

Health *POWER!*

Prevention News • SUMMER 2009



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Health Literacy in the VHA Healthcare System

This issue's theme, health literacy, reminds us of one of the challenges faced by many of our Veterans, as they access and receive health care in the VHA healthcare system. The challenge of inadequate health literacy is certainly not unique to Veterans nor to the VHA; an extensive body of literature and the large number of public and private programs on health literacy demonstrate the widespread nature of this problem.

A recent article in the *Journal of General Internal Medicine* by Parker et al. (2008;23:1273-6) discusses a report, "America's Perfect Storm: Three Forces Changing Our Nation's Future." This report predicts that the US is at risk due to inadequate and declining levels of overall literacy among adults as a result of three factors: stagnant low high school graduation rates, shifting demographics of the US population to more non-native English speakers, and increasing educational demands of higher-paying jobs. This report and several from the Institute of Medicine call for urgent actions to address health literacy concerns through "efforts to simplify health systems and the tasks they require of patients." As health care and health information continue to become increasingly complex, we must remain cognizant of the difficulties our patients face in trying to understand all that they are asked to do. Even what should be relatively simple and straightforward information, such as directions for taking medication, may be confusing and unclear to many patients. As Dr. Darren De Walt, our guest author for this issue, points out, we can reduce the burden on patients with low health literacy by focusing on the design of care delivery.

Given the estimated high prevalence of low health literacy and the importance of providing health care in a way that is assessable to those with low health literacy, one might assume that screening patients for literacy skills would be beneficial. Health communication could be adjusted for those whose screening tests showed poor skill levels. However, research has not supported this assumption. Several screening instruments for literacy have been developed for use in research settings, but their effectiveness has not been shown in usual clinical practice, where patients may be ill or anxious or where they have an established relationship with clinical staff. And the potential for harm is real. Screening for low health literacy may lead to "labeling" certain patients, resulting in feelings of shame and embarrassment. Studies have shown that many people with limited literacy have not disclosed their difficulty to others, even spouses. Being "outed" in their health care setting would likely only add to problems of accessing important health information.

Thus we should strive to be as clear and understandable as possible in communication with all patients, regardless of their literacy skills. Some have called

for applying the concept of "universal precautions" to this topic, meaning that we should use good communication techniques to confirm understanding and support comprehension with each and every patient. Several of the articles in this newsletter discuss how to apply this approach related to preventive care and wellness. Dr. Rose Mary Pries describes a training course in health literacy that will be available soon for VHA clinicians. This course is being developed in collaboration with the Health Literacy Program at the Harvard School of Public Health. It will also include information for facilities to assess their medical centers for clarity of communication for patients about how to find their way around the center.

As VHA moves toward a transformation in how we deliver care, toward the goal of "Veteran-centered care," improving how we communicate with our Veterans will be a key objective. They are counting on us to provide them with "the best care anywhere." ■

Linda Kinsinger

Addressing Health Literacy in our Clinical Interactions

Research done in the past 15 years has demonstrated that patients with low health literacy have worse health outcomes than patients with higher health literacy, independent of race, ethnicity, and socioeconomic status. Patients with low health literacy are less likely to receive preventive services, have worse control of chronic illnesses, have lower scores on many measures of health-related quality of life, are hospitalized more often, and experience earlier mortality than their counterparts with higher health literacy. Studies have confirmed that many patients, particularly those with low health literacy, do not interpret instructions on prescription labels correctly, even though, as clinicians, many of us assume the instructions are always understood. Creating effective interventions that address the problem of low health literacy can lead to better health outcomes.

Health literacy is the degree to which people can obtain, process, and understand basic health information and services to make appropriate health decisions. Research to date has focused on the skill level of an individual patient and how those skills are related to health outcomes. Those with lower skill levels have worse outcomes. Clearly, however, the level of skill needed to function in health

care (or any environment) depends on the level of complexity of the environment. Health care, in many situations, is incredibly complex and foreign to the people we serve. To date, no research has demonstrated that we can improve the health literacy of individuals as measured by current instruments. However, we have demonstrated that we can reduce the complexity of some health care situations, and, in that context, improve health outcomes for patients with low health literacy. As such, focusing on the design of care delivery may be the best strategy to reduce health literacy-related disparities.

I believe the easiest way to think about health literacy is to ask, “Does this patient know everything he needs to know to succeed in his health care when he leaves this office (or other health care setting), and is the information stored in a way that he can use it after he leaves?” This leads to several aspects of care that I can address. First, any communication I give must be clear and understandable. This is true whether I convey the information by speaking or in writing. It’s hard to believe, but true, that most written health information is at a readability level well above that of most healthcare consumers. It’s also true, but harder to measure, that much of our oral communication is presented in a way that’s difficult for patients to understand, process, and remember. And, even if written or said at a reasonably clear level, we have no guarantee that the patient in our care can understand and use the information. For these reasons, most experts advocate that we (1) reduce the complexity of our communication, and (2) confirm understanding after we present

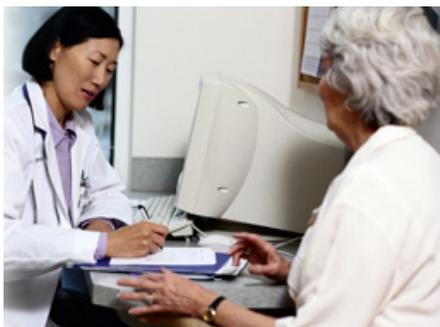
Contributed by

Darren A. DeWalt, MD, MPH

Cecil G. Sheps Center for Health Services Research

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Health literacy is the degree to which people can obtain, process, and understand basic health information and services to make appropriate health decisions.



information to a patient. Even knowing the measured health literacy level of a patient will not guarantee that the patient understands communications at that literacy level.

Reducing the complexity of our communication requires that we learn to distill our discussion to the “need to know” and “need to do” for each patient. As clinicians, we tend to revert to the style and framework of learning that brought us to our current careers. We often focus on pathophysiology, epidemiology, and laboratory tests. Although these may have meaning for some of our patients (those who are most like us), they are not necessarily meaningful or important for others. When we spend time trying to explain abstract concepts, we can distract from the need to know and need to do. Because the literature from cognitive science indicates that people have a relatively small capacity for storing information in short-term memory, I advocate trying to limit communication to patients (in any one session) to three main points. I choose those points carefully, and make sure they are action-oriented and reflect the need to know and need to do for that patient.

The only way to ensure that a patient understands the information we provide is to use the teach-back method. Not only does it allow us to confirm the patient’s understanding, it also helps to move the information from the patient’s short-term memory to long-term memory, thus increasing the chance that the patient will remember the information after she leaves the encounter. Performing the teach-back often feels awkward to clinicians who did not learn to incorporate it into their practice at an early stage in their careers.

However, most clinicians I work with have found that this practice identifies instances where they did not communicate effectively with patients, and helps them both refine their communication strategies and avoid medical errors.

Much of the discussion around health literacy has focused on disease-specific knowledge that applies to an individual’s health behavior. Indeed, many health behavior theories assume that the person has the requisite knowledge to adopt the behavior. However, most clinicians will quickly recognize that several factors other than disease-specific knowledge affect health behaviors and other health-related activities which affect outcomes. For example, to have good management of diabetes, a patient needs to know how to take her medicines (disease-specific knowledge). However, she also needs to know how to navigate her pharmacy benefits program and how to access other programs that require literacy skills. As clinicians, we need to keep in mind that literacy-related barriers extend beyond our conversations in the clinical setting. Interventions designed to reduce health literacy-related disparities must consider all of these factors.

In summary, low health literacy is common and related to poor health outcomes. Current approaches for addressing health literacy require that we improve how we communicate, focusing on the need to know and need to do, and ensure, with teach-back, that our clients understand. Without this approach, we will never achieve the “productive interactions” that are the central component of the chronic care model. ■

Making Your MOVE! Program Literacy-Friendly

Low health literacy directly affects an individual's ability to comprehend and act on health information. It also increases the difficulty of navigating an already complex health care system. Raising awareness about MOVE! health literacy may be the key to unlocking the potential to turn Veterans into informed consumers; to make good decisions about physical activity, diet, and behavior change; and to take responsibility for their health. It is important to note that *literacy level* does not always equate to *health literacy level*. Literacy is not a condition that makes itself easily visible. In fact, you can't tell by looking. Health literacy depends on the context. Even people with strong literacy skills can face health literacy challenges, such as when:

- They are not familiar with medical terms or how their bodies work.
- They have to interpret numbers or risks to make a healthcare decision.
- They are apprehensive or confused.
- They have complex conditions that require complicated self-care.

Health literacy problems affect people from all backgrounds, especially those with chronic health problems. As Dr. Darren DeWalt indicated in his article in this newsletter, we need to improve how we communicate, by focusing on the need to know and need to do, and ensure, with “teach-back” that MOVE! participants

understand. Incorporating the following strategies, tips, and MOVE! tools or materials will assist patients with low health literacy:

- Slow down—Take time to listen to concerns.
- Create a safe environment. Weight is always a sensitive issue. Establish an atmosphere of respect and comfort, which builds patient trust. If a provider thinks a patient is having difficulty understanding written or spoken directions, a good approach is to say, “A lot of people have trouble reading and remembering these materials. How can I help you?”
- Use plain, non-medical language where possible (i.e., instead of saying, “Patients with familial hypercholesterolemia should avoid consumption of...” say: “If you have a family history of high cholesterol, eat lower fat foods...”).
- Show or draw pictures—Use MOVE! handouts that have pictures (i.e., [Healthy Plate–N12](#); [Serving Sizes–N21](#); [Physical Activity Pyramid–P26](#); [Sample Stretches–P30](#); [Sample Strength Activity Plan For Beginners–P32](#); [BMI Chart–M06](#)). These handouts can be found at: <http://www.move.va.gov/Handouts.asp>.
- Use other available MOVE! handouts or produce additional easy-to-read materials.
- Make use of the [Spanish versions](#) of the MOVE! handouts, if appropriate (<http://www.move.va.gov/handouts.asp?language=spanish&handout=standard>).
- Limit the amount of information provided, AND repeat it. Remember that patients retain *less than half* of the information provided during each visit.

Contributed by

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Coordinator



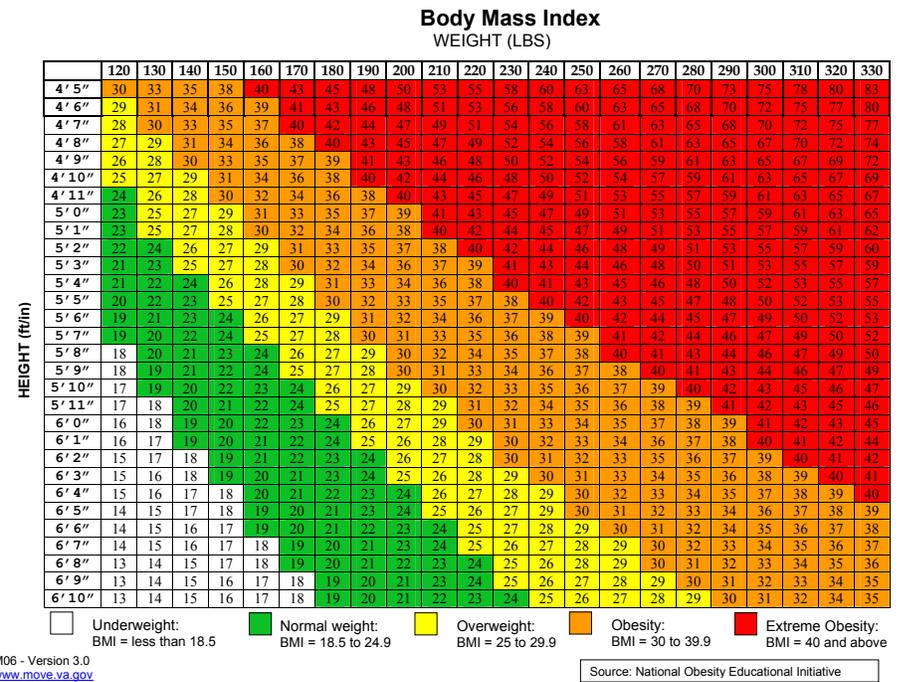
- Confirm understanding of your message. To verify that patients understand, or to uncover health beliefs and tailor teaching, providers might ask patients to “teach-back” by having the patient repeat or restate the instructions as the patient might tell a friend (e.g., “Can you tell me in your own words what we have discussed?”).

For Primary Care Providers, the MOVE! BMI chart can be a very powerful teaching tool. This color handout can be used to discuss the risks related specifically to a Veteran's overweight or obesity status. Used as a visual aid, providers can show patients the BMI for their specific height and weight. The Veteran can clearly see that if he or she is in the red zone, a MOVE! toward the green zone is needed.

A simple tracking method, like circling the Veteran's current BMI over time, can be a strong motivator for success. This tool avoids problems with numeracy (the ability to reason with numbers and other mathematical concepts) by giving the patient a clear visual image. With the provider's help, a patient can set a weight goal to help decrease health risks.

The MOVE! team is very interested in continuing to develop and provide tools to help patients absorb new information for increased learning. We have found that offering a variety of self-management support options is gaining popularity; research continues to demonstrate that self-management strategies improve patient outcomes by providing techniques and tools to help patients choose healthy behaviors by offering structure, repeating guidance, and encouraging collaborative relationships that support healthy behavior change. Because patients need a variety of support options, the NCP MOVE! team is working to develop new treatment modalities that will meet a variety of patient needs. Current and future NCP MOVE! Team projects include:

- Care Coordination Home Telehealth Weight Management Disease Management Protocol:** This strategy uses an in-home telephone messaging device. Home Telehealth communication devices use a conventional telephone line and provide a simple screen display, response buttons, and ports for medical devices such as electronic scales. The device can interact with the patient on a daily basis, providing information, posing questions, and prompting the patient to refer to additional hardcopy information provided as part of treatment.
- MOVE! Telephone Lifestyle Coaching:** This quality improvement project, initiated with VISN 2, allows the Veteran to receive guidance via telephone from a lifestyle coach at a centralized location. Although telephone support is only a recently emerging field of study, there is growing evidence that this coaching is an effective way to support self-management, whether for initial weight loss¹ or in maintenance of weight loss².
- eMOVE!:** This option will provide support for weight self-management via the Internet. It will extend care from face-to-face and telephone devices to the



Body Mass Index (BMI) Chart

Internet through a secure web portal. eMOVE! will provide the Veteran with tools, information, and e-counseling. Even though national implementation of the latest versions of MOVE! care will take time, there are many ways to address health literacy today! For those interested in taking a health literacy course to increase proficiency, visit the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) site (<http://www.hrsa.gov/healthliteracy/training.htm>) and take the on-line training titled **Unified Health Communication 101: Addressing Health Literacy, Cultural Competency, and Limited English Proficiency**. This course is a free learning tool that will help you:

- Improve your patient communication skills;
- Increase your awareness and knowledge of the three main factors that affect your communication with patients (health literacy, cultural competency, and low

English proficiency); and

- Implement patient-centered communication practices.

Another very useful publication is a collection of health literacy resources that includes tools for developing and evaluating materials and sources of easy-to-read materials, compiled by the **USDA Food and Nutrition Information Center** available at http://www.nal.usda.gov/fnic/pubs/bibs/edu/health_literacy.pdf.

REFERENCES

¹ Jeffery RW, Sherwood NE, Brelje K, Pronk NP, Boyle R, Boucher JL et al. Mail and phone interventions for weight loss in a managed-care setting: Weigh-To-Be one-year outcomes. International Journal of Obesity 2003;27:1584-1592.

² Svetkey LP, Stevens VJ, Brantley PJ, Appel LJ, Hollis JF, Loria CM, et al. Comparison of Strategies for Sustaining Weight Loss. The Weight Loss Maintenance Randomized Controlled Trial. JAMA. 2008;299(10):1139-1148.

News



2009 MOVE! Conference

NCP, in collaboration with the Employee Education System (EES), held the first of two summer conferences titled **“MOVE! Forward Together: The Changing World of Weight Management Intervention—Current Practices and Future Possibilities”** in Boston on May 5–6, 2009, for VISN’s 1–10. The conference will be repeated for VISN’s 11–23 on July 23–24 in Denver, CO.

The keynote speaker, Dr. Louis Aronne, is Director of the Comprehensive Weight Control Program at New York-Presbyterian Hospital/Weill Cornell Medical Center. His keynote presentation focused on *Current and Future Trends in Weight Management and the Importance of the MOVE! Weight Management Program for Veterans*. He also made a second presentation, on *Medications and Weight*. Additional speakers included several excellent VA subject-matter experts; VISN 1–10 MOVE! and MOVEmployee! innovation panelists; and NCP Prevention and MOVE! Team members. For the July 23–24 meeting in Denver, Dr. Randy Petzel, MD, acting Under Secretary for Health, will give the final presentation.

Topics included:

- MOVE! 101
- MOVE! Evaluation
- Using Technology to Provide Self-Management Support
- MOVE! Intensive
- Bariatric Surgery

Concurrent sessions were offered on:

- Nutrition and Physical Activity
- Motivational Interviewing
- Nuts & Bolts for New Facility MOVE! Coordinators
- MOVE! Cube Review

The final presentation was a motivational closing, *Moving Forward*, given by Dr. Michela Zbogor. The enthusiasm generated by the conference was apparent in the VISN Strategic Planning sessions, which concluded the conference. We look forward to the July 23–24, 2009 conference for VISNs 11–23.

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 #59445

- July 14

Contributed by
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The teach-back method, also referred to as the “show-me approach” or “closing the loop,” is a communication technique that can be used to assess patient comprehension of a clinician’s advice or instructions.

The Teach-Back Method— One Solution to Improving Health Literacy

In this issue’s feature article, Dr. Darren DeWalt touched on the myriad of problems that can be associated with low health literacy. Effective communication in the delivery of health care is important. Therefore, when patients encounter barriers to obtaining, processing, or understanding the basic health information and services needed to make appropriate decisions, the result can be poor health outcomes. When patients don’t understand or misinterpret information given to them by their clinician—as frequently happens when there is a mismatch between the clinician’s level of communication and the patient’s level of comprehension—adverse outcomes can follow, including medication errors or missed appointments. What’s more, the increasing complexity of the health care system and our understanding of disease processes themselves have the potential to exacerbate problems of low health literacy among our patients.

In his article, Dr. DeWalt offers some potential remedies to the problem of low health literacy. Other possible solutions that have been proposed to increase the effectiveness of the exchange of information between clinician and patient include slowing down one’s rate of speech; using plain, non-medical language when possible; using pictures; and repetition. Another means to improve communication and confirm patient comprehension is to use a technique known as the teach-back method.

The teach-back method, also referred to as the “show-me approach” or “closing the loop,” is a communication technique that can assess patient comprehension of a clinician’s advice or instruction. In basic terms, teach-back involves asking patients to explain or demonstrate in their own words what they have been told by the clinician. The approach is often described as a four-stage process. (1) The clinician explains or demonstrates a concept that is new or unfamiliar to the patient. (2)

The clinician asks the patient to explain or demonstrate the concept, which allows the clinician to assess patient recall and comprehension. (3) If needed to further improve understanding, the clinician clarifies or reiterates important points about the concept to the patient, tailoring the clarification to particular deficiencies of understanding shown in the second stage. (4) Finally, the clinician reassesses the patient’s understanding and recall by asking the patient to repeat or demonstrate the concept to the clinician one more time.

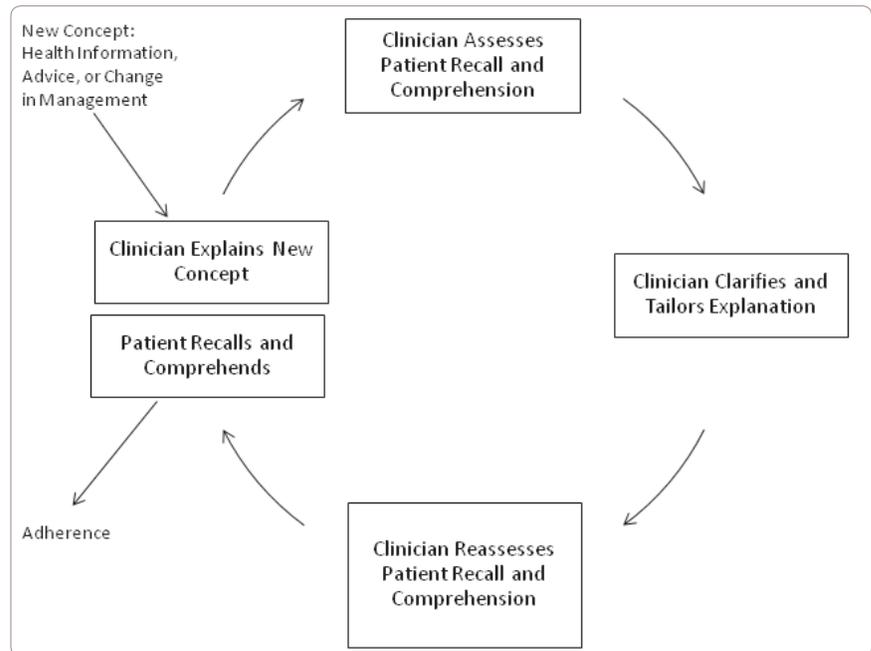
For example, a clinician may demonstrate or explain a new concept or practice to the patient, such as getting a screening test. The clinician then may say to the patient, “To be sure I explained this to you correctly, can you tell me in your own words what I just told you about getting checked for colon cancer?” Or, “If you had to explain to your friends/family/spouse what I just told you about getting checked for colon cancer, what would you say about it?” An opportunity for the

patient to restate the clinician's words and concepts then follows. If the patient cannot do this correctly, the clinician should explain the concept again, using pictures or simpler language. The process of restating the concept and asking the patient to teach it back to the clinician in his/her own words is repeated until comprehension is achieved.

Traditionally, after explaining a concept or dispensing medical advice, a clinician follows his or her own recommendations by asking the question, "Do you understand?" In the teach-back method, this simple question should be avoided as it frequently elicits a one word response from the patient, which is often "Yes." This response may not be reliable, as patients may be uncomfortable admitting to their provider that they don't understand, or patients may overestimate their level of comprehension. Another central feature of the teach-back method is the burden of accountability. If the patient is not able to restate the information to the clinician, the clinician should make the assumption that he or she did not teach it to the patient properly, in a way that the patient could understand. Responsibility for teaching is in the hands of the clinician. Therefore, if the patient did not understand what he or she was taught the first time, the clinician should teach the information again, using an alternate approach.

The teach-back method has many benefits. In the process of asking patients to restate concepts to the clinician in their own words, the clinician can more readily uncover where a misunderstanding lies and thus tailor his or her efforts toward correcting this. What is expected to follow from this process is improved adherence by patients, who now have a better understanding of the medical concept or advice, and are given more ownership in their health affairs. Furthermore, emerging evidence in the literature shows the positive effects of this process, both in terms

Graphic depiction of the Teach-back method



of patient understanding and improved health outcomes.

Despite these benefits, there is also evidence that the teach-back method is underutilized by clinicians. Possible reasons for this include a lack of clinician awareness about this conversation technique, a lack of belief in its effectiveness, or a belief that this method is too time-consuming and would prolong clinic visits with patients. To address these concerns, research is being done to improve awareness about the teach-back method, to improve the abilities of those who want to use this technique, and to demonstrate its benefits in improving health outcomes.

The teach-back method, involving an iterative communication process between clinicians and patients, is a method that can be used to improve patients' health literacy. Using it can help identify and correct areas of patient misunderstanding or confusion in a tailored manner, in hopes of increasing adherence to a clinician's recommendations or advice. In the end, when

clinicians and patients can improve their communication around health issues, the benefits can be enjoyed by everyone.

REFERENCES:

- Schillinger D, Piette J, Grumbach K, et al. Closing the loop: Physician communications with diabetic patients who have low health literacy. *Arch Intern Med.* 2003; 163:83–90.
- Osborne H. In other words...Confirming understanding with the Teach-Back Technique. *Health Literacy Consulting website.* <http://www.health-literacy.com/article.asp?PageID=6714>.
- Brown J, Baker C. Make sure your patient gets it: Provider tips for clear health communication. *DOC News.* 2005; 2(9): 20.
- Weiss BD. American Medical Association. *Health literacy and patient safety: Help patients understand. Manual for clinicians, 2nd ed.* Chicago, IL: American Medical Association Foundation and American Medical Association, 2007.

News



H1N1 Flu Information

The Office of Public Health and Environmental Hazards, VA Central Office is coordinating VHA's response to the H1N1 Flu. The main VA Internet site for H1N1 information is <http://www.publichealth.va.gov/h1n1flu/> and an H1N1 Flu Fact Sheet for patients and staff is available there.

VA has also established two toll-free call centers (open 8:00 a.m. to 8:00 p.m. EST) related to H1N1 flu:

- **Veterans and Family Members:**
1-800-507-4571
- **VA Staff:** 1-866-233-0152

VA employees should also be in communication with their supervisors, if they are ill, need to take leave, or have questions specific to their facility or office.

The main Federal web site for information on the 2009 novel H1N1 flu virus is the Centers for Disease Control and Prevention (CDC) www.cdc.gov/H1N1

2009 Prevention Forums

NCP, in collaboration with the Employee Education System (EES), held the first of two conferences, *Clinical Prevention Practice: Delivering the Best Preventive Care Anywhere*, in Arlington, Virginia, on April 29–30, 2009. Speakers from various federal agencies, including the National Institutes of Health, the Agency for Healthcare Research and Quality, and the Department of Health and Human Services, gave presentations, as did VHA staff. Topics included: the difference between intuition and science in cancer screening; an overview of the US Preventive Services Task Force (USPSTF); the future directions of prevention-related performance measures; and the challenges and possibilities of delivering

preventive care services in VHA primary care clinics. In the break-out sessions, smaller groups discussed specific implementation strategies for USPSTF recommendations, physical activity guidelines, and the use of technology to educate patients on the importance of preventive services. A panel of physicians and nurses from the field presented their improvement activities in the areas of lipid management; colorectal cancer screening, diagnosis, and follow-up; and women's preventive health services. The presentations were well received and we look forward to a repeat of the conference on July 21–22, 2009 in Denver CO. Registration is open until July 14, 2009. Email Kathleen.pittman@va.gov for registration link and information.

Preventive Medicine Field Advisory Committee

On April 28, 2009, NCP's Preventive Medicine Field Advisory Committee met at VA Central Office. This committee is comprised of representatives of VISN Preventive Medicine Leaders, other field-based clinicians who are preventive medicine subject-matter experts, and representatives from VHA Offices with a prevention focus. The committee is working with NCP to approve "Guidance Statements" on a comprehensive set of clinical preventive services including screenings, immunizations, health behavior counseling, and preventive medications for Veteran patients. The agenda included discussions and presentations on procedural issues in the Guidance Statement development process, prioritization of Guidance Statement topics, coordination with Primary Care and the Office of Quality and Performance, and an

UPCOMING CONFERENCE CALLS

VHA Monthly Prevention Call 2nd Tuesday of the month

1:00 pm ET

1-800-767-1750, access #18987

- July 14, August 11, September 8

implementation and dissemination plan for the approved Guidance Statements. Troy Knighton, MEd, EdS, LPC, Senior Program Manager/IDPIO Coordinator gave a "best practice" presentation to the group on implementation strategies used by the Infection: Don't Pass it On (IDPIO) campaign.

US Preventive Services Task Force/ Agency for Healthcare Research and Quality

The U.S. Preventive Services Task Force (USPSTF) has released three recommendations in the past several months. All of these recommendations are available at: <http://www.ahrq.gov/clinic/uspstfix.htm#Recommendations>

Screening for Skin Cancer: Updated Statement (2/09)

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of using a whole-body skin examination by a primary care clinician or patient skin self-examination for the early detection of cutaneous melanoma, basal cell cancer, or squamous cell skin cancer in the adult general population (*I statement*). This



recommendation applies to the adult general population without a history of premalignant or malignant lesions. Clinicians should remain alert for skin lesions with malignant features noted in the context of physical examinations performed for other purposes.

Folic Acid to Prevent Neural Tube Defects: Updated Statement (5/09)

The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400-800 µg) of folic acid. *(A recommendation)*

Aspirin for the Primary Prevention of Cardiovascular Disease: Updated Recommendations (3/09)

The USPSTF:

- Recommends the use of aspirin for men aged 45 to 79 when the potential benefit of a reduction in myocardial infarctions outweighs the potential harm of an increase in gastrointestinal hemorrhage. *(A recommendation)*
- Recommends the use of aspirin for women aged 55 to 79 when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage. *(A recommendation)*
- Concludes that the current evidence is insufficient to assess the balance of benefits and harms of aspirin for cardiovascular disease prevention in men and women 80 years of age and older. *(I statement)*
- Recommends AGAINST the use of aspirin for stroke prevention in women younger than 55 years of age and for myocardial infarction

prevention in men younger than 45 years of age. *(D recommendation)*

The previous recommendations, issued in 2002, were for a discussion between provider and patient for the prevention of Coronary Heart Disease only (not stroke) and were not gender-specific.

Centers for Disease Control and Prevention (CDC)

“Guide to Vaccine Contraindications and Precautions:” The 32-page guide summarizes CDC’s recommendations regarding common symptoms and conditions that do and do not contraindicate administering vaccines licensed for use in the United States. To access the guide, go to: <http://www.cdc.gov/vaccines/recs/vac-admin/contraindications.htm>.

Pneumococcal Polysaccharide Vaccine Information Sheet (VIS)

updated: The updated VIS incorporates recent changes in Advisory Committee on Immunization Practices (ACIP) recommendations regarding indications, mainly for smokers and people with asthma. Find the new VIS at <http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-ppv.pdf>.

Announcing the Discontinuation of Supporting Indicator ‘p5’: Education for Prostate Cancer Screening in Men

The External Peer Review Program, VHA Office of Quality and Performance, has stopped collecting data for the supporting indicator ‘p5’, which measures the extent to which men aged 50 to 69 are provided annual education about prostate cancer screening. The data to support this indicator will no longer

be collected and facility and VISN-level scores for this indicator will not be reported out, starting with the 3Q FY 2009 Executive Briefing Book (EBB). The VHA National Center for Health Promotion and Disease Prevention, Office of Patient Care Services, recommends that facility leadership consider deactivating clinical reminders used to support this indicator.

Why this supporting indicator is being discontinued

New evidence does not support routine prostate cancer screening or annual education about prostate cancer screening. Two large randomized control trials of prostate cancer screening were published in March 2009 in the *New England Journal of Medicine*.^{1,2} These studies suggest that prostate cancer screening, primarily with the PSA blood test, results in, at most, a very small absolute reduction in prostate cancer mortality in a core group of men after 10 years and leads to considerable testing, over-detection, unnecessary treatment, and harms. In August 2008, the US Preventive Services Task Force issued a recommendation against routine screening in men aged 75 and older, because the harms of screening outweighed the benefits in this age group. No recommendation was issued for men aged less than 75 at that time because the evidence was insufficient, as the two new trials had not yet been published.

Even though ‘p5’ was only a supporting indicator with no target and no accountability, the presence of the indicator implied to providers that they had some obligation to initiate an annual discussion about prostate cancer screening with their male patients. The



new evidence suggests that the harms of screening likely outweigh benefits in many men, regardless of age. Thus the 'p5' indicator is no longer relevant. Clinicians should certainly be prepared to discuss the benefits/harms of screening with men who ask about it, but are not expected to address the issue of prostate cancer screening annually with all men.

REFERENCES

- Schröder F, Hugosson J, Roobol M, Tammela T, Ciatto S, Nelen V, et al. screening and prostate-cancer mortality in a randomized European study. N Engl J Med 2009;360(13):1320-8.*
- Andriole GL, Grubb RL 3rd, Buys SS, Chia D, Church TR, Fouad MN, et al. Mortality results from a randomized prostate-cancer screening trial. N Engl J Med.*

2009;360(13):1310-19.

Meet Jesse James, MD—UNC Preventive Medicine Residency Program

NCP's affiliation with the University of North Carolina's Preventive Medicine Residency Program continues. Our newest resident, Dr. Jesse James, is a second-year preventive medicine and internal medicine resident. Dr. James is currently a candidate for a Masters of Public Health in the department of Health Care Leadership and Prevention. Prior to his work at UNC, Jesse attended Yale University School of Medicine and Yale School of Management, where he earned his MD and MBA degrees. Dr. James received his undergraduate degree from Florida Agricultural and Mechanical University where he

graduated summa cum laude. As a medical student, he became interested in continuous quality improvement while working as a Fellow at the Centers for Disease Control and Prevention. He is a native of Chicago's West Side and was raised in Atlanta. His interests in health care include Medicare policy, quality improvement, and chronic disease prevention.



New Brochures on USPSTF Cardiovascular Recommendations

The NCP and the Agency for Healthcare Research and Quality (AHRQ) partnered to produce a series of patient brochures and provider fact sheets on the cardiovascular recommendations of the U.S. Preventive Services Task Force (USPSTF). The series is entitled "Partnership for Health" and the topics include: Use of Aspirin to Prevent Cardiovascular Events; Screening for Abdominal Aortic Aneurysms; High Blood Pressure; High Cholesterol; Screening for Coronary Heart Disease; and the recommendation NOT to screen routinely for Vascular Disease (carotid artery stenosis

and peripheral vascular disease). The brochures and fact sheets are available electronically and in a PDF format suitable for printing. Samples of these brochures and fact sheets will be sent to each facility and the patient brochures can be ordered through the VA Forms Depot. The fact sheets and brochures can be accessed at: http://www.prevention.va.gov/Clinical_Resources_Partnership_for_Health.asp.

Partnership for Health
Department of Veterans Affairs

Heart and Circulation Clinician Fact Sheet

Screening for Abdominal Aortic Aneurysm

Your patients rely on you for accurate, up-to-date preventive health information. This fact sheet for clinicians provides information about screening for abdominal aortic aneurysm and is designed to complement the patient brochure.

- Talk With Your Health Care Provider About Screening for Abdominal Aortic Aneurysm

Who should be screened for Abdominal Aortic Aneurysms?

The U.S. Preventive Services Task Force recommends one-time screening for abdominal aortic aneurysm (AAA) for men aged 65-75 who have smoked at least 100 cigarettes in their lifetime.

Screening should be routinely recommended only when a positive net benefit (benefits outweigh harms) exists. There is good evidence that screening and surgical repair of large aneurysms (5.5 cm or greater in men 65-75 years of age who have ever smoked leads to decreased AAA-related deaths).

- Only men aged 65-75 who have ever smoked have a net benefit from screening for AAA. This group stands to benefit the most from early detection and requisite surgical treatment due to a relatively higher prevalence of larger AAAs compared to other patient groups.
- Men aged 65-75 who have never smoked and men age 65 are at lower risk.

What should I know about AAA?

AAA is an expansion of the aorta below the renal arteries to a diameter of 3.0 cm or larger. The prevalence of aneurysms detected through screening among VA patients age 50-79 is as follows:

AAA Size (cm)	Prevalence
1.0-2.9	2.9%
3.0-4.9	1.9%
≥5.0	0.3%

Source: Laine et al. The aneurysm detection and management study among VA patients: incidence, extent and treatment. Arch Intern Med. 2000;160:1421-1426.

The main risk of an aneurysm is rupture. Most (75-80%) individuals with ruptured AAAs do not survive to hospital discharge. The risk of rupture is proportional to aneurysm size. Larger aneurysms are more likely to rupture than smaller aneurysms. Studies have demonstrated benefits from surgical repair of aneurysms 5.5 cm and larger.

Partnership for Health
Department of Veterans Affairs

Heart and Circulation

Talk With Your Health Care Provider About **Screening for Abdominal Aortic Aneurysm**

Smoking increases your risk of having an aneurysm. If you are smoking now, do not smoke! If you quit now, you can reduce your risk of having an aneurysm.

Ask your doctor for help with quitting.

Here are some questions to ask your provider:

- Should I have this test?
- When would I benefit from having this test?
- Would I be harmed by this test?
- How do I get ready for this test?
- How do I get ready for this test?

Do you have other questions for your provider? Please write down here.

FY 2009 Prevention Mini-Grant Award Program

Contributed by

Leila C. Kahwati, MD, MPH

Deputy Chief Consultant for
Preventive Medicine

The National Center for Health Promotion and Disease Prevention (NCP), Office of Patient Care Services, sponsored its second mini-grant program this past winter. A request for proposals was issued at the end of January, and over 200 proposals were received. VA Medical Centers and Community-based Outpatient Clinics from all 21 VISNs submitted proposals, and NCP made 29 awards totaling \$194,000. Last year's mini-grant program focused on projects to enhance the HealthierUS Veterans initiative. This year's focus was broadened to include clinical prevention practice, MOVE! weight management, patient education, and general health promotion, in addition to HUSV. In particular, the NCP sought proposals for projects that would enhance dissemination of the new **Physical Activity Guidelines for Americans**, issued by the Department of Health and Human Services in Fall 2008.

The overall goal of this mini-grants program is to enhance prevention-related activities for patients within the Veterans Health Administration (VHA) by providing a small amount of "seed" funds to facilities. Congratulations to the facilities selected for a 2009 Prevention mini-grant award (see table on page 14). Future HEALTHPOWER! newsletters will feature more in-depth descriptions of the projects, once they have been completed.

Thanks to everyone who submitted a proposal and a special thanks to those who served as grant reviewers:

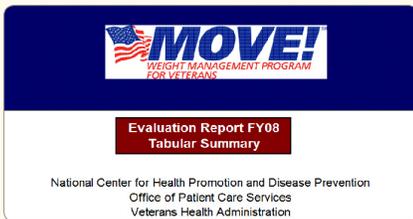
- Carla Anderson (VISN 8 CCCS)
- Rex Dancel (NCP/Preventive Medicine Resident)
- DesMarie DeCuir (VISN 4 Network Office)
- Sue Diamond (NCP)
- Richard Harvey (NCP)
- Rene Haas (VISN 22, Long Beach VAMC)
- Jesse James (NCP/Preventive Medicine Resident)
- Caryl Kazen (VACO Library)
- Theresa Kurtinaitis (VISN 11 Network Office)
- Lynn Novorska (NCP)
- Kathleen Ober (VISN 22, San Diego VAMC)
- Kathy Pittman (NCP)
- Joanne Shear (VACO, Primary Care)
- Barbara Snyder (NCP)
- Charlene Stokamer (VISN 3, VA New York Harbor HCS)
- Rosemary Strickland (NCP)

*Congratulations to
the facilities selected
for a 2009 Prevention
mini-grant award*

2009 Prevention Mini-Grant Awardees

Project Title	Location
MOVE-STRONG: A Low-to-Moderate Intensity Physical Activity Group for Overweight and Obese Veterans	VA Boston Healthcare System
Choose to Change Your Health: Creating a Wellness Coaching Resource for Patients	Western New York VA Health Care System
Inside and Outside the MOVE Kitchen: Nutrition, Culinary, and Exercise Education for Healthier Veterans	Syracuse VA Medical Center
Interactive Demonstration Kitchen for Health Promotion	Stratton VAMC (Albany, NY)
MOVE to Your Hearts' Desire	VA New Jersey Health Care System
Chronic Pain Self-Management Program	Philadelphia VA Medical Center
Nutrition Education Funds for Consistency of the VAMHCS MOVE! Initiative	Baltimore, MD VAMC
Exercise Proposal for Overweight Veterans and Those with Poorly Controlled Diabetes	Washington, DC VA Medical Center
Making Health and Fitness Fun for Families of Returning Combat Veterans	Durham, NC VAMC
Fitness Trail Upgrade	Charles George VAMC (Asheville, NC)
McGuire MOVE! Program Expansion Project	Hunter Holmes McGuire VAMC (Richmond, VA)
Basic Skills for Healthy Cooking: Vets Can Cook	James A. Haley VA Hospital (Tampa, FL)
Portion Control: Let's Eat Right!	Memphis, TN VAMC
Preventing Diabetes Through Multidisciplinary Group Education	VA Tennessee Valley Health Care System
Tobacco Cessation Education Dayton 2009	Dayton, OH VAMC
Bariatric Sized Meeting Chairs	Jesse Brown VAMC (Chicago, IL)
Translating Nutrition and Exercise Knowledge into Practical Application for MOVE! Patients	Edward J. Hines VA Hospital (Hines, IL)
Enhancing Education Outreach Through Telehealth Conferencing	William S. Middleton Memorial VA Hospital (Madison, WI)
Veterans...Improve your Fitness with the John H. Bradley MOVE! Program	John H. Bradley VA Outpatient Clinic (Appleton, WI)
Simple Cooking for Health	Marion, IL VA Medical Center
Lubbock, Texas CBOC MOVE! Program Enhancement	Lubbock, TX VA Outpatient Clinic
Creative Approaches to Integrating MOVE!, Physical Activity, and Health Behaviors in Mental Health	George E. Wahlen VA Medical Center (Salt Lake City, UT)
Chronic Disease Self Management Program (CDSMP) —PATIENT EDUCATION PROGRAM	Jonathan M. Wainwright Memorial VA Medical Center (Walla Walla, WA)
Cooking With Aloha	VA Pacific Islands Health Care System
MOVE! Health Care Center for Veterans	VA Northern California Health Care System
Sunshine + Exercise = Health + Happiness	VA Palo Alto Health Care System
East Clinic Satellite (ECS) Project	VA Southern Nevada Health Care System
A Multi-Media Approach to Education and Treatment of Veterans with Balance Impairment	VA Greater Los Angeles Health Care System
Healthier Ways	Iowa City, IA VAMC

News



FY08 MOVE Evaluation Reports

The FY08 MOVE Evaluation Reports have been released and are available at the MOVE! Intranet Website (MOVE Evaluation and Annual Report tab in the left hand navigation bar).

This report represents the status of the MOVE! Weight Management Program for Veterans at 139 facilities within the Veterans Health Administration (VHA) as of September 30, 2008. Data used for this summary were obtained from the MOVE! Visits and the Unique Patients Data Cubes hosted by the VHA Support Service Center (VSSC), the FY 2008 MOVE! Annual Reports submitted by each VHA facility, and supporting indicator data collected through the VHA External Peer Review Program (EPRP). Key findings within the RE-AIM evaluation framework domains (Reach, Effectiveness, Adoption, Implementation, and Maintenance) were evaluated and national, VISN, and facility-level results were tabulated.

Highlights:

- Nearly two-thirds of VHA outpatients seen in FY 2008 were screened for obesity and offered treatment, if indicated.
- Group visits remain the predominant mode of delivery and account for nearly 63% of all visits. The remaining visits were provided through individual face-to-face visits (26%) or phone (12%).
- Facilities continue to have high levels of leadership for the MOVE! Program

with almost all facilities reporting a MOVE! Facility Coordinator and Physician Champion. The percentage of facilities reporting a multidisciplinary coordinating committee increased from 79% in FY 2007 to 85% in FY 2008.

- The number of facilities reporting all key disciplines on the facility coordinating committee increased from 14% in FY 2007 to 44% in FY 2008.
- Staff sufficiency remains the major difficulty with respect to ongoing program maintenance.

Facilities continue to do well with screening patients and have done reasonably well at increasing patient engagement in treatment and treatment intensity despite what appears to be level staff allocation as compared to FY 2007. Practical and valid comparative facility and VISN-level clinical outcomes remain in development, but facilities are reporting high use of effective behavioral strategies that have been associated with better clinical outcomes.

The next MOVE Annual Report data collection will begin in September 2009.

The NCP anticipates having clinical outcomes for MOVE! suitable for facility-level comparison available in late FY10 along with “best practices” identified via a case-study approach at a selected sample of high and low performing facilities.

Contributed by
Rose Mary Pries, DrPH
Program Manager for Veterans Health
Education and Information

Project to Promote Health Literacy in VHA

Work is almost complete on VHEI's project in partnership with the Health Literacy Program, Harvard University School of Public Health, to enhance health literacy in VHA healthcare. This project includes three components, each of which will offer facilities and clinicians strategies to make VHA health care delivery and environments of care easier for veterans and family members to navigate.

The first component offers facilities the opportunity to comprehensively assess their physical environments including: the facility website, telephone answering systems, entry points and signage, ease of finding important locations, forms and notices, and use of technology. Analyzing the literacy environment enables a medical center to identify facilitating factors and barriers and to consider how to:

- Reduce literacy demands
- Align our expectations of patients and families with their skills
- Better serve patients, and
- Decrease costs associated with communication errors.

VA Medical Centers are extremely interested in environmental health literacy. VHEI needed ten facilities of different sizes and complexity (large/complex, medium size, small, CBOC) in various parts of the country to pilot test the environmental assessment instrument and process; fifty-six facilities volunteered as test sites.

Preliminary assessment activities included attempting to reach the facility by phone or to secure information about the facility and its location from its website. An important aspect of the environmental assessment is the "Walkabout." The Walkabout pairs a new staff member with a staff member who is more familiar with the facility. The former takes the

lead and attempts to find locations within the facility that are frequent destinations of patients and family members. The latter watches, listens and keeps a record of issues. Larger facilities chose to conduct their Walkabout using several pairs attempting to locate different destinations. Each pair used the same Walkabout assessment instrument to permit comparisons among pairs in larger facilities or among pilot test sites.

The pairs were encouraged to ask for assistance from staff or volunteers, but to wait until all patients and visitors were accommodated and not interrupt patient flow. Following this activity, the pair de-briefs identifying characteristics that facilitated and hindered navigation. The de-brief includes discussion regarding: overall ease of navigation; use of the written word; availability of assistance; navigation aides; signs (types, location, placement, color, floor color paths); and, language demands. The assessment also included the facility's use of technology.

Participants in the pilot unanimously agreed that assessing environmental health literacy was valuable. They noted that health literacy is not confined to print and verbal communication. It includes the whole hospital or clinic experience and the environment of care. Pilot participants were very creative in their approach to assessing environmental health literacy.

Participants in the pilot unanimously agreed that assessing environmental health literacy was valuable.

One facility suggested conducting the Walkabout in a wheelchair or walker to gain additional perspectives of navigating with physical limitations. Other sites began the Walkabout at the facility parking lots and garage and at the public transportation stop used by patients and family members.

Pilot sites also noted environmental health literacy's relevance in helping facilities meet The Joint Commission Standards related to providing information that is understandable and appropriate to the population served, and addressing the needs of those with vision, speech, hearing, language and cognitive impairments.

Several pilot sites reported that they have already used their assessment information and are working through the channels to recommend local changes. Examples of the changes under consideration are:

- Making major signage changes within the facility.
- Modifying their web and phone directions to the facility, including from public transportation locations; training

phone staff to offer better directions.

- Improving directions and signage to parking once patients and visitors arrive on the grounds and from one building to another.
- Improving directions to and identification of locations of labs and diagnostic studies.
- Convening a workgroup that meets weekly to develop plans for changes and improvements.

The second component of the project is a web-based interactive learning course, to be posted on the Employee Education System's (EES) Learning Management System (LMS), to help clinicians select or design print materials which will decrease literacy demands. The stress of illness can cause even highly literate people to have difficulty in understanding. The course is designed for nurses, dietitians, social workers, psychologists, and physicians and will offer discipline-specific continuing education units (CEUs).

Too frequently, health literacy is viewed as focusing only on print materials and readability, but good communication is

also critical to enhancing health literacy. The third component is also a web-based interactive continuing education program on LMS which provides discipline-specific CEUs to nurses, dietitians, social workers, psychologists, and physicians. It offers clinicians effective strategies to educate and counsel patients and family members to increase their understanding and participation in the healthcare process. This component addresses taking medications; managing a chronic disease; and the reading, math/numeracy, writing, and speaking skills associated with the clinical encounter. This component also includes the literacy needs of elders, patients with vision or hearing limitations or cognition problems.

The three components offer examples of best practices from the literature, and the VA and non-VA experience to reduce the literacy demands placed on patients and family members. The project also provides an extensive bibliography. The three components will be pilot-tested in July or August, 2009. ■

News



Patient Education: TEACH for Success Train the Facilitator Conference Scheduled for July 28–31, 2009 in New Orleans

VHEI continues to collaborate with the EES to offer Patient Education: TEACH for Success. TEACH helps clinicians use evidence-based health education, counseling, and communication skills with patients and their family members. If your facility needs additional or new TEACH facilitators, or if you would like to

begin to offer TEACH, this will be your opportunity.

VAMCs select staff who will be trained at this national conference to serve as local TEACH facilitators. Facilitators conduct TEACH at their facilities. VAMCs and VISNs fund participants to attend the conference. EES provides all facilitator and local participant learning manuals, and all the additional resources needed to conduct TEACH at the local level.

WHAT: The FY09 Patient Education: TEACH for Success Facilitator Training

Program (EES Project No. 09.ST.PH.TEACHCONF.A)

WHEN: 8:00 am Tuesday, July 28 through 12:00 noon, Friday, July 31, 2009

WHERE: Westin New Orleans Canal Place Hotel, New Orleans, LA

MORE INFORMATION: You'll find the program brochure, instructions to travelers, and online registration link on the VA Learning Catalog at http://vaww.sites.lrn.va.gov/vacatalog/cu_detail.asp?id=25291.

DON'T DELAY! Registration is limited to



48 participants, so we encourage you to register quickly.

If you'd like additional information about TEACH, please contact Barbara Snyder, Health Educator, VHEI, at (919) 383-7874 ext 248, barbara.snyder2@va.gov, or for administrative questions about TEACH, contact Lauren Elliott, EES Project Manager at (314) 894-6457, lauren.elliott@va.gov.

An Outstanding Career in Health Education Draws to a Close

This summer, VHEI will say a fond farewell to a devoted champion for health education. Dr. Pam Hebert is retiring from VHEI to begin a new life journey. Dr. Hebert began her VHA career in 1981 as one of the original regional Patient Health Education Coordinators when the Patient Education Program expanded to the Regional Medical Education Centers. As a regional patient education coordinator in Birmingham, Alabama, she provided consultation and technical assistance to the VISNs and facilities in the Southeast to help them organize, develop, and deliver patient education services and programs to veterans and their families. She led the design work and served as faculty for both of the VHA-wide HIV prevention programs. She also served as a member of the faculty for the VHA Bayer programs on patient-clinician communication, and coordinated that national program.

In 2006, Dr. Hebert joined the new Office of Veterans Health Education and Information to serve as Health Education Coordinator. Throughout her career, she has been committed to planning and delivering evidence-based,

patient-centered health education. Dr. Hebert is a vigorous proponent for experiential learning that offers the opportunity for constructive, supportive feedback. She exemplified this as a member of the planning committees and master faculty for the VHA-wide continuing education programs, Enhancing Patient Education Skills, and the current Patient Education: TEACH for Success.

As a member of the VHEI staff, Dr. Hebert continued her close connections with the field. She cultivated strong relationships with the field-based Patient Education Network. One of the roles that she valued and enjoyed the most was that of mentor. Dr. Hebert coached many Patient Education Coordinators as they oriented to their new positions, and later helped them successfully deal with opportunities and challenges.

One of her important recent accomplishments was working with a committee of experts from the field to develop the pending VHA Handbook 1120.03, Patient Education Procedures for Accreditation by The Joint Commission (TJC), along with the educational conference calls, tip sheets, and resources to help facilities meet TJC patient education standards.

Her efforts over 28 years have always focused on the education and health-care needs of veterans. It will be hard to imagine the Office of Veterans Health Education and Information without Pam Hebert, but we will draw on the programs, resources, and lessons she leaves with us to continue to promote Veterans Health Education in VHA. We wish her the best for a wonderful retirement.

UPCOMING CONFERENCE CALLS

VHEI Patient Education Hotline 1st Tuesday of the month

1:00 pm ET

1-800-767-1750, access #16261

- July 7, August 4, September 1

VHEI Patient Education Conference Call

4th Friday of April, July, October

1:00 pm ET

1-800-767-1750, access #19360

- July 28

Do We All Understand What “Wellness” Is?

Contributed by
Richard Harvey, Ph.D.
Program Manager for
Health Promotion

The term “wellness” gets tossed around pretty casually, partly because it has been a buzzword for a number of years, and probably because there has been so much recent press about companies offering employee wellness programs. In VA wellness programs, we encourage employees (and patients/family) to exercise, eat right, reduce stress, and live a “wellness lifestyle.” As wellness leaders, health educators, prevention leaders, and clinicians we may have a very good grasp of the recommended health enhancement behaviors involved in a wellness lifestyle. However, it is human nature to assume that others also understand information with which we are fully familiar. Examples abound when a physician talks with his/her patient about a medical condition that is well understood by the physician, but about which the patient has little idea and probably some misconceptions as well. Miscommunication and misunderstanding often results, to the detriment of the patient. When we talk with employees or patients about wellness behaviors, we also may wrongly assume that they understand what we are talking about.

For example, when we hear someone talk about wellness, the mention of exercise and going to the gym usually occurs in the same breath. A common misperception is that wellness means exercise, period! Others may add that wellness also means eating lots of salads. We know that much more than exercise and salads is involved in living a wellness/healthy lifestyle, but the public perception often lacks those details. So when we recommend that a person engage in 150 minutes or more of moderate-intensity physical activity each week, as well as resistance exercises at least twice each week, what does that person really understand? Unless it is very clear that physical activity must start slowly and increase gradually as tolerated, the sedentary individual may attempt to exercise at an intensity that is unsustainable and presents a high risk for injury. In many cases, doing that becomes so painful that the person gives up, stops exercising

altogether, and forms a negative attitude towards physical activity. An opportunity to help someone achieve better health and well-being is thus lost. When we recommend eating a healthy diet that is low in fat, salt, and sugar and high in fiber, what does the recipient of that recommendation understand? Can the employee/patient now eat only “rabbit food?” There appears to be a great deal of public misperception about which foods are indeed healthy and which ones are not, and the labeling and promotional messages on the front of food products and in advertisements don’t always convey accurate information. Just as with exercise, people who are not fully informed may go overboard on eating a “healthy” diet by changing too quickly, eating too many high-fiber foods at the outset, giving up sweets entirely, and so on. That also is probably unsustainable, and usually results in regression to the former unhealthy eating pattern and another

Serving as a role model for others can provide a motivating example not only for family members and friends, but for the worksite as well!

lost opportunity. We also advise people to lower their stress. What does that mean? How is one supposed to go about doing that? Too often people are only given superficial platitudes such as “stop worrying,” “rearrange your daily schedule,” or “learn to relax,” without any suggestions for, or support in, doing so. In such cases, a robust effect is unlikely.

The point here is that we must talk with rather than at our employees and patients to assure that they fully understand what we are suggesting they do. This allows them to make up their own minds. Using patient-centered strategies, we can assist people with formulating their own plans for changing a health behavior rather than prescribing a specific behavior change for

them. Going over the details is important. To help employees or patients begin eating a healthier diet, we must assure that each person understands what foods and serving amounts are indeed healthy, and that he/she has a self-generated plan for how to incorporate those foods into his or her current eating habits. It must be clear that healthier eating should be the result of a gradual process, rather than a quantum leap. The same process applies to helping a person begin to increase physical activity. The individual must know what kind of physical activities are possible for beginners, what activities are likely to be helpful, what intensity is appropriate, and come up with a realistic self-generated plan to achieve an increased activity level

gradually. Similarly, the reduction of stress can be a complicated endeavor, so working with the employee or patient on the details of the specific situation and on what steps the person thinks are realistic helps to guarantee a positive result.

Health literacy limitations clearly apply to many of our VA employees and patients, and extend to wellness behaviors as well as understanding of disease states and treatments. To be most effective, we in the community of wellness leaders, health educators, and clinicians are best advised to heed the recommendations pertinent to health communication and health literacy in general. ■

News



The next General Employee Wellness call will be on August 25th at 2:00 Eastern time. The tentative speaker is Ms. Lucy Polk, Director of the Work Life office at the Office of Personnel Management in Washington, DC. She will tell us about all the exciting new employee wellness initiatives that are being considered as part of health care reform with strong support from the Obama administration. The call in number is 1-800-767-1750, code 63047#.

As part of an effort to strengthen wellness activities for patients and assist with establishing robust “Veteran-Centered Care” in VHA, an initiative to offer widespread training in motivational communication skills to VHA clinicians is underway. A planning committee made up of national leaders in Motivational Interviewing and other VHA leaders in mental health and primary care is chaired by NCP. The committee has been working to develop a standard curriculum for motivational communication skill training to be utilized throughout VHA and a plan for implementing the training over a period of the next several years.

UPCOMING CONFERENCE CALLS

General Employee Wellness
Every other month, 4th Tuesday

2:00 pm ET

1-800-767-1750, access #63047

• August 25

News



BE **ACTIVE** YOUR WAY VA! 2009 CHAMPIONS' CHALLENGE

Contributed by:

Sue Diamond RN, MSN
Program Manager for
Community Health

NCP partnered with Veterans Canteen Service (VCS) this spring to sponsor the 2009 Champions' Challenge. The Champions' Challenge was a physical activity challenge designed to help promote the 2008 Physical Activity Guidelines for Americans that were released by the US Department of Health and Human Services on October 7, 2008 (www.health.gov/paguidelines). The 2008 Physical Activity Guidelines for Americans are the first comprehensive guidelines on physical activity ever issued by the Federal government. They provide science-based guidance to help Americans aged 6 and older improve their health through appropriate physical activity. The Guidelines provide information and guidance on the types and amounts of physical activity that provide substantial health benefits. One of the key Guidelines for adults is that for substantial health benefits, adults should do at least 150 minutes a week of moderate-intensity

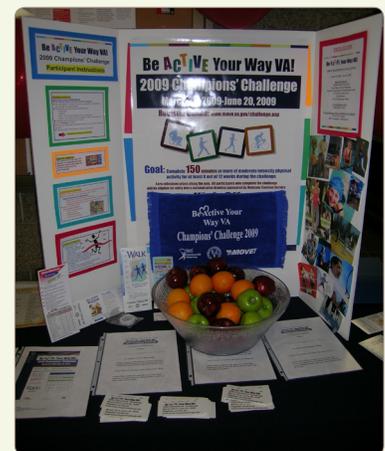
aerobic activity. Aerobic activity should be performed in episodes of at least 10 minutes and preferably, it should be spread throughout the week.

The 2009 Champions' Challenge slogan was Be **ACTIVE**Your Way VA! The Challenge goal was for participants to complete at least 150 minutes a week of moderate-intensity physical activity for 8 out of 12 weeks between March 29, 2009 and June 20, 2009. Participation was offered online only and was targeted at Veterans and VA employees; however anyone was welcome to participate. Registration was open for the first 4 weeks of the Challenge. VCS provided prizes for registration, completion of the 3 week milestone and completion of the 8 week challenge goal. All participants who completed the full 8 week challenge were eligible for entry in a national prize drawing sponsored by VCS. The national prize drawing will be held on July 28, 2009 at VCS Central Office in St. Louis, MO.

VA Facilities and VISN offices were extremely responsive to a request to support the Champions' Challenge locally and to name Champions' Challenge coordinators. 175 Champions' Challenge coordinators were named throughout VHA. NCP led 3 national conference calls for



Take the Stairs Day at Malcolm Randall VAMC Gainesville, FL



St. Cloud, MN Champions' Challenge Display



coordinators and formed a mail group for communication and information sharing. Local coordinators enthusiastically supported the Champions' Challenge, formed local Champions' Challenge teams and hosted kick off events at their facilities. Debi Bevins in VA Central Office led a Zumba demonstration at the VACO kick-off, described by one spectator as "West Side Story on espresso overdrive." NCP and VCS launched the national kick-off of the 2009 Champions' Challenge at the National Disabled Veterans Winter Sports Clinic (WSC) in Snowmass, Colorado on March 29, 2009. The Veterans at the Winter Sports Clinic were inspiring examples of people who overcome obstacles to remain physically active. Many Veterans at the WSC said "no problem" to getting 150 minutes or more of moderate-intensity physical activity weekly.

The VA Medical Center in Durham, North Carolina led the nation in Veteran participation in the Champions' Challenge, with 380 registered Veterans. Durham's Champions' Challenge coordinator Jacki Tatum RN, MSN attributes much of their success to a cohesive multidisciplinary local Champions' Challenge team, Veteran recruitment by the local MOVE! coordinator, a 4-day kick-off with registration tables in the main lobby and near central check-in, CBOC participation and a lot of positive reinforcement. North Florida/South Georgia Veterans Health System led the nation in total recruitment and also high completion rates. Barry Murphy,

CTRS, the Employee Wellness and local Champions' Challenge coordinator, attributes their success to a multidisciplinary planning group, encouragement from the Employee Wellness Council, participation and support by Executive Leadership, marketing and communication. Barry reported that he experienced people coming up to him on a regular basis to share their stories about weight loss, a recent milestone and enthusiasm for the Challenge. Barry stated: "People are asking me, what's next? I know the Champions' Challenge has not only changed lives, but saved lives." He also stated that he appreciated the "well-organized and easy-to-use online monitoring system." VISN 6 led the nation in employee participation with a 12% collective facility employee participation rate. Mary Foster RN, MSN, and Darlene Edwards, VISN 6 PAO, served as VISN coordinators. They held VISN conference calls and established a VISN 6 goal for VISN participation at or greater than the miles between the facilities in the network. Additionally, VISN 6 office employees actively participated in the Champions' Challenge.

The Champions' Challenge was a national success with 43% of the 27,484 registered participants reporting completion of the 3-week milestone and 31% reporting completion of the full 8-week Challenge goal. Congratulations to everyone who participated in the Champions' Challenge, especially those who met the full 8-week Challenge goal. We hope that you will continue regular physical activity each week and realize

UPCOMING CONFERENCE CALLS

HealthierUS Veterans National Call

3rd Tuesday of the month
3:00 pm ET

1-800-767-1750, access #35202

- July 21, August 18, September 22

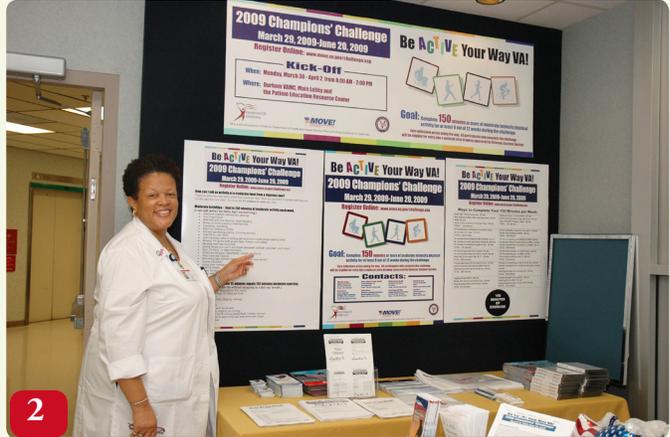
the long-term health benefits associated with this behavior. A special thanks to our colleagues in the Veterans Canteen Service for their generous and collaborative partnership in this event and their commitment to promoting healthy lifestyle behaviors in the VA community.



Electronic Champions' Challenge signs posted in the lobby at the John J. Pershing Poplar Bluff, MO VAMC



1



2



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4



5



6

1. Debi Bevins leads a Zumba demonstration at the VACO Champions' Challenge kick-off.
2. Jacki Tatum, RN, MSN, at the Champions' Challenge display in the main lobby of the Durham, NC VAMC.
3. Hula Hoop booth at the Alexandria, LA Champions' Challenge Kickoff.
4. Sophia Hurley, MSPT and Linda Kinsinger MD, MPH enroll Veterans in the Champions' Challenge during mealtime at the National Disabled Veterans Winter Sports Clinic.
5. 2009 Champions' Challenge kick-off at the Washington, DC VAMC.
6. Blind Veteran skiing with a guide at the Winter Sports Clinic.

CALENDAR *of* EVENTS

NATIONAL VETERANS WHEELCHAIR GAMES

July 12–15 in Spokane, WA

PREVENTION CONFERENCE

“Clinical Prevention Practice: Delivering the Best Preventive Care Anywhere”

July 21–22 in Denver, CO

MOVE! CONFERENCE

“MOVE! Forward Together Training”

July 23–24: for VISNs 11–23 in Denver, CO

TEACH PROGRAM

July 28–31 in New Orleans, LA

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NCP MISSION

The VHA 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.

