

HEALTH *POWER!*

PREVENTION NEWS

FALL 2008

THEME:

MOTIVATIONAL COUNSELING

In this newsletter, you'll find:

From the Chief Consultant	Page 2
Enhancing Health Behavioral Change Through Motivational Interviewing	Page 3
Motivational Counseling and <i>MOVE!</i>	Page 6
Front-line Experience: Putting Motivational Counseling Into Practice.....	Page 9
The Evidence Base for Motivational Counseling Strategies	Page 12
Veterans Health Education and Information.....	Page 15
Motivation?.....	Page 19
My HealtheVet—VA Expands Anywhere, Anytime Internet Access to a Veterans Personal Health Record	Page 21

From the Chief Consultant

People don't change their behavior unless it makes a difference for them to do so. - Sharon Stone

I don't know the context in which the actress Sharon Stone made the comment above, but I think it hits the nail on the head in describing what motivates people to make behavior changes to improve their health. We all tend to get pretty comfortable in our daily routines and habits (our "ruts") and it takes a good effort to make even beginning changes in them. Many of those daily habits don't need to be changed as they don't negatively impact health. I drive to work the same way every day because it's the best route I've found and now I don't really have to think about it. It's a comfortable rut to be in.

But some habits do have adverse effects on health and changing them will make a difference in people's lives. Unfortunately, those "bad" ruts can be just as comfortable as the "good" ones and change is often not easy. As individuals and clinicians, what is there to do? The good news is that there are specific techniques that can be used with patients (and even ourselves) to understand and improve the motivation needed to make changes in the right direction.

This edition of the HealthPOWER! newsletter presents information about one of those techniques, called Motivational Interviewing/Counseling. Jacki Hecht, our feature contributor, describes the underlying philosophy of MI and the core skills necessary to engage in it. Those of you who attended NCP's *Promoting Behavioral Change: Opportunities for Patients, Employees and Organizations Conference* in New Orleans this summer will remember Jacki for the great keynote address she gave on this topic. She provides several informative references for those who'd like to dive deeper into this topic.

Five of NCP's program areas have an article related to the theme of motivational

interviewing/counseling. Dr. Ken Jones discusses the role of motivational counseling in the MOVE! Weight Management Program. He offers some specific statements that clinicians may find useful in talking with patients. Dr. Leila Kahwati provides several examples from the field about how MI is being used in practice. She also has written a brief review of the evidence about MI for specific content areas. Although the evidence base is strong for some conditions, more research is needed for others. A number of VA researchers have projects related to MI, which will likely lead to important contributions to the literature. Dr. Rose Mary Pries describes the role of MI in patient-clinician interactions and presents helpful guidance for applying this strategy in discussions with patients. And Dr. Richard Harvey reminds us not to forget about using these techniques with ourselves, in making our own healthy behavior changes. Dr. Harvey notes that there is growing interest in many VHA program areas to provide training to clinicians in MI. We anticipate working closely with leaders in Primary Care, Mental Health Services, and Public Health to develop a common core curriculum for MI training, so that together we can provide training for a wide range of VHA clinicians.

We hope that you also enjoy the guest article about My Health@Vet news and the news updates from NCP. We'd love to hear from you about what you'd like to see in future editions of HealthPOWER! If you would like to contribute a guest article, please contact the editors, Nancy Granecki and Connie Lewis.

Linda Kinsinger, MD, MPH
Chief Consultant for Preventive Medicine

The good news is that there are specific techniques that can be used to understand and improve the motivation needed to make changes in the right direction.

Address suggestions, questions, and comments to the Editorial Staff:

Nancy Granecki
Connie Lewis
Kate W. Harris (contract)

Address:
3022 Croasdaile Drive
Suite 200
Durham, NC 27705
(919) 383-7874 (Phone)
(919) 383-7598 (Fax)

Enhancing Health Behavior Change Through Motivational Interviewing

Page 3
HealthPOWER: Prevention News
Fall 2008

Enhancing and promoting patient self-care is becoming ever more important as the cost of medical treatment continues to rise and increasing numbers of people are living with complex, chronic illnesses. However, helping patients to effectively engage in health-promoting behaviors is not an easy task. It often involves engaging the patient in a partnership, in which the patient and provider *together* explore the primary health concerns, medical and behavioral treatment options, and the course of action that will best meet the patient's needs. Motivational Interviewing (MI) has shown promise as a therapeutic communication style that lends itself to helping people achieve health behavior change (Hettema, 2005). MI is a patient-centered, goal-oriented approach for facilitating change through exploring and resolving ambivalence (Miller, 2006). When using an MI approach, clinicians recognize that patients may have ambivalence about change: *"I want to, and I don't want to change,"* simultaneously. The goal of MI is to engage patients in an open discussion that allows them to examine conflicting feelings about change safely and make more-informed decisions about their health behaviors.

Capturing an MI "Spirit"

The underlying philosophy or "spirit" of MI is captured in three core tenets:

- Honoring patient autonomy.
- Collaborating with patients as partners.
- Evoking the patient's experiences and strengths.

Rather than viewing patients as having deficits that need correcting or fixing, clinicians using MI aim for better understanding of patients' existing assets as a starting point for building motivation. The question, *"Why is this patient not motivated?"* becomes *"What is this patient motivated to do?"*

A Fluid Style of Communication

MI also involves using a balance of different communication skills and styles to address the shifting viewpoints patients express. For example, sometimes clinicians may want to gather more information by asking questions, and sometimes they may want to provide education and information about treatment options. At other times, clinicians may be most effective by listening to the patient and not interrupting. These three skills of *asking*, *informing*, and *listening* can be used in a fluid, guiding style to help patients make more-informed choices as to the best medical and behavioral treatment plans.

Values as a Guiding Force

It is common for patients to want healthier outcomes without having to make significant changes. For example, many people would like to lose weight, but don't want to eat healthier foods, limit portion sizes, or engage in routine exercise. Similarly, others might want to breathe better and have more energy, but prefer to continue smoking. Thus, people become stuck in this discrepancy between their current behaviors and broader values or ideals, and tend to gravitate toward the status quo of no change. People often describe strong, internally driven reasons for change that have some sense of urgency as their catalyst for committing to making a sustainable lifestyle behavior change. For example, a middle-aged man might decide to join a weight-loss program after learning that he is pre-diabetic and will require medication if he can't regulate his blood sugar on his own through diet and exercise. A young mother might conclude that it's time to quit smoking when she adds up all of the money she is spending on cigarettes and realizes that she could buy a new computer for her family. Therefore, it can be helpful for clinicians to explore patients' values, along with the benefits of change and the potential consequences of

This month's feature article was contributed by Jacki Hecht, RN, MSN—
Weight Control and Diabetes Research Center
The Miriam Hospital
Providence, RI

(Continued on page 4)

Enhancing Health Behavior Change Through Motivational Interviewing (cont'd)

(Continued from page 3)

staying the same, to help patients verbalize how these factors influence their decisions about change.

"OARS": The Four Core Skills

OARS is an acronym for the four core skills often used in MI:

- Open-ended Questions
- Affirming
- Reflective Listening
- Summarizing

Open-ended Questions invite the patient to say more than just a one-word response, and therefore elicit more information. *Affirmations* serve to validate patients' perspectives and help them recognize their strengths.

Reflective Listening lets patients know the clinician is listening and trying to understand their perspective, and encourages patients to further clarify their viewpoints. Reflective listening also allows patients to hear their own words and ideas in a way that helps them reconsider the significance of what they mean. *Summarizing* helps to pull the important pieces of the conversation together so that patients can consider the various bits of information that were shared. When used together, these four clinical skills help patients explore their own desires, strengths, and internal resources and consider why, how, and when change might occur.

Developing MI Skills and Style

Although the skills and style of MI sound intuitive and simple, developing these skills and refining this approach requires ongoing training, practice, and supervision. The VA offers online training at <http://vaww.chce.research.va.gov/apps/bmiforsuv/default.html>. Additional training opportunities, along with a comprehensive reference list and supportive learning tools, are available at www.motivationalinterview.org.

For more information on Motivational Interviewing:

Hettema J, Steele J, Miller WR. Motivational interviewing. *Annual Review of Clinical Psychology* (2005) 1:91–111.

Miller WR, Rollnick S. *Motivational interviewing: Preparing people for change (2nd edition)*. New York: Guilford Press, 2002.

Miller WR, Rollnick S. *Motivational interviewing: Preparing people to change addictive behavior*. New York: Guilford Press, 1991.

Miller WR. Motivational factors in addictive behaviors. In: Miller WR, Carroll KM (eds.). *Rethinking substance abuse: What the science shows and what we should do about it*. New York: Guilford Press, 2006: 134–150.

Rollnick SR, Miller WR, Butler CC. *Motivational interviewing in health care: Helping patients change behavior*. New York: Guilford Press, 2008.

The acronym OARS means:

- Open-ended Questions
- Affirming
- Reflective Listening
- Summarizing

The theme for the next HealthPOWER!

Prevention Newsletter is:

Reaching Out to the OEF/OIF Veteran



The NCP attended the following Veterans Service Organization conventions this summer, exhibiting for both MOVE! and HUSV:

- Vietnam Veterans Leadership Conference
- AMVETS National Convention
- VFW National Convention
- American Legion National Convention

This was a wonderful opportunity to speak to veterans throughout the US about the importance of exercise, healthy diet and weight management to prevent and manage obesity and diabetes.

The NCP recently met with the YMCA of the USA to explore the possibility of partnership between the VA and YMCA. The discussion included a wide range of potential projects. We are currently working on three specific projects. Details will be available in future newsletters.

The 2008 HUSV mini grant recipients are busy implementing their projects. We anticipate publishing a digest of all the projects once completed and reported back to NCP. A complete listing of grant projects can be found on the HUSV web site: www.healthierusveterans.va.gov



Upcoming Conference Calls

HealthierUS Veterans National Call
 3rd Tuesday of the Month,
 3:00 PM ET
 1-800-767-1750, Access Code #35202
 September 16, October 21

The screenshot shows the HealthierUS Veterans website in a Microsoft Internet Explorer browser window. The address bar shows the URL <http://www.healthierusveterans.va.gov/>. The page header includes the United States Department of Veterans Affairs logo and a search bar. Navigation tabs include VA Home, About VA, Organizations, Apply Online, Locations, and Contact VA. The main content area features a 'Tip of the Week' with the text: "Get a dog and walk it. Don't have one? Borrow one." Below this is a photo of people walking a dog and a circular logo with the text "Eat Healthy * Be Active * Get Fit For Life". A 'What's New' section states: "More than 40 HealthierUS Veterans projects have been planned. Click here to see the what and where of these projects." A sidebar on the left contains links for HealthierUS Veterans Home, About HealthierUS Veterans, Eat Healthy, Be Active, Get Fit for Life, Fitness Challenges, Frequently Asked Questions, HealthierUS Veterans Toolkit, My HealthVet, National Center for Health Promotion and Disease Prevention, Viewer Software, and Site Search. At the bottom, there are links for Español, VA Forms, Locations, Contact the VA, and other resources. The footer indicates the page was reviewed/updated on September 9, 2008.

Screenshot of HealthierUS Veterans website

MOVE! Weight Management Program for Veterans

Motivational Counseling and MOVE!

Jacki Hecht gave an excellent overview of Motivational Counseling. As is frequently quoted, using motivational communication approaches can move us from “wrestling” with patients to being “dance partners.” This is especially true for MOVE!, because our “treatments” are limited: support and guidance are the key ways in which we can assist patients. Several studies have specifically examined the impact of MC on weight and diabetes management/prevention and generally have found favorable results.¹ Many contemporary clinical research interventions, such as the Diabetes Prevention Project, now fully incorporate MC into their programs of care, and MOVE! is no exception. Just to remind you, we have guidance on MC in our [Clinical Reference Manual](#), our [Pocket Guides](#), and our online training (see MOVE! Intranet Website).

We know it is that it is helpful to have some handy statements to use at different points in the process of communicating with patients about lifestyle issues. Here are some possible ways to open discussion of these issues:

Bringing Up The Issue

Most obese patients know they are overweight and probably have made many attempts in the past to lose weight. It's also quite likely that the patient is maintaining some weight loss from an all-time high, and bringing excess weight up as a problem may not appropriately recognize the patient's previous success. Patients may not fully comprehend that their weight can affect their current health status; you should listen for this. Although it is your business to give the best care and recommendations possible to patients, remember that

they are in control of their weight-related behavior and you should essentially seek permission to talk about this issue. You can imply this in your comments rather than just stating it outright. Many patients say that they believe that virtually every health problem they have is blamed on them for their excess weight. Thus, it may be helpful to bring up weight independently, rather than in response to a health complaint. Ultimately, patients will only make changes if they view the changes as **important** and feel that they will have the skills, resources, and support to make the changes. The MOVE! team can help with the skills and resources, but the healthcare team members have a key role in assisting patients decide if a specific health behavior change is important for them at this time.

Here are examples of opening statements:

"I am concerned that you are carrying extra weight and that this may be causing you problems now and may cause further problems for you in the future. What weight-related problems have you noticed?"

"As you know, we measure your height and weight annually. I see that you are carrying excess weight, and I am concerned that the weight might be affecting your health right now. Tell me what you have tried or what you are doing now to manage your weight."

"I can see that your weight has been gradually creeping up. I know that you are concerned about getting diabetes, like your Mom, and you know that her weight had a lot to do with her diabetes. How are you feeling about the added weight?"

(Continued on page 7)



MOVE! Weight Management Program for Veterans

(Continued from page 6)

In responding, reflect what has been said, affirm positives, and listen for ambivalence and process the ambivalence. Try to **reflect** rather than responding with questions. Start your reply like this: **"It sounds like ____"**. It is also helpful to elicit from patients the reasons why they might not want to make a change, as these are real barriers. Patients, after laying out challenges, will often talk themselves into why they should make the change.

Patients are only likely to make changes that are important to them. Therefore, evoking the importance of weight management from patients is key to this process. We have been trained to focus on health outcomes, but should remember that lab values and diagnoses may be irrelevant to patients. Successfully managing weight to "be there for my grandchildren," to be a model for grandchildren, or staying fit to keep one's edge at work or sports may be more important reasons for patients to make healthy lifestyle changes than having specific medical goals.

We are finding that, when offered, about 10% of patients will accept *MOVE!* care. Although this leaves room for improvement, it isn't a particularly low acceptance rate for a behavioral health intervention. *MOVE!* care is designed for patients who are "ready" to make lifestyle changes. Focusing lifestyle change efforts on patients who are ready is a good utilization of resources. With a patient who is still "on the fence" regarding weight loss, communication goals are quite different. With the ambivalent patient, we should consider it a success if the patient leaves the appointment knowing (1) we are concerned about their weight, (2) that possible personal reasons for making these changes have been identified, and (3) when ready, *MOVE!* is here to help. To support these messages,

we developed the *MOVE!* handout, "[So, You're Not Ready Yet?](#)"

If you engage patients in conversations based on MC, and they go away considering whether they want to make changes in the future, you should consider this a success. We have heard anecdotally that some patients are spontaneously calling in a few months after their primary care visits and saying, "You offered me enrollment in *MOVE!*, but I wasn't ready at that point. I am ready now." This is exactly the kind of result we are looking for with Motivational Counseling.

¹ *Rubak S, Sandbaek A, Lauritzen T, Christensen B. Motivational interviewing: a systematic review and meta-analysis. British J Gen Pract 2005;55(513):305-312.*

*Contributed by Ken Jones, PhD
National Program Director for Weight Management*

Focusing lifestyle change efforts on patients who are ready is a good utilization of resources.

Reference Tools - Microsoft Internet Explorer provided by VA NCP

Address: <http://www.move.va.gov/ReferenceTools.asp>

UNITED STATES DEPARTMENT OF VETERANS AFFAIRS

VA Home About VA Organizations Apply Online Locations Contact VA Search

Health Care
Benefits
Burial & Memorials
NCP Home
MOVE! HOME
MOVE!23 Questionnaire
MOVE! Handouts
More About MOVE!
MOVE! Q & A
What's New
HealthierUS Veterans
President's Challenge
Additional Resources

MOVE! WEIGHT MANAGEMENT PROGRAM

MOVE! Reference Tools

The following are collected weight management resources for health professionals. Click on a category listed below to be taken to corresponding reference tools.

You will need Adobe Acrobat Reader in order to view the files.

- [VA Weight Management Policy](#)
- [BMI/Obesity](#)
- [Reference \[Link to VA Weight Management Policy section\]\(#\)](#)
- [Discipline Specific Pocket Guides](#)
- [Implementation](#)
- [MOVE!23 Patient Questionnaire](#)
- [Behavior Change](#)
- [Nutrition](#)
- [Physical Activity](#)
- [Patient Handouts](#)
- [Modules for Group Sessions](#)
- [Weight Loss Medications](#)
- [Bariatric Surgery](#)

Screenshot of *MOVE!* Reference Tools webpage



MOVE! Weight Management Program for Veterans News

We are pleased to announce that VA Forms will soon be carrying the *MOVE!* Patient Folders that include the 10 standard handouts. To support the soon-to-be-released Home TeleHealth Tele*MOVE!* (*Home TeleMOVE!*) Program, we are also working with Forms to stock and distribute a *MOVE!* Handout Booklet with all of our handouts. The devices Home *TeleMOVE!* will direct patients to view handouts when appropriate, and the Booklet will enhance access to the handouts. We expect all of these to be available shortly and will release ordering information when available.

Unfortunately, some of the newer “atypical antipsychotic” psychiatric medications can result in rapid weight gain and the development of weight-related disorders such as diabetes. VA is beginning a campaign to educate patients and prescribers about these risks. A task force looking into this issue has recommended that patients who need to be on these medications should be offered enrollment in *MOVE!* to maximize weight management skills, which may assist the patients in buffering the side effects of the medications. To increase *MOVE!* availability, Mental Health programs are looking at ways to offer *MOVE!* in the mental health clinical setting.

We enjoyed meeting the *MOVE!* team members from VA facilities at the training sessions on Healthcare Communication held in New Orleans and San Francisco. Many of you proposed very creative action plans for *MOVE!*. The national *MOVE!* team is here to help in implementing our programs. Remember, we are just an email (*MOVE!* @va.gov) or telephone call (1-866-962-MOVE) away.



Upcoming Conference Calls

MOVE! VISN and Facility
MOVE! Coordinators Call
2nd Tuesday of the First
Month of each Quarter
3:00 PM ET
1-800-767-1750, Access
Code #59445
Next call: October 14



Front-line Experience: Putting Motivational Counseling Into Practice

Despite good evidence to support the effectiveness of screening tests, vaccinations, and health behavior counseling, some patients are ambivalent about receiving these services or making healthy behavior changes. Motivational counseling may be an effective strategy for working with these patients. Your VHA colleagues have put motivational counseling strategies to work within their own practices in several interesting ways.

From the Hampton VAMC in Virginia (contributed by Martha Chick-Ebey, MSW)

We have been running a drop-in group medical appointment primary care clinic for homeless veterans since 2004. Part of the clinic structure is a half-hour patient health education group. The nurses use this time and every interaction with veterans (for example, during clinic check-in, medication reconciliation, and medical procedures and referrals) to discuss health behaviors such as smoking, substance abuse, and management of the patients' chronic diseases. Motivational counseling is one of the approaches that we use. Just recently, four of the veterans in the group provided multiple examples of how the clinic had helped them quit smoking, reduce blood pressure, reduce substance abuse, and better manage/learn about depression, stress, and other mental health issues. One veteran provided me with an entire page full of specific things about the clinic that he found helpful and why.

From the San Francisco VAMC in California (contributed by Rina Shah, MD)

I attended the NCP/EES-sponsored meeting "Promoting Behavioral Change" in San Francisco in June 2008. Since then, I have incorporated motivational

counseling strategies into my practice. Doing this has really changed my approach to and response from patients, and provided several benefits. I find that a more meaningful and honest dialogue occurs around issues of tobacco use, alcohol use, and medication and/or diet adherence. These strategies have also helped me assist patients in exploring where the barriers to change are, in a non-confrontational way that clearly demonstrates to patients that I care about them. I find that patients provide more information than before, because they seem more engaged in the conversation. This makes it easier for me to tailor advice and treatment plans to a patient's individual circumstances, which increases the chance of success. Although I have found these strategies most helpful in dealing with tobacco use and alcohol dependence, the overall communication style (open-ended questions, reflective listening) has carried over to my communication with patients about general medical conditions, such as diabetes. I would strongly encourage primary care providers to seek out training in these skills.

From the Mountain Home VAMC in Tennessee (contributed by Phyllis Fisher, NP)

We use a "family concept." Approximately 30%–40% of our patients who are grandparents are helping with or are completely in charge of rearing their grandchildren. When patients are considering having vaccinations to prevent disease, we ask about the impact their decisions will have on their family members. We encourage them to keep current on all preventive measures to "set an example" for their family and others.

From the Salem VAMC in Virginia (contributed by Kathleen Lynd, SW)

We established the Metabolic Assistance

VHA facilities who have put motivational counseling strategies to work within their own practices:

- Hampton
- San Francisco
- Mountain Home
- Salem

Prevention Practice and Policy (cont'd)

(Continued from page 9)

Group Intervention Clinic (MAGIC) in October 2007 to give primary care providers an alternative when helping patients with uncontrolled diabetes, hypertension, and/or lipid cholesterol problems. The MAGIC uses a multidisciplinary team of clinicians including physicians, mid-level providers, pharmacists, case managers, registered nurses, medical assistants, and a behavioral health specialist. The clinic provides a "one-stop shop" for veterans to see different types of providers and receive support and encouragement from other patients with similar problems. Motivational counseling is a common strategy used by all MAGIC clinicians.

*Edited by Leila Kahwati, MD, MPH
Deputy Chief Consultant for Preventive Medicine*



Prevention Practice and Policy News

NCP Staff Update

We are pleased to announce that a new Program Manager for Prevention Practice has been hired. Kathleen S. Pittman, BSN, MPH, joined the NCP staff on September 2, 2008. She received her BSN from West Virginia University and her MPH from the University of North Carolina at Chapel Hill. She has held various clinical and administrative roles during her career. For the past 19 years, Kathy has been employed by the Durham VAMC, where her most recent position was Quality Improvement Coordinator for the Ambulatory Care Service. Kathy was also the Team Leader for the Durham VAMC Colorectal Cancer Collaborative and the writing team for the 2008 Robert W. Carey Performance Excellence Award application. She can be reached at 919-383-7874, Ext. 235 or at kathleen.pittman@va.gov.

News from the US Preventive Services Task Force (USPSTF)

Updated *Screening for Prostate Cancer* recommendations were released by the USPSTF in August 2008. For men ≥ 75 years of age, prostate cancer screening is **not** recommended (Grade "D" recommendation). For men < 75 years of age, the USPSTF found insufficient evidence

to recommend for or against screening ("I" statement). The Recommendation and Rationale statements and Evidence Reviews are available at the Agency for Healthcare Research and Quality [website](#) and were also published in the August 5 issue of *Annals of Internal Medicine*.

Other updated USPSTF recommendations include: *Screening for Asymptomatic Bacteriuria* (July 2008), *Screening for Lipid Disorders in Adults* (June 2008), and *Screening for Type 2 Diabetes Mellitus in Adults* (June 2008). Visit www.preventiveservices.ahrq.gov for more information about all of the updated recommendations.

The USPSTF has also created a new video to help clinicians understand and use "I" (insufficient evidence) statements in practice. It can be found at: <http://www.ahrq.gov/clinic/ivideos.htm>.

News from the Task Force on Community Preventive Services

New and updated recommendations for increasing screening for breast, cervical, and colorectal cancer have been published. More information is available

(Continued on page 11)

Prevention Practice and Policy News (cont'd)

(Continued from page 10)

on the Community Guide website at <http://www.thecommunityguide.org/cancer/screening/default.htm>, including a succinct table of Task Force findings and recommendations on breast, cervical, and colorectal cancer. Findings were also published in a July 2008 supplement to the *American Journal of Preventive Medicine* (Increasing screening for breast, cervical, and colorectal cancers. *Am J Prev Med* 2008;35(1S):1-76).

Vaccine Update

HPV Vaccine Safety:

HPV vaccine (Gardasil®) safety has recently generated many questions and attracted considerable media attention. To provide answers, CDC-FDA information on Gardasil safety is now posted on CDC's Vaccine Safety website at <http://www.cdc.gov/vaccinesafety/> and on the FDA CBER website at <http://www.fda.gov/cber/safety/gardasil071408.htm>.

CDC Releases 2008 Influenza Guidance:

New recommendations from the CDC's Advisory Committee on Immunization Practices (ACIP) for the 2008-2009 influenza season have been released. The complete article is available on the MMWR website, at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5707a1.htm?s_cid=rr5707a1_e.

Delays in the availability of the Shingles Vaccine (Zostavax®):

Merck & Co., Inc, announced delays in manufacturing and shipping of the new shingles vaccine due to high demand for this vaccine and the related Varicella vaccine used in children. As of September 8, 2008, delays of 10-14 weeks between order and order fulfillment can be expected. Check with your local VA pharmacy or the Merck website (<http://www.merckvaccines.com>) for the latest information on vaccine availability.

Immunization Resources from the Immunization Action Coalition (IAC):

- Questionnaire for patients to see what vaccines they might need: <http://www.immunize.org/catg.d/p4036.pdf>

- Easy-to-read single page explaining adult vaccine recommendations: <http://www.immunize.org/catg.d/p4030.pdf>
- A more detailed 3-page summary of recommendations: <http://www.immunize.org/catg.d/p2011.pdf>

Check out all of the IAC's resources and join their mail group at www.immunize.org

Immunization Resources from the CDC:

- 11X17 color poster of adult vaccine recommendations <http://www.cdc.gov/vaccines/recs/schedules/downloads/adult/07-08/adult-schedule-11x17.pdf>

Conjugate Meningococcal Vaccine (MCV4) Information

Many of our newer veterans who are returning to college may inquire about whether they need to receive a meningococcal vaccine. The answer depends on whether they were previously vaccinated, which vaccine was used, and what risk factors they may currently have. Check out the CDC's web page on meningococcal vaccine (<http://www.cdc.gov/vaccines/vpd-vac/mening/default.htm>) for accurate, up-to-date information on this vaccine.

Request for Prevention Success Stories

If you or your facilities have experiences or lessons to share with your VHA colleagues, please consider contributing an article to this HEALTHPOWER! newsletter. Contact Kathy Pittman (Kathleen.pittman@va.gov) for more information.



Upcoming Conference Calls

VHA Monthly Prevention Call

2nd Tuesday of the Month,
1:00 PM ET
1-800-767-1750, Access Code
#18987

October 14, (November 11 call is cancelled), December 9

Research and Evaluation

The Evidence Base for Motivational Counseling Strategies



As is often the case with a new drug, screening procedure, or diagnostic test, the uptake and interest may occur faster than the evidence base that supports its effectiveness. Fortunately, the era of evidence-based behavioral health care has arrived. A body of randomized controlled trials on Motivational Interviewing (MI) is accumulating, making systematic reviews possible. The Cochrane Collaboration, a highly respected organization that conducts rigorous systematic reviews, has developed protocols for their first two reviews of Motivational Interviewing. As with any behavioral health intervention, evaluation using systematic review methods is tricky. Interventions and measures are often not standardized across studies, and information about the fidelity of intervention delivery is often missing. Further, studies may be too heterogeneous to combine quantitatively within a meta-analysis. This is further complicated with respect to MI, in that MI is often described more as a specific kind of counseling style as opposed to a discrete intervention that can be rigorously tested in research studies. Despite these limitations, systematic reviews on MI interventions can be helpful for summarizing the body of evidence in this area. The following information is summarized from four systematic reviews cited at the end of this article.

MI and Addiction Disorders

The largest number of trials evaluating MI has involved treatment of substance use disorders, specifically alcohol and drug abuse. These trials have consistently demonstrated that MI is an effective strategy compared to no treatment, and that it is at least as effective as other accepted, but more intense, treatment strategies. The effect sizes seen in these studies are variable, ranging from 0.30 to 0.95. Studies also suggest that MI is effective even when performed by non-specialists in substance abuse.

MI and Smoking

The evidence is more mixed with respect to smoking cessation. Trials of MI for smoking have occurred in highly variable populations (pregnant women, adolescents, pediatric practices, general adult practices, and patients with schizophrenia) and this may explain some of the inconsistencies in findings. Studies suggest that MI may be most useful for increasing the chances of a future quit attempt among patients who are not interested in quitting now. Its effectiveness is less clear among patients who are ready to quit.

MI and Weight, Diet, and Exercise

The few trials available in this area typically compare MI to placebo or "traditional advice giving." This limits comparison of effectiveness with other behavioral approaches. The studies do suggest a small to moderate favorable effect on outcomes such as BMI, cholesterol, blood pressure, and physical activity. These effects, however, varied greatly among studies, thus limiting the ability to make general statements about the effectiveness of MI in these areas.

MI and Chronic Health Problems (Diabetes, Asthma, Hypertension, Heart Disease)

Few trials have evaluated the use of MI in these areas; systematic reviews in this area, therefore, include observational studies. These observational studies have generally

Four systematic reviews of Motivational Interviewing

- MI and Addictive Disorders
- MI and Smoking
- MI and Weight, Diet, and Exercise
- MI and Chronic Health Problems (Diabetes, Asthma, Hypertension, Heart Disease)

(Continued from page 12)

been of lower quality than those conducted in the areas of addiction disorders and contain little information about how clinicians were trained in MI and the fidelity with which MI was delivered. The evidence to date in this area suggests some face validity and little to no harm in using MI techniques for these conditions, but clinicians should recognize that the evidence is currently insufficient to assess MI's effectiveness in dealing with the behavioral aspects of these chronic health conditions.

Features of MI

Most studies evaluated the use of MI in individual, face-to-face encounters only. Its use in group settings or over the phone is not known. Effective MI encounters average nearly 60 minutes and are more effective when delivered over longer durations (e.g., 12 months vs. 3 months). There is great interest in studying "briefer" interventions that capture the "spirit" of MI, but which can be delivered in shorter periods of time.

Summary

The evidence clearly supports the effectiveness of MI in dealing with addiction disorders other than tobacco. The evidence base is still accumulating for its use as a specific intervention for dealing with other behavioral health issues. Before MI interventions can be routinely recommended as a preferred strategy across the continuum of behavioral health issues, though, higher quality studies and information about the dose and training required to deliver an effective intervention, along with intervention costs, are needed. So, should we wait until all of the evidence is in to use MI in applications other than addiction disorders? Although the benefits may not yet be entirely clear, the harms are probably very low, if any. As we wait for growth of the evidence base to determine effectiveness for improving patient health outcomes, clinicians may find that the communication style

embodied by MI is a more satisfying way of communicating with patients around difficult behavioral health issues.

Systematic Review References:

Burke B, Arkowitz H, Menchola M. The efficacy of motivational interviewing: a meta-analysis of controlled clinical trials. *Journal of Consulting and Clinical Psychology* (2003) 71:843–861.

Dunn C, Deroo L, Rivara F. The use of brief interventions adapted from motivational interviewing across behavioral domains: a systematic review. *Addiction* (2001) 96:1725–1742.

Knight K, McGowan L, Dickens C, Bundy C. A systematic review of motivational interviewing in physical health care settings. *British Journal of Health Psychology* (2006) 11:319–332.

Rubak S, Sandbeck A, Lauritzen T, Christensen B. Motivational interviewing: a systematic review and meta-analysis. *British Journal of General Practice* (2005) 55:305–312.

Other References:

Fiore MC, Jaén CR, Baker TB, et al. *Treating tobacco use and dependence: 2008 update*. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. May 2008.

Resnicow K, DiIorio C, Soet J. Motivational interviewing in health promotion: It sounds like something is changing. *Health Psychology* (2002) 21:444–451.

Contributed by Leila Kahwati, MD, MPH



Clinicians may find that the communication style embodied by MI is a more satisfying way of communicating with patients around difficult behavioral health issues



Research and Evaluation News

MOVE! Annual Report

The deadline for submission of the *MOVE!* Annual Report is October 31, 2008. Instructions and access to the online report form are available at: <http://vaww.move.med.va.gov/srLaunch.asp>

Agency for Healthcare Research and Quality (AHRQ) Partnership

The NCP has collaborated with AHRQ to develop complementary patient and provider brochures and fact sheets for the US Preventive Services Task Force recommendations in the area of cardiovascular screening and prevention. The brochures were pilot tested in September and distribution information for the final versions will be available soon. Thanks to the following VHA providers and patient health educators for participating in the pilot test of these materials:

Providers	Patient Health Educators
Nina Ferguson	Rosetta Latimore
Thompson Matthews	Stephen K. Harmon
Patricia Mossop	Anita T. Farrish
Vinodini Krishnan	Pamela Lattimore
James Toth	Laureen Pada
Karen Curtis	Kathy Denison
Andrew Gorchs	Rosemary Gill
Connie E. Yant	Sandee Cegielski
Nancy Bauer	Jacqueline L. Tatum
Nadine Cartwright-Lowe	Deb Schumacher
Rose Birkmeier	



Delivering health care in a patient-centered way is desirable, but it may seem a vaguely defined goal. Motivational Interviewing (MI) offers clinicians and patients specific ways to enhance their communications and effectively integrate patient-centeredness into time-limited clinical encounters.

According to the Commonwealth Fund in a much-cited article in the *Journal of General Internal Medicine*,¹ patient-centered care has 8 dimensions:

1. Respect for the patient's values, preferences, and expressed needs.
2. Information and education.
3. Access to care.
4. Emotional support to relieve fear and anxiety.
5. Involvement of family and friends.
6. Continuity and secure transition between health care settings.
7. Physical comfort.
8. Coordination of care.

Motivational Interviewing supports the formation of therapeutic relationships and development of patient-centered care in several ways. The first component of MI is to establish rapport. For returning patients, clinicians can quickly chat with patients about family, hobbies, or a vacation mentioned at the previous visit. For new patients, this may be the time to ask questions that will facilitate future conversations, such as, "It's really warm today. I like to garden. But in this hot weather, it's not easy to spend time in the garden. What do you like to do in your spare time?" By using the four core MI skills—*Asking Open Questions*, *Affirming*, *Reflective Listening*, and *Summarizing*—clinicians demonstrate respect for the patient's values, preferences, and needs.

Motivational Interviewing helps clinicians identify patients' concerns and needs via *Asking Open Questions*. For example, "What's your biggest concern right now?" Clinicians can use patients' responses to tailor treatment plans to patients' specific concerns, goals, and lifestyles. *Open Questions* also help identify behaviors that patients would like to change, by focusing on the patient's motivation,

willingness, and ability to change specific behaviors.

Conversations about behavior change optimally occur when patients and clinicians view each other as partners, an important component of the spirit of MI. Patient-clinician partnership also permits the relationship to be maintained if the patient is not ready to take action. The clinician can ask, "As your *doctor/nurse/other discipline*, I am concerned about you and your health. I recognize (*Reflective Listening*) that you have said that, for now, you are not interested in *insert health behavior change*. But out of my concern for you, may I have your permission to ask about it in the future?"

Motivational Interviewing also encourages clinicians to express empathy. When patients share their concerns or fears, clinicians can offer emotional support, another dimension of patient-centered care.

Understanding the patient's feelings and perspectives without judging or blaming does not need to imply acceptance. Acceptance is possible without agreement or endorsement. The clinician may differ with a patient's views and respectfully express the divergence. However, it is extremely important to *Listen* to patients to understand their perspectives. *Listening*, accepting, and respecting patients' perspectives build the therapeutic, patient-centered relationship.

Setting the agenda is the next component of MI. Setting the agenda permits the clinician to identify and respect the patient's values, preferences, and expressed needs, the first dimension of patient-centered care. Clinicians can effectively use this information to create a treatment plan tailored to each patient, increase adherence, and engage the patient in

(Continued on page 16)



Veterans Health Education and Information (VHEI) (cont'd)

(Continued from page 15)

health behavior change. Setting the agenda also opens the door to discussion about possible health behavior changes. Permitting patients to identify behaviors they would like to change immediately increases buy-in with the change process. The Davis article on patient-centered care¹ also includes patient engagement in care as an attribute of patient-centered care.

Clinicians can assess importance to patients by *Affirming* patients' past successful behavior changes or coping strategies. This enhances patient confidence to make new health behavior changes. For example, "Remember when you started walking more, and you started by just walking to the mailbox, then worked your way up gradually to walking for 30 minutes a day?" or "Remember when we added two new medicines to the ones you were already taking? You did a great job juggling times you take your medicines, even though one of the new ones could not be taken close to mealtimes."

Motivational Interviewing also includes assessing readiness. It can be done using questions ("People can differ a lot when it comes to how ready they are to *insert health behavior change*. How ready do you think you are?") or using a numerical scale ("If 0 was totally unprepared and 10 was absolutely sure you will be able to *insert health behavior change*, what number would you give yourself?"). A patient response lower than 7 tells the clinician that the patient probably will not succeed in changing the behavior. Additional probing may identify specific barriers that the patient would need to overcome, and the clinician may be able to help the patient find ways to resolve those issues. The clinician can also ask what it would take for the patient to give himself/herself a higher score. Then, the clinician can deal

specifically with the issues the patient identifies.²

Negotiation is a critical element of partnership, the therapeutic relationship, and patient-centeredness. It permits clinicians to use their clinical expertise—and patients to use their knowledge of their goals and lifestyle to achieve the desired clinical outcomes while keeping patients in control. *Asking Open Questions, Affirming, Reflective Listening, and Summarizing* help clinicians and patients discuss possibilities for behavior change. These core skills help patients make changes that are important to them and therefore lead to enhanced health outcomes.

Summarizing permits clinicians to pull together the other MI skills while enhancing patient-centeredness. An effective summary depends on the information gathered through *Asking Open Questions, Affirming, and Reflective Listening*. It demonstrates that by *Asking Open Questions and Listening*, the clinician gains information important to the patient to develop the most effective patient-specific treatment plan. It *Affirms* and validates patients' perspectives and acknowledges their successes and coping skills.

Motivational Interviewing is an effective way to enhance patient-clinician communication and facilitate health behavior change. Its effects are more powerful than active listening or simple reflection used alone. MI also helps clinicians build therapeutic relationships. It creates rapport and engages patients in discussions about their needs, priorities, and health behavior change. To counsel patients most effectively, it is important for clinicians to use a variety of approaches, such as stages of change,³ self-efficacy, and modeling, along with MI. These strategies complement MI, permit clinicians to work with each patient as an individual, and use evidence-based counseling techniques to gain important

(Continued on page 17)

Four core MI skills—

- *Asking Open Questions*
- *Affirming*
- *Reflective Listening*
- *Summarizing*

Veterans Health Education and Information (VHEI) (cont'd)

Page 17
HealthPOWER: Prevention News
Fall 2008

(Continued from page 16)

information to create the most effective treatment plan, engage the patient, and support health behavior change.

References

1. Davis K, Schoenbaum SC, Audet AM. A 2020 vision of patient-centered primary care. *J Gen Intern Med* 2005;20:953–957.
2. Rollnick SR, Miller WR, Butler CC. *Motivational interviewing in health care: Helping patients change behavior*. New York: Guilford Press, 2008: 60–61.
3. Miller WR, Rollnick S. *Motivational interviewing: Preparing people for change*. New York: Guilford Press, 2002: 201–216.

*Contributed by Rose Mary Pries, DrPH
Program Manager for VHEI*



Veterans Health Education and Information (VHEI) News

Health Literacy Project

The Health Literacy Project is the result of a partnership between VHEI and the Harvard University School of Public Health's Health Literacy Program. The Project consists of three components:

1. An assessment of environmental health literacy. We have just completed a pilot of the environmental health literacy process and instrument. The following sites were selected as pilot sites from the 56 facilities that volunteered:
 - Battle Creek VA Medical Center (VAMC)
 - VA Gulf Coast Health Care System—Biloxi VAMC
 - Honolulu Outpatient Clinic (OPC)
 - Longview, TX Community-Based Outpatient Clinic—a part of the Shreveport VAMC
 - Minneapolis VAMC
 - VA Caribbean Health Care System
 - VA Eastern Colorado Health Care System
 - VA Maryland Health Care System
 - VA Northern California System of Clinics
 - White River Junction VAMC

The feedback from the pilot sites is currently being analyzed. Based on the feedback, the process and instrument may be modified. If the pilot is successful, the planning committee will recommend to VHA leadership that the environmental health literacy assessment be offered system-wide. We are currently completing this component of the Health Literacy Project

2. Distance learning for clinicians on selecting or developing print resources for patients and caregivers with low health literacy skills. This will also help facilities meet Joint Commission standards on providing understandable health information. This component of the Health Literacy Project will be completed by the first quarter of FY09.
3. Providing clinicians training via distance learning on the most effective communication skills to use when counseling and educating patients and family members with more limited health literacy. Because we recognize that print resources are only one part

(Continued on page 18)



Upcoming Conference Calls

**VHEI Patient Education
Hotline (1-800-767-1750
Access Code 16261#)**

First Tuesday of each month
at 1 pm ET
October 7, November 4,
December 2

**VHEI Patient Education
Conference Call (1-800-
767-1750 Access Code
19630#)**

Fourth Fridays of January,
April, July and October, 1
pm ET
October 24, 2008, and
January 23, 2009



Veterans Health Education and Information (VHEI) News (cont'd)

(Continued from page 17)

of educating and counseling patients and their caregivers, this is an important component of the Health Literacy Project. We anticipate that this training will be available in November 2008.

Helping the Field Meet Joint Commission Patient Education Standards

Meeting Joint Commission patient education standards has been the topic of several conference calls. A Handbook on this topic should become available during the first quarter of FY09. The Handbook will provide guidance on effective ways to meet Joint Commission patient education standards. It will also include forms, templates, and tip sheets to facilitate this effort. Because Joint Commission

standards will be revised in 2009, we will update this guidance and the resources when the new standards, elements, and measures of success become available.

Health Education and Information Program Handbook

A VHA Health Education and Information Program Handbook will soon enter the concurrence process. This Handbook will help the field create the organizational structures and functions needed to help facilities enhance their Patient Education Program to effectively meet the needs of veterans, family members, and staff.

For information about any of these VHEI projects, please contact Dr. Rose Mary Pries, (919) 383-7874, Ext. 250 or rose_mary.pries@va.gov.



New Orleans Conference July 16-17, 2008

NCP Prevention Conferences

NCP hosted prevention conferences this year in San Francisco June 18th-19th and in New Orleans July 16th-17th. Identical conferences were held in different parts of the country to make it easier for staff to attend and allow for smaller audience sizes. The conferences focused on training in motivational communication skills, which have been widely identified as a critical need for VA staff, and on general prevention program implementation strategies. Participants were given the opportunity to practice communication skills discussed and receive feedback in small groups. Small groups of participants also met together to discuss mutual interests, suggest solutions to barriers, and make program change plans.

Both conferences were designated a "Healthy Meeting" featuring opportunities for an early morning walk, a stretch break, and healthy food offerings at lunch and breaks. The participants and faculty all appeared to like the smaller and more interactive format of these meetings and the "Healthy Meeting" feature generated positive comments. We can look forward to all NCP conferences in the future having health-promoting features and smaller audience sizes where feasible.

Motivation?

The theme for this issue of the HealthPOWER! Prevention News is Motivational Interviewing (MI). MI comprises a set of healthcare communication strategies shown to lead to improvement in the health behaviors of patients/clients, most notably in the areas of substance abuse and smoking cessation. Research related to the application of MI in other areas of health behavior is ongoing and looks promising. Patient care is enhanced through its use.

We, as employees, also have health habits that could stand some improvement! Who is going to motivate us? Our physicians? Our spouse or significant other? A platitude we read? Not too likely! And does motivation come from other people in the first place? Not really. In the end, we simply have to motivate ourselves.

We can use some of the MI strategies on ourselves. For example, suppose that we know we need to begin exercising, but we haven't done so and have no intention of doing so within the next 6 months. We are in the *precontemplation* stage of behavior change when it comes to exercise. How can we get motivated? One strategy is to think seriously about whether or not our lack of physical activity is getting in the way of things we would like to do but don't because we aren't physically fit, or getting in the way of the kind of person we really want to be, or making us feel bad either physically or emotionally. If we make an honest effort to think about this, it will often spur us to action.

If (or, ideally, when) we reach the *contemplation* stage, in which we seriously consider beginning to exercise, it will help motivate us to examine the pros and cons of making this change. We can do this by making a list of all the positive things about beginning to exercise, as well as a list of all the positive things about *not* beginning to exercise. Similarly, we list the negative things about beginning to exercise, and the

negative things about *not* beginning to exercise. Then we look at how important each of these things is to us. Absolute honesty is critical for this to be effective. Examining these lists allows careful consideration of what is truly valuable to us and what is not. It addresses the issue discussed in MI of "importance," that is, how important is the anticipated outcome relative to making a designated change in behavior? It also helps us answer the question "What would it take to make exercising more important to me than it is now?"

Once we have decided that we are indeed going to begin exercising, we are in the *preparation* stage. Here it is helpful to investigate carefully and plan exactly how, what, when, and where we will exercise. Motivation comes from finally making progress rather than feeling "stuck," and may also come from the encouragement of others. This addresses the issue of "confidence," because making specific plans gives us a path we can actually follow. Focusing our thoughts on the positive aspects of our decision to begin exercising will help maintain our motivation. As planning proceeds, we may also find it helpful to give ourselves little rewards along the way.

Once we begin exercising, we are in the *action* stage. Our motivation is maintained and strengthened by the fact that exercising makes us feel more energetic and sleep better, have more self-confidence, possibly begin losing unwanted weight, and sometimes even receive praise from others. Exercising with others keeps our motivation high, and gives us an opportunity for accountability. It is also very helpful in this stage to build

(Continued on page 20)

Stages of Behavioral Change

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance



Employee Health and Wellness (cont'd)

(Continued from page 19)

in daily goals—and critically important to give ourselves meaningful rewards for achieving those goals. Keeping a daily record of our exercise helps keep us motivated. The probability of relapse back to our former habits is relatively high, so it is a good idea to have a “plan B” ready for those times when our routine is interrupted by vacations, illness, temporarily lower motivation, or any other factor.

Once we have been exercising regularly for 6 months or more, we are in the *maintenance* stage of change. Our exercise has become routine, but the possibility of relapse is still quite high.

Exercising with others remains very helpful at this stage, as does setting realistic goals, keeping a record, and enjoying at least occasional rewards for meeting our goals. Positive self-talk keeps our confidence high and our attitude positive. As always, any continued encouragement from others is appreciated.

Overall, we know in general that motivation is driven by having goals and achieving them, by being rewarded for our behavior, by being encouraged by others, and, through it all, by our own positive thinking! We can do it!

*Contributed by Richard Harvey, PhD
Program Manager, Health Promotion*



Upcoming Conference Calls

General Employee Wellness
October 28th—2:00pm ET
1-800-767-1750 #63047
October 28, December 23



Employee Health and Wellness News

National Training in Motivational Communication Skills

At a meeting in the Patient Care Services offices in Washington, DC on July 14, 2008, a proposal to conduct broad national staff training in motivational communication skills was presented to the Employee Education Service. The proposal is a joint effort of NCP, the Office of Mental Health Services, the Office of Public Health and Environmental Hazards, Primary Care, and the Office of Nursing Services. This training would be conducted with clinicians throughout the VHA over the course of several years, and is anticipated to be robust enough to instill meaningful clinician–patient communication skills. The proposal, although favorably received, has not yet been formally approved for funding by the Employee Education Service. Let’s look forward to the exciting possibilities of this motivational communication training!

My HealtheVet

www.myhealth.va.gov

VA Expands Anywhere, Anytime Internet Access to a Veteran's Personal Health Record

Celebrating 5 Years of www.myhealth.va.gov

Pioneering. Innovative. Ambitious. Award-winning. All words used to describe the Department of Veterans Affairs (VA)'s Personal Health Record, My HealtheVet, an online web portal which launched nationwide on Veterans Day 2003. To celebrate its five-year anniversary this year, My HealtheVet will expand online features of the American veteran's Personal Health Record to enhance patient-provider relationships and continue integration with the VHA's much-lauded Electronic Health Record (EHR).

My HealtheVet is more than just access to online health information and a gateway to online benefits and services. It enhances veterans' communication with their primary healthcare team members and allows veterans to become active partners in their health care. With over 622,500 users now registered on www.myhealth.va.gov, it's clear that this anywhere, anytime Internet access to VA health care—with features like online VA prescription refills (which tops www.va.gov searches), access to health measurements, and a one-stop shop for VA benefits—improves patient satisfaction and enhances quality health care within VA nationwide.

"With the 2008 enhancements of My HealtheVet, America's veterans, their care takers and care givers will soon have access to personal, secure, convenient and informed personal health information to not only improve their health but to become partners in their health care," said Secretary of Veterans Affairs Dr. James B. Peake.

VA developed My HealtheVet (www.myhealth.va.gov) to be a one-stop location where veterans of all eras can receive critical medical and benefits information and be able to input and view some of their own medical records online. Earlier this year, My HealtheVet was selected as the Gold Award winner for Best Practices in Consumer Empowerment and Protection Awards in the Category of Patient/Consumer Safety by the Utilization Review Accreditation Committee (URAC). URAC is an independent nonprofit group known as a leader in promoting healthcare quality through its accreditation and education programs.

"These awards demonstrate how VA and its leaders continue to provide innovative Information Technology solutions to enhance veteran and employee health, and improve the quality of care VA's health care system provides," said Dr. Michael J. Kussman, VA's Under Secretary for Health. "I encourage America's veterans and others to log on to My HealtheVet and forge a new partnership with us to make their health care decisions."

This article was contributed by Stacie Rivera, MPH—VHA Office of Information



Melvin Marks, nominee for the Jefferson Award and dedicated supporter of My HealtheVet, on his Harley (with a MHV banner) at a parade. (Previously published in Vanguard, Jan-Feb 2008)



VETERANS CANTEEN SERVICE

Department of Veterans Affairs

"Proud to Serve Genuine
American Heroes
Every Day"



**to Healthier Choices
this Holiday Season**

**Ask about
our loyalty**



**meal
program in
the food
court**

**Offer good through
December 31, 2008**



Look for our new and tasty



- **LOW CALORIE:** < 600 total calories
- **LOW FAT:** limited to 30% calories from fat
- **LOW SODIUM:** < 800 mg of sodium
- **LOW CHOLESTEROL:** < 100 mg
- **HIGH FLAVOR**



NCP is partnering with Veterans Canteen Service (VCS) in a campaign to promote the Wise Up meals available in VA Cafeterias. During the months of November and December, veterans, visitors and employees can participate in a Loyalty Program....buy 9 Wise Up meals and get the 10th meal free. Participants with completed loyalty cards will be entered into a drawing for a VCS gift card.



NCP Staff Update:

Long time staff member, **Rosemary Strickland RN, MSN** will be retiring on September 30, 2008. Rosemary served as the Executive Assistant to the Chief Consultant at NCP for the past six years. She has served a total of 21 years in the VA system. She has been instrumental in the success of NCP and a mentor and support to all. We wish her the very best in her retirement and will miss her tremendously.

Nancy Granecki, RN-BC, MSN, joined NCP in April 2008 from the Durham VA Medical Center. She has a 28 year VA career and 32 years of nursing experience. Her various nursing roles have included Med-Surg, ICU, management, home health, and staff development. Nancy is a North Carolina native. She obtained her BS in Nursing from East Carolina University and her MSN, with a focus in nursing education, from the University of North Carolina at Greensboro. Nancy's role at NCP is Special Assistant to the Chief Consultant.

Bobby Lucas was recently selected for the position of Program Support Assistant. He came to NCP after 1 year with the Durham VAMC Library Service and 22 years as a Retired Master Sergeant with the US Air Force. Bobby comes to NCP with assets that include his BBA in Human Resources Management and a myriad of highly creative skills in Administration. Welcome to NCP, Bobby!



**VA National Center for Health Promotion
and Disease Prevention
Office of Patient Care Services**

Chief Consultant for Preventive Medicine—
Linda Kinsinger, MD, MPH

Executive Assistant—
Gregory Moore, SPHR

Administrative Officer—
Pamela Frazier, BS

Program Support Assistant—
Bobby Lucas

Program Analyst—
Connie Lewis

Special Assistant—
Nancy S. Granecki, RN, MSN

IRM/ISO—
Kraig Lawrence, BBA, CSP
Steve Cosby

Contract Editor
Kate W. Harris

Deputy Chief Consultant for Preventive Medicine—
Leila C. Kahwati, MD, MPH

Program Manager for Prevention Practice—
Kathleen S. Pittman, RN, MPH

Prevention Policy Coordinator—
Terri Murphy, RN, MSN

Program Manager, Community Health—
Sue Diamond, RN, MSN

Research and Evaluation Analyst—
Trang Lance, MPH

Program Manager for Health Promotion—
Richard Harvey, PhD

National Program Director for Weight Management—
Kenneth Jones, PhD

MOVE! Project Coordinator, Contractor—
Susi Lewis, MA, RN

MOVE! Dietitian Program Coordinator—
Lynn Novorska, RD, LDN

MOVE! Physical Activity Coordinator—
Sophia P. Hurley, MSPT

MOVE! Program Management Analyst —
Tony Rogers

Program Manager for VHEI—
Rose Mary Pries, DrPH

Health Education Coordinator—
Pamela Hebert, DrPH, CHES

Health Educator—
Barbara Hebert Snyder, MPH

Calendar of Events:

September

9/4/08—YMCA Meeting—Washington, DC
L. Kinsinger, S. Diamond

9/8-11/08—VHA Web Communications Training
St. Petersburg, FL
L. Novorska, T. Rogers

9/16-19/08—STVHCS Meeting—Corpus Christi, TX
P. Hebert

October

10/3-7/08—Obesity Society Meeting—Arizona
K. Jones

10/22-23/08—Advisory Committee on Immunization
Practices, CDC Atlanta, GA
L. Kinsinger

10/22-23/08—Task Force on Community Preventive
Services, CDC—Atlanta, GA
L. Kahwati

10/27-31/08—Robert W. Carey Symposium
Washington, DC
K. Pittman



VA National Center for Health Promotion
and Disease Prevention (NCP)
Office of Patient Care Services
Suite 200
3022 Croasdaile Drive
Durham, NC 27705

Postage

NCP Mission Statement

The VA National Center for Health Promotion and Disease Prevention (NCP), a field-based office of the VHA Office of Patient Care Services, provides input to VHA leadership on evidence-based health promotion and disease prevention policy. NCP provides programs, education, and coordination for the field consistent with prevention policy to enhance the health, well-being, and quality of life for veterans.