my range-of-motion. I was able to deal with this through a course of physical therapy.

Like many other people with diabetes, I met the diagnostic criteria for “the metabolic syndrome,” in which a triad of diabetes, high blood pressure⁶, and dyslipidemia⁷ came together, and created combined risks to my quality-of-life and length-of-life.

The first bit of good news came in seeing the well-organized way in which the healthcare system helped me deal with the diabetes. My doctor handed me a packet when he made the diagnosis. Along with useful information, the things in the packet led to me receiving, within days:

- A blood glucose meter in the mail
- An appointment with a registered nurse to learn how to use the meter
- An appointment with a registered dietitian to plan a diet which would assist me in controlling the diabetes
- An enrollment in a 4-session course at a local hospital to learn about the diabetes and related issues. This course covered a range of topics including holiday planning, sick-day planning, and the effects of poor blood sugar control. I was urged to bring my wife with me to these classes, so we could learn this information together (which we did).

I was also told that I could get refresher education (individual or group course) if and when I needed it. I later learned that the organized diabetes treatment and self-help community had fought the battles before me, so the

⁵ Pictured at the beginning of the article (left) is the screening poster, along with CSPNJ Executive Director Jack Bucher; (right) are members of the screening team, including collaborators from Essex County Hospital Center and CSPNJ.

⁶ In my case, related to the nephropathy

⁷ Problems with my cholesterol and other blood fat levels

insurance reimbursements were covered under law, which made this kind of “outpatient initiation” possible.

Over the years, I have struggled with my diabetes. I have changed my diet, but not enough to control the diabetes without medication. There have been times when I tested my blood sugars twice a day, and others when my doc and I agree that daily testing is unnecessary due to good control. I am the kind of person who pays a lot of attention to minimizing my intake of simple sugars, and to looking at the glycemic index⁸ of the foods I buy. When evaluating new choices among prepared foods, I spend a long time in the grocery store, and then go through the process of selecting and trying foods that will lower the glycemic index and not cause too much digestive discomfort by being too high in fiber or having too much of certain artificial sweeteners.

I have gone through a range of diabetes medications. For a while, I was working with an endocrinologist³, and then chose to return my diabetes management collaboration to my primary doc. I now take 2 medicines every day for the dyslipidemia, 2 for the high blood pressure, 2 for the diabetes, 1 for an eye condition, and 1 for a minor thyroid condition not directly linked to the diabetes, as well as a vitamin supplement recommended by one of the doctors to help deal with the nephropathy. One of the diabetes medicines is a drug which I need to inject twice a day under the skin of my belly. It was a tough choice taking that med on, but my doctor and I worked through various options, and I decided on this drug because it causes my pancreas to “wear out” more slowly than the other choices, and therefore means that I will have a longer time before I need to go on insulin.

I certainly spend more time with doctors than I expected to. My internist sees me 4 times a year, as does my podiatrist¹⁰. I have about six eye doctor appointments a year, split between a retina specialist and a “front of the eye” specialist. I also get sent by my internist for lab tests and other testing (exer-

cise stress EKG¹¹s, vein ultrasound, etc.) with some frequency. He spends a lot of time counseling me on the higher risk factors for various conditions which my diabetes causes, and the resultant need for more screening examinations. Between the medications, diet, and other lifestyle changes, my laboratory values are basically “within normal limits.”

I have attended a few meetings of diabetes self-help groups. Like any other self-help group, these are places where I can

- Get practical advice from my peers
- Benefit from the shared empathy in the room
- Benefit from the opportunity to help others.

I was also involved for a few years with a weight-loss self-help group.

If you are reading this article because you have recently been told that you do (or might) have diabetes, I want to finish with a few words of encouragement. Dealing with the condition *will* have a major impact on your life. It does not need to take over your life. It does involve many of the kinds of changes which can be healthy for most people. I do feel that the energy I put into this is worthwhile in terms of the impact it is having on the quality of my life, and my ability to live a longer life.

SOME QUESTIONS AND ANSWERS

ABOUT DIABETES

Q: What is the difference between “pre-diabetes” and diabetes.

A: Pre-diabetes is a condition in which blood glucose levels are higher than normal but not high enough for a diagnosis of diabetes. Research tells us that people with “pre-diabetes” diagnosed are likely to develop diabetes within 10 years if they do not lose 5-7% of their body weight. We also know that people with “pre-diabetes” have an increased risk of cardiovascular disease, such as heart attack and stroke.

Q: Is diabetes serious?

A: Yes, very serious. Untreated diabetes is identified as a cause of (and in several cases, the leading cause of):

- Slow Healing Wounds
- Higher Risk of Infection
- Loss of Vision
- Loss of Kidneys
- High Blood Pressure
- Impotence
- Loss of Toes and Feet
- Muscle Injury

⁸ A function of how fast the food metabolizes into glucose in the bloodstream

⁹ a doctor who specializes in various diseases of the “ductless glands,” including diabetes.

¹⁰ The frequency of foot disease, sometimes leading to loss of feet and toes, is so high for people with diabetes that most of us are urged to work with a podiatrist.

¹¹ Electrocardiograms

- Heart Attack
- Stroke and other Circulatory Diseases
- Complications of Pregnancy/Risks to a Fetus
- Cognitive Decline and Dementia

Q: Does diabetes come from eating too much sugar?

A: Not directly. Type II diabetes, which is the kind that does not come on in early childhood, may be caused by eating a diet that has too much sugar or other carbohydrates, or by body size and shape, or by other “contributing factors.” People with diabetes can still eat foods with sugar, but they need to limit their sugar intake carefully.

Q: Does having diabetes mean that I am going to need to be on insulin?

A: No. Some people control their diabetes entirely through diet. Many control it entirely with oral medications (pills). People need to work through their options in conjunction with a medical practitioner.

Q: If a certain medicine has helped cause my diabetes, should I consider stopping that medicine in order to control the diabetes?

A: Not necessarily. Getting off the medicine that caused the diabetes is not necessarily going to make the diabetes “go away.” People need to work through their medicine choices, with the information and advice of a medical practitioner.

Q: Will I be dealing with diabetes, and the medicines and other treatments, for the rest of my life?

A: Not necessarily. Some people are able to reverse their diabetes through weight loss. Others are not. Many factors are involved, including how long the diabetes was active before treatment started.

Q: Will I need to change the way I eat to help control the diabetes?

A: Probably. People with diabetes need to pay a large amount of attention to *what* they eat, and some attention to *when* they eat.

Q: Will I need to find and see a specialist to help me deal with my diabetes?

A: Not necessarily. Some primary care doctors and nurse practitioners, and many doctors and nurse practitioners in internal medicine, treat diabetes. Depending on your practitioner’s experience and your condition, he or she can talk with you about how to decide whether to see a specialist.

Q: Will treating the diabetes cost me more money?

A: Possibly not. Whether you are on Medicare, Medicaid, or private insurance, your diabetes medicines, testing supplies, doctor visits, and other diabetes-related medical services are covered just like the medications and treatments for conditions other than diabetes. There are ways to eat better on a tight budget, as well as to increase exercise for basically no money. We urge you to keep reading our newsletter (subscribe by sending an e-mail to nleditor@cspnj.org) for ideas on improving your diet, exercise, and health management.

Q: Will it be hard to learn the things I need to about dealing with my illness, such as using a blood sugar meter or changing my diet.

A: Like any other learning, you can expect to put effort into it. There are resources in the healthcare system to help you learn, including

- diabetes educators and dietitians/nutritionists
- diabetes education courses
- self-help and support groups
- books and magazines
- websites, such as the American Diabetes Association (www.diabetes.org) and the National Diabetes Information Clearinghouse (www.diabetes.niddk.nih.gov).

DO YOU NEED A PRIMARY HEALTH PRACTITIONER?

Common sense and some research tell us that:

- People do better overall in “primary” healthcare when they have permanent relationship with an individual primary care practitioner (for adults, a doctor or nurse practitioner specializing in general practice, family practice, or internal medicine). There are several reasons, including the continuing relationship between the practitioner and patient, the centralization of health records, higher likelihood of identifying potential drug-drug interactions, and the role of one person in keeping track of necessary screening and treatment interventions.
- That permanent relationship, sometimes known as a “medical home,” is as important, and probably more important, for people dealing with a long-term health condition typically managed by primary practitioners, such as diabetes, high blood pressure, or asthma.
- Being on prescription medications managed by a psychiatrist or psychiatric nurse practitioner can be considered such a long-term condition. This is because the medications do create physical health risks, and the mental health prescriber may not be in a position to manage those risks and complications.

- It is often difficult to get and keep a primary practitioner or medical home when one is insured by fee-for-service Medicaid, or has no insurance benefits.

We believe that it is worth the effort to try to establish a medical home. New Jersey residents who are covered by a Medicaid HMO should call the customer service number on their HMO ID card. People in Medicaid who do not have an HMO (including those covered through General Assistance Family Care, and many mental health service recipients), can find lists of providers at www.njmmis.com, work through their local Medical Assistance Customer Centers (MACC). The MACCs cover single or multi-county areas, and can assist people with locating primary care and specialty practitioners in their area (including dental).

- Atlantic, Cape May, and Cumberland: (609) 561-7569
- Camden, Burlington, Gloucester, Mercer, and Salem: (856) 614-2870
- Essex: (973) 648-3700
- Hudson: (201) 217-7100
- Middlesex and Union: (732) 777-6977
- Monmouth and Ocean: (732) 761-3600
- Morris, Somerset, Hunterdon, Sussex, and Warren: (973) 631-6440
- Passaic and Bergen: (973) 977-4077

For people not covered by Medicaid, one good starting point is the list of Centers for Primary Healthcare maintained by the NJ Department of Health and Senior services at <http://web.doh.state.nj.us/apps2/CancerFacilities/cphc.aspx>. This list contains facilities in every county except Somerset and Hunterdon which offer free or sliding-scale healthcare. The other routes for finding free or low-cost healthcare would be:

- Contacting 211 and/or your town or county social services
- Asking for help from the mental health professionals and/or self-help center you are already involved with
- Asking the people at your local Center for Independent Living (CIL), listed at www.virtualcil.net/cils/query-iandr.php?state=nj
- Contacting your local hospital and asking where they refer people without coverage looking for non-emergency healthcare.

THOUGHTS ON EXERCISE, EATING, AND DRINKING

By Steve Jakubowycz

Inspired by "The Problems with Our Soft Drinks" in the December 15, 2008 issue

I find that exercise is a big part of instilling a healthy diet. When I assert effort to move my body when it does not want to move, I find that the accomplishment boosts my self-confidence, and makes it easier for me to maintain a healthier lifestyle. Putting my body through rigorous exercise prevents me from putting things into my body that would be counterproductive to a good workout. I feel that when one takes care of one's physical well-being, then he or she thinks less of smoking, drinking excessively (if at all), or eating foods that are unhealthy. A certain self-respect develops in oneself, and this only magnifies itself to proportions where good health is achieved and fewer physical ailments result.

Renowned nutritionist Dr. Gary Null said that we should only be ingesting two teaspoons of sugar a day. The average American gets 20-30 teaspoons a day. It is no wonder that diabetes is on the rise. Unfortunately, many people can succumb to their surroundings. If the environment they live in neglects good health and people in that environment smoke, drink, abuse substances, or eat unhealthy foods, then that person may soon pick up those harmful habits. It is easier to give in to bad habits than it is to adopt good ones.

I drink as much water as I can. When I weight lift or do yoga, I do not want to pollute my body with unnecessary food that will only wear down my body's resistance. Do I have a sweet here and there? Yes. Probably more than I should at times. I especially have to watch out because I do take a medication that has been known to cause weight gain and diabetes.

I have read that 80% of people who exercise do not exercise enough. I used to fall into that category. I have signed up with a gym. I have been attending it on the average of three times a week, and have taking one yoga class so far.

I bring water to work, carry water when out on errands, and ask for water in restaurants. I am not sure that the water at restaurants is the most pure water one can have, yet I do so anyway. It is my understanding that, according to a news article I read, so-called "spring water" is anything but that. Therefore, at home, we use a pitcher that uses a water filter to run the tap water through and get fresh healthy drinking water. By purchasing 20 oz. or

other sizes of water bottles, the pitcher of water can be poured into them and be used at home and are readily portable for travel. We change the filter every three to four weeks, and we have been using that same pitcher for quite some time. Often, I do drink water with a lemon wedge and even at times with lemon and lime wedges, although rarely with only limes. I also drink hot herbal teas. They really soothe my stomach and produce a sense of calmness.

I find that the best foods to eat in order to support exercising and taking care of my body are fruits and vegetables. I have read recommendations ranging from 3-5 servings of fruits and vegetables a day all the way up through 7-9 daily servings. I eat at least 3-5 servings a day, and sometimes do reach up to 7 or even more on rare occasions (usually when I am exercising regularly and frequently). I eat a wide variety of fruits and vegetables. Occasionally I make smoothies with a blender, mixing different fruits to drink my nutrition. Sometimes the food is from the fruit market, and sometimes I buy frozen vegetables (usually with the sauces included), although I feel they may not be as nutritional

In conclusion, I try to exercise to stay healthy, I try to drink plenty of water eat well to stay healthy and fuel my exercise, and my exercise helps me choose to eat better. I know these routines and reasons work for me, and I hope they can be helpful to others.



THE BLUES

By Nancy Wertheim Swarbrick

Blues ain't nothing but a good man feelin' bad....

We've all heard this expression, but it is only part of the story. Blues music is a journey one undertakes to purge negative feelings and to convert negativity into positive emotion. The end result of this expression is a harvest of pure joy.

It requires something of the user in that one has to be willing to confront their devils... to let the issues that sadden, anger, or frighten them into the core of their being. The blues player (or singer) has to admit that he or she is upset, frustrated, or furious

with their current condition. It is in this completely humbled state that the darkest of times begin the transition toward the light. This concept also rings true for most forms of recovery.

Some folks are "born with the Blues." As a child I noticed Blues, Gospel, and Dixieland chord patterns in old records, movies, *Betty Boop*, and other cartoons of the day. I danced around and imitated Louis Armstrong, The Mills Brothers, Hattie McDaniel, etc. I viewed this as "Good-time" music and related solely to the end result, and not the pain and suffering that these individuals endured.

The Blues was born in the cotton fields, slave ships, and cold dark cabins of the American South. African-Americans suffered greatly by the hand of white oppression. In part because they were not allowed to read or write, they were denied the basic right of communication. They were, however, allowed to sing at church and at work. They created a form of expression through song that would allow them to communicate their feelings, express their humor, and humiliate their oppressors. They developed a coded language with instructions and details that would show some of their fellows the way to freedom in the North.

After the Civil War, the tradition of creating communication through song continued. In the big cities Blues men and women wrote songs about lost love, loneliness, raw sex, racial inequality, financial woes, and the ups and downs of personal relationships. These songs are infused with exaggeration, double entendre, and -- most of all -- humor.

Breaking up with his cheating girlfriend, a blues man complains about the money he wasted on her:

***Yeah my Mama told me
And your good friend too,
When you get that wig
That's the way you gonna do.***

***You just give me back my wig
Honey now let your head go bald.
Really didn't have no business
Honey buyin' you no wig at all.***

***Goodbye little one
All I got to say.
Give me back my wig and be
On your merry way....***

In the end the author is having a laugh at his own expense!

My personal journey with the Blues harmonica began to take shape in high school. I was a tomboy, a little more interested in partying than studying, and was clearly nonconformist. I had difficulty with reading and concentration. Attempts to learn to play an instrument through traditional means had failed. I began to fool around with the harmonica and eventually learned to play some songs by ear. I carried the harmonica with me all through college. While working with the College Concert Committee, I had the opportunity to meet some famous musicians. I once asked Blues man, Jr. Wells for advice on playing harmonica. He told me... "ain't no chick can play harmonica...!" This only cemented my dream of playing with a band, traveling, and making recordings. I was determined to succeed.

I have now played for over thirty years. Playing the harmonica has taken me all across the United States and over seas. I have appeared on stages with Bruce Springsteen (a benefit), Levon Helm, David Johansen, Clarence Clemmons, Willie Dixon, and James Cotton. I have met hundreds of my musical heroes and to use my expression to spread hope and joy. I have enjoyed teaching and helping others fulfill their dreams.

But when I talk about what the Blues means to me on a personal level (not on a social or business level), it has nothing to do with fame or fortune. I have played through financial and marital woes, through cancer, sex discrimination, jealousy, the loss of my mentor, loss of family members and cherished pets, a close friend's suicide, and the loss of my two best friends. My band had a gig the same week that our beloved guitarist passed away. The guys came to me and asked what we should do. The obvious answer to that question was, "We play... that's what we do." It was very difficult at the start of the performance that night, but soon we were jamming, reminiscing, and even laughing over the good times.

Some songs I play to my husband. My expressions of happiness and love for him come through my harp. When I play, I close my eyes... and the world around me disappears. All of the bad things in my life are suspended. I am in a zone that is shared only by the musicians who are playing with me. Not only are we in each other's hearts and minds, but we are sharing complete trust in one another. This is a very private place and it is a very exclusive club. We share each other's core emotions. Then, when the song is through, we open our eyes and look at each

other as if to say, "Wow, what a ride!" A second later we give a nod to the audience... and witness the joy that we have shared with them.

I started many years ago looking not only for "fun", but also for the camaraderie and acceptance that playing in a band would provide. It has been very hard work, but thirty years later the harmonica is still opening doors for me. I can walk into a club filled with young people – I am disabled, overweight, and well over fifty... and I know that I will be accepted and respected by night's end. There is a common chord that strikes at the heart of all humanity and I believe that it is the Blues.

The Blues is much more than a good-man- feeling-bad... it is a celebration of life - - the good times and the bad!

Known as "Big Nancy," Nancy Wertheim Swarbrick has been a prime mover in the blues scene for over thirty years. Her credits include presenting, managing, recording, and performing. She is best known for playing her harmonica or "blues harp". Former Albert Collins guitarist Debbie Davies writes, "(Nancy is) one of the rare breed of really good female harp players. She has toured in the past with lots of big names, and garnered a lot of respect. There's no fluff; this is a real deep blues harp player!"

Please feel free to visit Nancy at www.bignancy.com. Please feel free to share your stories about your life passions with this newsletter – nleditor@cspnj.org.



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I WANT TO BE A GOOD CAPTAIN

I want and need to be captain of my own "ship of health." Being captain is all about being responsible for my own health. As captain, I need to be in a position to lead my healthcare team and make the right decisions. I recognize that "health" in this context is broad, and applies to physical, mental, and dental care and conditions. I also perceive that the "captain" role really includes both the leadership function and most or all of the "crew" roles of day-to-day implementation that I cannot, or choose not to, delegate.

I have come up with a list of the knowledge, skills, and attitudes that I think are needed for the job: My confidence and competence in these roles varies greatly, but I

am prepared to chart my course and navigate toward being able to:

- (1) access and evaluate credible and unbiased health information from a variety of sources;
- (2) communicate effectively with my healthcare practitioners, both in order to give them information to support me, and to gather information in order to arrive at treatment decisions;
- (3) make healthcare decisions with an eye on the big picture of longevity and life comfort, rather than risks of short-term discomfort;
- (4) maintain appropriate healthcare records, including personal health histories, family health histories, and medication charts, and make the information available to the professionals who are treating me;
- (5) handle the administrative details of procuring healthcare, including making appointments, getting to or from appointments, and dealing with costs and billing and insurance issues;
- (6) recognize common illnesses and injuries that might not require professional care, make reasonable decisions when and how to treat them, to treat them in a way that does not aggravate any other health conditions I have, and know when a situation might be better handled with the assistance of a healthcare professional;
- (7) identify medical emergencies, know how to obtain emergency medical care, and be prepared (Rx records, advance directives, etc.) to access that care;
- (8) understand my existing health conditions and risks, including the various interventions I need to take to control symptoms, maximize recovery, and maintain a watchful eye for new/increased symptoms or after-effects;
- (9) make decisions regarding medication usage (prescription and OTC¹²), to acquire and administer those medications, and to monitor for effectiveness and side-effects;
- (10) understand how my diet,¹³ exercise, and sleep affect my health, and make appropriate decisions to maximize the quality of each;
- (11) understand the importance of fresh air, sunlight, and sanitation (including food sanitation) in maintaining and improving my health, and to make appropriate decisions to maximize the quality of all of those;
- (12) make appropriate decisions about the use of harmful substances;
- (13) understand the importance of motivation on health behavior change, know how to motivate myself, and know when it makes sense to get outside mentoring or motivational help;
- (14) understand my limitations that can place my health at risk, such as overexertion and overexposure to sun;
- (15) consider developing/maintaining emergency life-preserving skills, such as CPR¹⁴ and water rescue;
- (16) be able to assess the risks of injury in a situation, and make appropriate decisions to maximize safety;
- (17) understand and obtain the kinds of routine health treatments and screening examinations appropriate for my age, gender, and condition;
- (18) understand the interrelationship of physical health, mental health, and well being, and to make decisions based on that relationship;
- (19) understand the use of professional supports¹⁵, natural supports, and self-help groups in health maintenance, and make appropriate use of each;
- (20) understand the issues around the management of acute and chronic pain, and to make appropriate decisions;
- (21) understand and apply the unique impacts of sexual/reproductive health, including contraception, fertility, pregnancy, and the risks of STDs¹⁶ on the bigger picture of my health;
- (22) understand and apply my legal rights in health care settings and in relationships with health care providers and payers;
- (23) make and communicate necessary decisions regarding end-of-life care and organ donation; and
- (24) serve as health captain to those who depend on my captainship (my younger kids and pets), and in a mentor/model role for other family members and friends as needed.

¹² over-the-counter

¹³ which includes intake of food, water and other beverages, alcoholic beverages if any, vitamins, and supplements

¹⁴ Cardio-Pulmonary Resuscitation

¹⁵ including both mainstream and "alternative and complementary" healthcare

¹⁶ Sexually Transmitted Diseases