

Health *POWER!*

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HEALTH PROMOTION AND DISEASE PREVENTION METAMORPHOSIS

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Linda Kinsinger, MD, MPH
Chief Consultant for
Preventive Medicine

IPT: A Short-Cut Name for Long-Term Results

CBC, BUN, CT, MRI, LDL, HDL, HbA1c, BP, HCTZ, ACEI, HIV/AIDS, COPD, etc., etc. – the world of health care is full of abbreviations and short-cuts for the longer names of lab tests, procedures, medications, diseases, and many other things that we use every day. They make our life simpler because they save us time in not having to write out the full words and, truth be told, using them makes us feel like “insiders” when we know what they all mean (if you’re uncertain about any of these, see the footnote at the end of this article). When I was a medical resident, I once tried to write a whole progress note using only abbreviations – amazingly, it wasn’t that hard. Within VHA (you know, Veterans Health Administration), we have our own additional short-cuts – VACO, VISN, VAMC, CBOC, CPRS, MHV, and so on. There’s even a long list of “official” VA abbreviations (<http://vaww1.va.gov/Acronyms/>).

As NCP (that’s our abbreviation for the VHA National Center for Health Promotion and Disease Prevention) and other program offices have worked on the Secretary’s Transformational Initiatives over this past year, we’ve learned a whole new set of abbreviations and short-cuts:

T21, OHT, NMHC, PCMH, PCC, OMR, IPT, among others. I suspect that most of you may not be as familiar with these terms – I hadn’t heard of most of them myself until the past few months. I’ll let you in on the inside story:

- T21 refers to the “Transformational Initiatives for the 21st century.”
- OHT is the “Office of Healthcare Transformation,” the new office created to oversee VHA’s transformational initiatives, led by Dr. Jim Tuschmidt.
- NMHC means “New Models of Health Care,” the name of a group of transformational initiatives designed to point to a new direction for how VHA provides healthcare for our Veterans.
- PCMH refers to “Patient-Centered Medical Home” (I’d guess many readers know that one by now).
- PCC stands for “Patient-Centered Care,” an initiative that will re-focus our healthcare to put our patients in the center of all that happens with them.
- OMR is short for “Operational Management Review,” a high-level process led by VA Deputy Secretary Gould and his team to manage the very complex task of transforming the way VA does business and provides services to Veterans.
- Finally, IPT means “Integrated Project Team,” a term for the group of individuals representing various offices and organizations within VA who are working together on each of the transformational initiatives or the specific projects within those initiatives.

Of all these new short-cut terms, I’ve come to develop a deep appreciation for the concept of the IPT. Here at NCP, we

have established an overall IPT to guide the development of our transformational initiative, the VHA Preventive Care Program. We also have project-specific IPTs to lead the development of two components of the Preventive Care Program – the Health Risk Assessment and the Veterans Health Library (of course, in keeping with the alphabet-soup approach, we refer to those as the “HRA” and the “VHL”) and also for the new processes that will support the implementation of the Preventive Care Program – the facility Health Promotion and Disease Prevention (HPDP) Program infrastructure and the integration of HPDP services into PCMH and training of PCMH staff in patient-centered communication. Members of our overall IPT include representatives of the Employee Education System, the Office of Health Information, the Office of Nursing Services, the Office of Workforce Management and Consulting, the Office of Information and Technology, the Office of Finance, the Office of the Deputy Secretary for Health for Operations and Management (“10N”), and several union representatives. On the project-specific IPTs are representatives from the Office of Patient Care Services (specifically, Primary Care, Mental Health Services, and Medical Informatics), the Office of Public Health and Environmental Hazards, the Office of General Counsel, the Office of Acquisition, Logistics, and Construction, and many field-based clinical staff.

Whew! As you can see, these are large groups, covering a wide range of program areas and expertise. We meet by conference call with the overall IPT on a monthly basis, at a minimum, and more often as needed. For now, the HRA and

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Nursing and Prevention: A New Transformational Partnership

Contributed by

Evelyn Sommers, MHSA
Health Systems Specialist, and
Karen Ott, RN, MSN
Clinical Executive
Office of Nursing Services

In the past year, VA has taken a historic next step in redefining care through adoption of the Patient-Centered Medical Home model of care. The Patient-Centered Medical Home (PCMH) Model is a patient-driven, team-based approach that delivers efficient, comprehensive, and continuous care through active communication and coordination of health-care services. Although PCMH resides in primary care, its goal is to integrate care across the continuum and to educate Veterans in self-management so they can take ownership of their health and drive their individual plan of care. Nurses and Health Promotion and Disease Prevention (HPDP) experts play incredibly important roles in empowering patients to write their own health care plan for life—the Owner’s Manual for their health. By helping to track and reevaluate the plan over the years, nurses and HPDP experts also make it possible for our Veterans to live the healthy lives they had envisioned.

In the new PCMH, each Veteran on the panel of patients is considered a member of the PCMH “teamlet” along with the Provider (Physician, Nurse Practitioner, or Physician Assistant) and a Registered Nurse (RN) Care Manager, a Clinical

Associate (Licensed Practical Nurse, Nursing Assistant, or Health Technician) and a Clerical Associate. When other team members are needed (such as pharmacists, social workers, and physician and nurse specialists), consultations are made to reach out to them for their expertise and integrate and coordinate their care into the Veteran’s plan of care on either a short- or long-term basis.

Although this new model contains many nursing roles and all nursing roles are important to its success, the RN Care Manager stands out as the critical teamlet role within this PCMH team. The RN Care Manager is responsible for providing comprehensive and coordinated care and communicating health information to the Veteran and about the Veteran. Through regular communication using both face-to-face and other methods to deliver care, the RN Care Manager both advocates for the Veteran and helps the Veteran be accountable for his/her health goals.

Preventive care is an important element of the comprehensive care that the RN Care Manager is responsible for providing to the panel of patients. Health Promotion and Disease Promotion programs will assist all nurses, and especially the RN Care Manager, to emphasize the importance of healthy lifestyle choices and the role that health promotion plays in the plan of care. Resources such as patient education material and consultations from facility HPDP Program Managers, and the new role of the Health Behavior Coordinators, will provide the RN Care Manager with an array of information and

tools like the forthcoming Health Risk Assessment. In addition, the RN Care Manager can seek assistance with health coaching and motivational interviewing or advice on which tools are best for the continued plan of care for the Veterans. Likewise, RN Care Managers can spread the latest information from the HPDP offices and new research and best practices to the other team members, especially the Veterans.

Therefore, by working together in synergy, nurses and HPDP professionals will continue to provide Veterans with the best care anywhere. ■

By working together in synergy, nurses and HPDP professionals will continue to provide Veterans with the best care anywhere.

VHA's Patient-Centered Medical Home News for Health Promotion and Disease Prevention and Nurses: 10 Things You Can Collaborate on Now

1. Assess the programs you already have in place at your facility, and then project what you will need as the Patient-Centered Medical Home implementation begins.
2. Explore new partnerships at your facility: how can nurses enhance the sharing and distribution of health promotion information? What currently works in your own individual unit, and service line practices and what brainstorming can you do together?
3. Foster regional information sharing and networking. Reach out to colleagues in your VISN or at other facilities similar to yours. Develop wiki sites or hold your own Live Meetings to share best practices and lessons learned.
4. Ask your Veterans about the types of programs and health promotion and disease prevention information that interest them, and the mode of communication that best suits them.
5. Establish ways to regularly share HPDP information and other resources between HPDP Committees, and with PCMH nursing staff and Veterans, using both face-to-face and other methods of communication.
6. Discuss the impact of Health Coaching and Motivational Interviewing with nurse colleagues.
7. Identify Veterans who may be in need of health coaching as well as the existing resources for nursing and staff education.
8. Partner with the facility Staff Education Department to develop preventive care programs that include health coaching and other topics for continuing nursing education. (Ask about CEUs for local health promotion coaching program).
9. Explore other health promotion and medical home websites for ideas on ways to incorporate health promotion and disease prevention concepts into the VA PCMH model for nursing practice.
10. Visit the Patient-Centered Medical Home websites and review "Things You Can Do Now" from Primary Care (<http://www1.va.gov/PrimaryCare/pcmh/>) and Office of Nursing Services (http://www1.va.gov/NURSING/featured_initiatives.asp).



Delivering HPDP Services Within PCMH

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

VHA already has a proven record of delivering many health promotion and disease prevention (HPDP) services to Veterans at a rate higher than that of people not getting care through the VA. For example, data from the Office of Quality and Performance show that the VHA is a leader in screening Veterans for breast, cervical, and colorectal cancers. For many of the clinical preventive services, tools and processes are already in place for delivering high quality care. However, efforts to assist Veterans with health behavior change can be improved. Dr. Richard Harvey's article on Health Behavior Change Training has more information about how patient centered communication and health coaching skills can help Veterans explore their own reasons and desires for change.

Panel of Patients

With the transformation to a medical home concept, clinic staff can work as a team to assist their panel with healthy lifestyle changes. RN Care Managers can use a population approach to target the greatest need for HPDP services. Panel-specific data reports can identify patients who are at risk for chronic diseases as well as patients who already have chronic conditions. Clinical reminder reports can identify patients due for screenings for certain cancers and mental health issues like depression and alcohol misuse. RN Care

Managers can use the team meetings to report panel HPDP data, develop improvement plans, and evaluate outcomes.

These data can be used to consider what kinds of actions might ensure the panel receives preventive care, such as:

- Does the percentage of patients in the panel who have received the HPDP service (e.g., pneumococcal immunization) fall below the target set for the facility? If so, what approaches are available to increase the percentage? If the data are not broken down to the individual patient level, can the teamlet get the names of the patients who have not received the service? Quality Management and Clinical Informatics staff may be able to assist in developing data reports.
- What types of communication techniques are available for HPDP messaging? Would it be possible/better to use written letters, phone reminders, secure messaging (when available) or face to face visits? Should a facility-wide campaign be considered?
- Are group clinics needed for the panel? This might be decided over time with trending of the data.
- Are other teamlets' panel data similar? If not, are there process differences among the teamlets? Does this issue need to be brought to the facility HPDP Committee?
- What topics tend to need referrals outside of the teamlet? Are there gaps in referral programs? If so, is this a problem that needs to be addressed at the Service level?
- Do certain patients or groups of patients show up on the data reports routinely? Do some patients seem to be falling through the cracks? Do these patients

Our Veterans receive the highest level of comprehensive health promotion and disease prevention services when all team members coordinate their efforts.

show up for their appointments? Have the patients ever had a discussion with the teamlet about health promotion/disease prevention?

Clinic Visits

On a day-to-day level, teamlet members need to decide how they will deliver HPDP services. Questions to help in decision making are:

- How will health behavior screenings be conducted until the Health Risk Assessment (HRA) is available? Who will conduct the screening? Who will discuss risks with the patient?
- When is the best time to do the health behavior screening review (prior to visit, at the visit)?
- Who is the best person to introduce the subject of HPDP to the patient?
- What parts of the health coaching process will be done by each member? When? To what extent?
- How can members of the expanded team help in delivering HPDP messages?
- What are the indicators for referrals outside of the teamlet? What are the options?
- Who is the best person to arrange referrals and follow-up?
- Who is the best person to conduct follow-up?
- What are the HPDP training needs of the teamlet?

There is no one answer for the questions; the answers will depend on the makeup of the teamlets, available resources, and where they are in the PCMH transformation process.

A Veteran should receive the same standard of care no matter where he/she seeks care. However, there are different delivery

models that can offer the same standard of care. One model that could be used is one where teamlet members share responsibility for HPDP delivery. Below are some possibilities to consider for sharing the responsibilities.

Clinical Associate:

- Review HRA answers
- Introduce HPDP topics and ask if patient interested in further discussion
- Complete certain clinical reminders
- Track and administer immunizations
- Make pre-visit or follow-up calls using protocols at the direction of the RN Care Manager

Primary Care Provider:

- Assess patient readiness for health behavior change
- Advise patient of health benefit of change and refer to RN Care Manager
- Invite discussion around appropriate clinical preventive services
- Complete certain clinical reminders

RN Care Manager:

- Discuss specific HPDP needs of patients during teamlet huddle
- Discuss HRA results with patient
- Develop action plan with patient that becomes part of plan of care
- Arrange for follow-up with patient based on patient action plan
- Complete certain clinical reminders
- Refer to expanded team members or programs for more intensive care as appropriate
- Collaborate with other team members for support in HPDP services

Variations of the above functions are possible depending on the skill level, position capability, interests, and time

available to interact with each patient. For example, protocols may need to be written to allow RN Care Managers and Clinical Associates to complete certain clinical reminders or administer immunizations.

Expanded Team Contributions

Other team members are also important in the delivery of HPDP services. Dietitians can assist teamlet members in being proactive in identification of potential diet issues. They can lead or assist in group clinics for general or focused nutrition topics. Staff from Primary Care Mental Health Integration, Geriatrics, Women's Health, and Social Work and other programs can also be helpful resources to tailor HPDP or referral services for special populations such as women, frail elderly, and OEF/OIF Veterans. Physical activity specialists can assist in developing physical activity resources or classes. Pharmacists can use coaching techniques in their work with Veterans who are not adhering to their medication regimen. Members of the facility HPDP Program Committee are resources and additional support for teamlet HPDP activities. The facility HPDP Program Committee will include representatives from PCMH at the parent facility and all affiliated CBOCs. These representatives can serve as liaisons between teamlet staff and the Committee. Our Veterans receive the highest level of comprehensive health promotion and disease prevention services when all team members coordinate their efforts. ■

Health Behavior Change Training: A Quantum Leap for Care in the Patient-Centered Medical Home

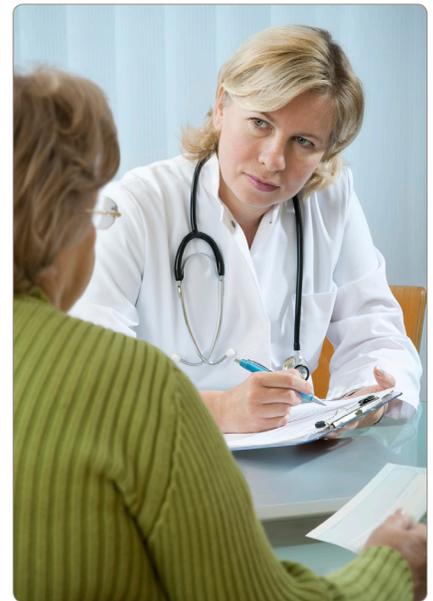
Contributed by
Richard Harvey, PhD
Program Manager for
Health Behavior
Training

The patient-centered medical home (PCMH) in the VHA brings with it an emphasis on helping Veterans improve their health behavior in areas such as tobacco use, physical activity, diet, weight, stress, and alcohol intake. Staffing levels for the medical home are anticipated to be higher than in the past, allowing increased attention to these concerns. To help patients effectively change their health habits, staff must have the skills to bring about behavior change. The Health Behavior Coordinators, Veterans Health Education Coordinators, and the Health Promotion/Disease Prevention Program Managers at each medical center will provide medical home staff with onsite training in health coaching, motivational interviewing, prevention, health literacy, shared decision making, and related areas. Other training related to patient-centered care and how to best function as a medical home team is planned by the PCMH leadership.

Staff members with skill in health coaching can help patients make difficult changes in their health habits. For example, a 59-year-old male Vietnam Veteran leads a sedentary life, eats a diet rich in fat-laden and sugary foods and virtually no vegetables, and at 272 lbs. has been

obese for over 25 years. He now has borderline type II diabetes, hypertension, and hypercholesterolemia, as well as pain in his knees and back due to excess weight and physical inactivity. He expresses an interest in doing something about his weight and lifestyle, but works daily and doesn't have time to actively participate in the MOVE! program. In a patient-centered manner, fully respecting his preferences and autonomy, the staff member offers to support his efforts to make improvements. If he agrees, she offers to help him establish his own realistic and achievable short-term goal(s) regarding his food intake and physical activity, such as eating one vegetable serving each day or taking a short walk after supper. She also offers to help him think through a plan that he will create himself and is pretty sure he can carry out. She also offers to follow up with him by phone every week for the first couple of months at times that will work for him, and as needed thereafter. Given this opportunity for helpful support, the patient readily accepts the offer and feels excited and hopeful that this time he will be successful. The staff member then proceeds to help him think through some goals and a plan, and establishes a date and time for follow-up calls.

Patient-centered communication and health coaching skills are needed to do this effectively. Knowing how to work in a nonjudgmental fashion with the patient rather than at the patient is a skill, as is helping the patient establish some realistic goals and develop his own plan rather than simply telling him what to do. These skills will be taught to medical home staff.



In addition, medical home staff will be given information on various prevention “messages” to pass on to patients when that information is relevant. In the example above, the patient might have said, “I don’t know what to do.” The nurse might have responded by saying, “I do have some information that I think might be helpful to you. Would you like to hear it?” If the patient said yes, then the nurse would have passed on the information about physical activity alternatives and benefits, and ways to begin eating a healthier diet. After providing the information, she would ask for his thoughts about those things and how he thinks any of that might be useful to him.

These interactions must be accomplished with consideration for the patient’s health literacy. Health care workers often overestimate patients’ understanding of health information or instructions. When patients don’t understand important information about their health or their treatment, less than desirable outcomes often result. Completing the online health literacy modules will educate medical home staff about health literacy and help them meet the literacy needs of their patients and avoid misunderstandings.

But what about the “unmotivated” patient? Motivational interviewing is a “guiding” form of interaction that helps patients uncover their own intrinsic motivation to make their lives better. In a nonjudgmental and patient-centered fashion, staff may ask patients about what they value in life; what goals, hopes, and

aspirations they have; and whether or not their current lifestyle is consistent with those values and is likely to meet those goals and aspirations. The patient described above might initially have been asked, “If you keep on living the way you do now, what do you think your life and your health will be like five years from now? Will you be able to do the things you want at that point?” The staff member seeks to fully understand the patient’s thoughts and feelings through open-ended questions, reflecting back his/her understanding of what the patient says, getting the patient to correct any mistaken impression or elaborate on the subject, and summarizing the conversation at various points to confirm understanding. When patients feel understood, they are much more likely to participate in a partnership with their healthcare worker, and more likely to make positive changes. In particular, statements that favor making a change in health behavior are encouraged through more detailed reflection, requests for elaboration, and affirmation of the patient’s strengths and ability to carry out a proposed change. This is because the more a person talks about possibly making a change, the more likely it is that he/she will actually make that change. Along the way, patients may be assisted with thinking through the pros and cons of a possible change, as well as how important it is to them to make an improvement in their health habits and what it would take to make it more important. Helping patients examine how confident they feel

about their ability to make a change and what it would take to let them feel more confident prompts their thinking about a plan to carry out the change. In a subtle manner then, patients are guided toward making improvements in their health behavior. If the 59-year-old Veteran above had said, “I just can’t lose weight, so I have had to accept that fact and I have given up trying,” the nurse might have used the motivational interviewing process to guide the patient toward reconsidering his position and accepting the help offered. Motivational interviewing skills have been shown to be effective in many areas of behavior change, including medication adherence, exercise, smoking cessation, alcohol/drug usage, and a number of others. Such skills are essential to have, and training will be provided to medical home staff at the local level.

Enabling VHA medical home staff to acquire the skills to undertake health behavior change promotion and counseling represents an opportunity to make a quantum leap in the services we provide. In turn, Veterans will improve their health through the changes we assist them in making, which should lead to making their medical care easier for us and for them. Veterans who make these changes will feel better about themselves, and are likely to be more satisfied with their care. In addition, we will no doubt feel good about our ability to care for our patients in such a meaningful way. It’s a win-win proposition!■

NCP/VHEI Supporting PCMH Via Education

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

Continuing education contributes to VHA's transformation to Patient-centered Care and the Medical Home. The Office of Veterans Health Education and Information (VHEI) partnered with the Employee Education System (EES) and others to design two educational programs that support Veteran-centered Care Principle #9: Using education and information to empower Veterans.

TEACH for Success

VHEI created the course, *Patient Education: TEACH for Success*, as a way to enhance the health education skills of Veterans Health Administration (VHA) clinicians. Because all clinicians who provide care are responsible for patient education, Patient Education: *TEACH for Success* is designed as an interdisciplinary learning experience. However, because it is of particular relevance to the patient-centered medical home (PCMH), the emphasis in FY-11 and FY-12 will be to assure that PCMH staff receive this training.

The course's content is drawn from research studies on the most effective patient education interventions. *TEACH* concentrates on the face-to-face interaction between clinicians and patients. It uses skill practice with targeted feedback and case scenarios to practice strategies and techniques designed to assess patients' needs and provide education in brief encounters. Both are critical to the success of encounters in the PCMH.

TEACH uses a train-the-trainer design in which facilities select individuals to

serve as facilitators for the course. These facilitators are trained at national or regional programs, and then return to their facilities and present the course to clinicians. EES accredits both the train-the-trainer and local *TEACH* programs. In each VA facility, the Veterans Health Education Coordinator serves as lead facilitator and course manager. The newly hired Health Behavior Coordinators at each facility will also be trained as *TEACH* facilitators. In several large VA facilities, additional clinicians also serve as *TEACH* facilitators.

The expectation is that the course will be offered in each facility on an ongoing basis for VA clinicians from all professional disciplines. The emphasis in FY-11 and FY-12 will be to assure that PCMH team members receive *TEACH* training which focuses on patient-centered communication, health education, and health coaching skills.

TEACH is divided into five units, plus an introduction. During the introduction, participants complete a self-assessment to determine their personal profile of patient education skills. This helps them focus their attention during each unit as they develop new skills and reinforce existing ones.

The titles of the units express *TEACH*'s patient-centered philosophy and highlight the five critical skill sets for effective patient education practice:

- Unit T—Tune in to the Patient
- Unit E—Explore the Patient's Concerns, Preferences, and Needs
- Unit A—Assist the Patient with Behavior Changes
- Unit C—Communicate Effectively
- Unit H—Honor the Patient as a Partner

VHA is committed to partnering with patients to achieve improved health outcomes.

The *TEACH* content also integrates VHA initiatives such as patient-centered care, customer service standards, and partnership with patients. It helps clinicians develop or enhance skills to achieve these organizational goals. Identifying the patient's concerns and needs is an essential part of patient-centered care. The *TEACH* course helps clinicians easily identify the patient's needs and concerns and integrate these needs into the patient education they provide. This approach is emphasized in every *TEACH* unit.

Patients make daily decisions to promote their health and well-being and to manage their health problems. Our goals should be to address their concerns and help them make good decisions. This course emphasizes health coaching and self-management education as ways to assist patients with these life tasks.

VHA is committed to partnering with patients to achieve improved health outcomes. Both the patient and the clinician bring expertise and skills to the encounter. Both of their perspectives should be honored. Shared decision making is an

essential component of the partnership between patient and clinician. Generally, the best treatment plan is one that has been mutually developed by the clinician and the patient.

TEACH emphasizes practical, specific, brief techniques that participants can use with most patients in a variety of clinical settings.

Finally, *TEACH* meets The Joint Commission standards for assuring that clinicians are prepared to deliver education services to patients and family members. The goal is to help VA clinicians enhance their patient education competencies.

Health Literacy Courses on LMS

The second educational effort specifically supports Recommendation #9 to guide VHA in creating Veteran-centered care, by providing education and training to all staff and volunteers in the principles and practical strategies for implementing and sustaining Veteran-centered care, including consideration of cultural competency and health literacy. In partnership with the Health Literacy Program

at Harvard School of Public Health and EES, VHEI created three Learning Management courses to enhance health literacy in VHA. The three interactive courses focus on:

1. Selecting and designing print materials to enhance health literacy.
2. Assessing environmental health literacy, including: the facility website, telephone answering systems, entry points and signage, ease of finding important locations, forms and notices, and use of technology.
3. Communication strategies to enhance health literacy.

The three courses offer examples of best practices from the literature as well as the VA and non-VA experience to reduce the literacy demands placed on patients and family members. The three components are scheduled for pilot-testing in June 2010, and available on LMS shortly after the pilot.■



The Facility Health Promotion and Disease Prevention Program Committee: Supporting Integration of HPDP into Clinical Care

The stated vision of the Veterans Health Administration (VHA) Preventive Care Program is that “the Veteran will experience health promotion and disease prevention (HPDP) clinical interventions that are seamlessly integrated across the continuum of their health care and are delivered in a variety of modalities matched to the Veteran’s needs and preferences. VHA clinicians and clinical support staff will value and participate in the delivery of HPDP interventions for patients as appropriate to each Veteran’s priorities and overall plan of care.” The establishment of a robust HPDP program at the local level is essential to the success of the overall Preventive Care Program. The foundation of the facility HPDP Program is the HPDP Program Committee. This Committee is responsible for transforming the VHA Preventive Care Program vision into a reality for the facility and its affiliated community based outpatient clinics (CBOCs). An ambitious endeavor indeed!

The mission of the facility HPDP Program Committee is to ensure the

integration of health promotion and disease prevention services into clinical care delivery within the medical center and affiliated CBOCs. Committee members should hold expertise related to the core prevention messages. Their collective expertise will help to enhance, improve, and develop HPDP programs and services for Veterans throughout their facility and CBOCs. Required members of the committee include: the HPDP Program Manager (Chair), the Health Behavior Coordinator (Co-Chair), the MOVE! Coordinator, the Smoking and Tobacco Use Cessation Lead Clinician, the Veterans Health Education Coordinator, the My HealtheVet Coordinator, representatives from primary care at the parent facility and each affiliated CBOC, and a Primary Care-Mental Health Integration (PC-MHI) representative. Additional staff may also be added to the Committee as members of the core committee or as workgroup or subcommittee members. To guide the formation and direction of each facility’s Committee, NCP has developed a sample facility HPDP Program Committee Charter.

Enhancing Existing Programs

Members of the HPDP Program Committee will also work together to develop strategies to enhance and improve existing programs. For example, if a MOVE! coordinator reports that patient participation is dropping off after 1-2 visits, the Committee can work together

Contributed by

Sue Diamond RN, MSN

Program Manager for Health Promotion and Disease Prevention Programs and

Kenneth Jones, PhD

National Program Director for Weight Management

to develop several strategies: they can follow up with patients who miss or cancel a MOVE! visit; increase the use of motivational interviewing to promote sustained engagement in the program; collaborate with PCMH staff to obtain patient feedback; and/or improve assessment of patient readiness to participate in the program prior to referral. Based on the feedback obtained, the Committee can consider ways to reformat the program to better meet patient needs and preferences. Examples of reformatting might include enhanced telephone support, offering evening or weekend programming, enhancing physical activity programming, or even special MOVE! programming for women Veterans or younger Veterans. Similar strategies could be employed to improve My HealtheVet in-person authentication rates, participation in smoking and tobacco use cessation programming, improvements in brief alcohol counseling by PCMH staff, etc. When the Health Library, Health Risk Assessment, and secure messaging are available, the facility HPDP Program Committee will be charged with leading the implementation and integration of these resources for the facility.

Supporting and Providing HPDP Clinical Care

To achieve facility HPDP program goals, the HPDP Program Committee will need to develop strategies to ensure that clinicians and clinical support staff in

the parent facility and affiliated CBOCs, including new employees, receive training, ongoing skill development, and mentoring in health coaching, motivational interviewing, and other patient-centered communication strategies. This will help to optimize the ability and confidence of clinicians and clinical support staff to assess Veterans' health behaviors and assist Veterans with health behavior change. The training plans for the Preventive Care Program are ambitious and will require effort, engagement, and assistance of all HPDP Program Committee members. The goals are to make sure all PCMH staff are trained, confident, and effective in using new communication skills when talking to patients about health behaviors and health promotion and disease prevention messages, programs, and services.

Most of the members of the facility HPDP Program Committee are also involved in the provision of HPDP-related clinical care. It is expected that the HPDP Program Manager and Health Behavior Coordinator will work closely with PCMH staff as they develop new processes

to routinely assess major health behaviors that contribute to morbidity and mortality (such as tobacco use, problem alcohol use, physical inactivity, and poor dietary habits) and provide interventions to assist with health behavior change. HPDP Program Committee members can play a critical role in group and individual wellness clinics and in providing moderate or high intensity programs that address risky health behaviors.

Conclusion

As the Veterans Health Administration shifts care from a focus on disease management to a patient-centered focus on the overall health of Veterans, new clinical programs and increased uptake of existing programs that support health promotion and disease prevention will be needed. The facility HPDP Program Committee will lead the efforts to integrate health promotion and disease prevention services into clinical care delivery throughout the parent medical facility and affiliated CBOCs. ■

The mission of the facility HPDP Program Committee is to ensure the integration of health promotion and disease prevention services into clinical care delivery within the medical center and affiliated CBOCs.

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VHL project IPTs are meeting much more frequently (up to twice a week), because of the intense work being done to get these projects launched.

What's been remarkable to me about our IPTs is the sense of true partnership among all these offices and organizations that has grown from our work together. Although the main ideas for transforming preventive care began within NCP, the growth of those concepts into real, tangible, operational products and processes has been a result of the important input from the members of the IPTs. No program office or organization, by itself,

has all the information, perspective, and know-how to do this work alone. A variety of voices is needed to fully flesh out the many details that must be addressed to put these programs into place.

With the high level of attention being paid by senior leadership of the Department, those of us on the IPTs have a collective sense of the urgency and importance of developing these transformational initiatives so that they provide the best care possible for our Veterans. While the short-cut term "IPT" may be new to me, the concept of working closely with others in VA to achieve this goal is

actually a long-standing one. It's really the only way to attain the long-term results that we all want to see. ■

Footnote: CBC – complete blood count; BUN – blood urea nitrogen; CT – computed tomography; MRI – magnetic resonance imaging; LDL – low density lipoprotein; HDL – high density lipoprotein; HbA1c – hemoglobin A1c; BP – blood pressure; HCTZ – hydrochlorothiazide; ACEI – angiotensin-converting enzyme inhibitor; HIV/AIDS – human immunodeficiency virus/acquired immunodeficiency syndrome; COPD – chronic obstructive pulmonary disease

Linda Kinsinger

News



Updates to “Guidance on Clinical Preventive Services” NCP Intranet Pages

We’ve made some updates and additions to the new NCP intranet web pages related to Guidance on Clinical Preventive Services. VA staff can access the home page for this initiative by typing: http://vaww.prevention.va.gov/Guidance_on_Clinical_Preventive_Services.asp into their browser.

Three new features have been added:

1. A ‘Coming Soon’ section has been added. This section lists the guidance statements that have been approved by the Preventive Medicine Field Advisory Committee and are being circulated for input from the field through VISN Chief Medical Officers and VISN Health Promotion Disease Prevention Program Leaders. Currently these statements include:
 - a. Seasonal Influenza Immunization
 - b. 2009 H1N1 Immunization
 - c. Herpes Zoster (Shingles) Immunization
 - d. Pneumococcal Immunization
 - e. Tetanus/Diphtheria (Td) and Tetanus/Diphtheria/Pertussis (Tdap) Immunizations
2. Guidance Statements that have been approved by the Preventive Medicine Field Advisory Committee but have not yet been released for field input are listed as ‘In development’ on the indexes of statements. Currently this list includes:
 - a. Aspirin for the Primary Prevention of Cardiovascular Disease
 - b. Aspirin or NSAIDs for the Primary Prevention of Colorectal Cancer*
 - c. Chlamydia and Gonorrhea Genital Infection Screening

Guidance on Clinical Preventive Services

Welcome!

This website lists approved VHA clinical preventive services guidance statements for patients receiving care from VHA healthcare facilities. These guidance statements are intended to provide VHA clinicians and other interested individuals with a one-stop source for guidance on clinical preventive services and resources in VHA. [Read more...](#)

Clinical Preventive Services	
Screenings	Immunizations
Preventive Medications	Brief Health Behavior Counseling

Links to Specific Guidance Statements:

To find out about Individual Clinical Preventive Services:

Use the [A-Z Index](#) or [View by Clinical Area](#) (e.g., cancer, cardiovascular, etc)

What's New:

- [Abdominal Aortic Aneurysm Screening](#) (January 2010)

Coming Soon:

- 2009 H1N1 Influenza Immunization
- Herpes Zoster (Shingles) Immunization
- Pneumococcal Immunization
- Seasonal Influenza Immunization (2009-2010)
- Tetanus/Diphtheria (Td) and Tetanus/Diphtheria/Pertussis (Tdap) Immunizations

New guidance statements are being developed and posted to this site all the time. If you are looking for guidance about a clinical preventive service that has not yet been posted, please consult the following sources in the interim:

Links:

- [VHA Publications search page](#) (VHA Directives, Handbooks, Information Letters, etc.)
- [Electronic Preventive Services Selector tool](#) (U.S. Preventive Services Task Force recommendations)
- [2010 Adult Immunization Schedule](#) (Advisory Committee on Immunization Practices, CDC)

[Read more about how Clinical Preventive Service policy is developed in the VHA.](#)

- d. Colorectal Cancer Screening
 - e. Hepatitis C Screening
 - f. HIV Screening
 - g. Lipid Disorders Screening
 - h. Tobacco Use Screening and Counseling
3. Links to recommended resources are provided in case you are looking for guidance on a clinical preventive service that has not yet been posted.

*Note: It is important to remember that some of the guidance statements will specify that a particular service is NOT recommended (example: Aspirin/NSAIDs for the Primary Prevention of Colorectal Cancer).



MOVE! Update

Dr. Ken Jones was invited to present on the new Care Coordination Home Telehealth – Weight Management – Disease Management Protocol (TeleMOVE!) at the national Office of Telehealth Service training meeting, “Telehealth 2010 and Beyond: Expanding Patient-Centric Care” held in St. Louis in May. He presented with Melissa McZell, RN from the Tampa VAMC. Ms. McZell played a key role in piloting the Health Hero and Viterion versions of TeleMOVE! in Tampa. Jones and McZell were also invited to discuss TeleMOVE! in the CCHT strategic planning breakout session. Nineteen VISNs accepted special funding to implement TeleMOVE!. Weekly “Issues and Solutions” Live Meeting calls take place on Wednesdays from 2pm-3pm Eastern time - 1-800-767-1750 Access Code 81572. To access the CCHT share point, click on the link below and then click on the “modality” TeleMOVE – this is where many of the day-to-day operations and education documents reside. <http://vaww.infoshare.va.gov/sites/telehealth/stc/STC%20Programs%20Document%20Library/Forms/all.aspx>

The MOVE! online training has been revised, re-certified for continuing education, and is now available on the Employee Education System - Learning Management System (LMS). Ideally, this training should be completed annually by all MOVE! team members. Care coordinators who are providing care with the new TeleMOVE! program are required to complete this training. The content varies slightly by discipline, and includes the following five tracks:

- Dietitian (RD, LDN, DTR)
- Nurse (Primary Care RN, LPN)
- Physician (Medical Care Provider,

Nurse Practitioner, Physician Assistant)

- Psychologist (Behavior/Mental Health Professional, Psychiatry, Social Work, Psychiatric RN, NP, PA)
- Rehabilitation Specialist (Physical Activity Specialist, PT, OT, KT, RT, Others)

To access the MOVE! Web Based Training follow these simple steps:

1. Link to LMS <https://www.lms.va.gov/plateau/user/login.jsp>
2. Once logged into the LMS system, type keywords "MOVE! Web" into the Search Catalog box and click on Go.
3. When the course title is displayed on the next page, click on the Go to Content button at the right to begin the course.
4. You will be asked to set your discipline prior to beginning the course.

The National MOVE! team has worked closely with the staff of the National Acquisitions Center and Prosthetics and Sensory Aids Services to establish a new national contract for pedometers. One accelerometer-based pedometer has been selected to replace the two models currently available. The current contract runs through October 16, 2010. The new pedometer will be available after October 17, 2010. In addition to counting steps taken, the new unit has some advanced functions available for patients who may want more detail about their physical activity. It is a smaller size overall, and can be carried in a pocket, a purse or worn on a belt. The enhanced features provide information regarding:

- the total time per day of all activity
- total exercise time for episodes of sustained activity that exceed 10 minutes (being active for at least 10

minutes has added benefits) and

- steps and exercise time for the last seven days

Since this unit is a bit more complex, the National MOVE! team is working on two new handouts, one to assist MOVE! team members in training patients and setting stride length, and another handout focused on how patients will use the pedometer. While the technical team evaluated and tested sample devices and aimed to select a reliable product that will meet general patient needs, there may be problems that arise with the pedometer during the course of the contract period. In these cases, it is very important for MOVE! team members to file a Quality Improvement Report (QIR) with Prosthetics and Sensory Aids Services to document malfunctions, etc. properly and provide a means for a solution. The QIR initiates a process of resolving problems with the contracted vendor, and will result in an early termination of the contract if problems are not satisfactorily resolved.

As of April 3, 2010, Veterans and others may now access the MOVE!23 Patient Questionnaire (MOVE!23) via eBenefits. Created in 2007 by the President's Commission on Care for America's Returning Wounded Warriors (Dole/Shalala Commission), the eBenefits portal (www.ebenefits.va.gov) is a one-stop shop for benefits-related online tools and information. The portal is designed as a single login access point to online benefits and related services for Wounded Warriors, Veterans, Service members, their families, and those who care for them.

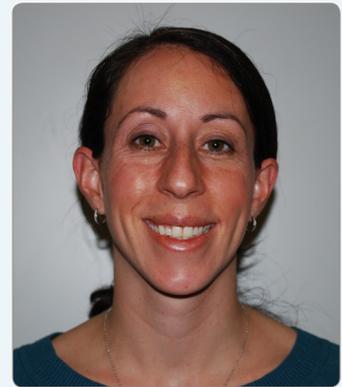


HPDP Training News

As part of the Preventive Care Program for the Patient-Centered Medical Home, facilitator training for the TEACH program is being offered exclusively to those Veterans Health Education Coordinators who are not already so trained, and to the new Health Behavior Coordinators, either July 21-23 in Arlington VA, or August 4-6 in Las Vegas NV. Intensive training in motivational interviewing is being offered to Health Behavior Coordinators August 10-12 in Chicago, IL. Travel expenses will be paid by NCP. Brochures for these training sessions are either currently available, or will be available soon. For more information on TEACH contact Barbara Snyder (Barbara.snyder2@va.gov), or for motivational interviewing contact Dr. Ken Jones (Kenneth.jones6@va.gov) or Sue Diamond (sue.diamond@va.gov).

Tiffany Wedlake, MD, MPH - UNC Preventive Medicine Residency Program

NCP's affiliation with the University of North Carolina's Preventive Medicine Residency Program continues. Tiffany Wedlake, is a second-year preventive medicine resident. She received her MPH from the Department of Public Health Leadership in Health Care and Promotion in December of 2009. Prior to her work at UNC, she worked for the US Army as both a contractor and an active duty physician. She was stationed at Walter Reed Army Medical Center, Korea, and Fort Bragg during her time with the Army. She completed an internship in Pediatrics at the National Capital Consortium, a combined program between the National Naval Medical Center and Walter Reed. She attended the Medical College of Georgia where she earned her MD. Dr. Wedlake received her undergraduate degree from the University of Georgia where she graduated summa cum laude with honors. As a resident, she became interested in preventive medicine through exposure to the Army's Preventive Medicine program at Walter Reed. She is a native of Atlanta. Her husband is a Major in the 82nd Airborne Division and she has two boys. Her interests in health care include obesity prevention, military medicine, policy making, and program development.



CALENDAR *of* EVENTS

NCP Conference Call

2nd Tuesday of the month

1:00pm ET

1-800-767-1750, access #18987

• Upcoming calls—July 13, August 10, September 14

Preventive Medicine Field Advisory Committee Call

1st Monday of the month

• Upcoming calls—July 12, August 2

VISN MOVE! Coordinators Call

2nd Tuesday of the second and third month of each quarter

3:00 pm ET

1-800-767-1750, access #59445

• Upcoming call—August 10

Health Promotion/Disease Prevention Conference Call

1st Tuesday of the first month of each quarter

1:00pm ET

1-800-767-1750 access code 35202

• Upcoming calls—August 3, September 7

Facility MOVE! Coordinators and Physician Champion's Call

2nd Tuesday of the first month of each quarter

3:00 pm ET

1-800-767-1750, access #59445

• Upcoming calls—July 13, October 12

Patient Health Education Hotline Call

1st Tuesday of the month

1:00pm ET

1-800-767-1750, Access Code 16261

• Upcoming calls—August 3, September 7



**Department of
Veterans Affairs**

VHA National Center for Health Promotion and Disease Prevention (NCP)

Office of Patient Care Services

Suite 200, 3022 Croasdaile Drive Durham, NC 27705

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.

**Address suggestions, questions,
and comments to the editorial staff:**

Nancy Granecki, Special Assistant
Connie Lewis, Program Analyst
Kate W. Harris, Editor (contract)

Suite 200
3022 Croasdaile Drive
Durham, NC 27705
Tel 919-383-7874
Fax 919-383-7598

Visit our website at:
www.prevention.va.gov