Health POWER!

Prevention News • SPRING 2011

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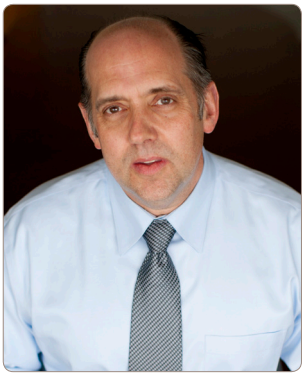
Jay Shiffler
Communication Specialist



Forward Movement

Spring is here! Can you believe how fast time is flying? I am new to VA and impressed at the pace of change in our organization. With VHA's Transformation efforts and the Healthy Living Campaign, our work toward Veteran-centered care is moving full-speed ahead.

This quarter's Health*POWER*! theme is Patient-Centered Care. Our newsletter cover shows four hands putting together a puzzle. This represents the teamwork that is needed to make PACT work. Successful teamwork is a beautiful thing!

Our guest writer for this issue is Dr. Tracy Gaudet who is the Director of VHA Office of Patient-Centered Care and Cultural Transformation. Her article on page 4 lays out a convincing case for the need to transform VA's health care system. She also explores how the PACT system can stay focused on the Veteran.

On page 7, Dr. Michael Goldstein and Becky Hartt Minor reinforce TEACH concepts and purpose. They also describe how Motivational Interviewing helps create a conversation between clinician and Veteran, which ultimately improves our health care delivery system.

Kathy Pittman offers advice on tools and resources for health promotion and disease prevention communications on page 9. These tools were developed here at NCP with input from many other program offices and field staff.

On page 11, Terri Murphy describes the development and pilot testing of clinical reminders to support delivery of two of the Healthy Living Messages: Eat Wisely and Be Physically Active.

Dietitian Lynn Novorska gives us an excellent update on the new dietary guidelines from the U.S. Departments of Agriculture and Health and Human Services on page 14.

Finally, Dr. Ken Jones announces MOVE! is celebrating its 5th Anniversary and highlights two patient success stories.

Enjoy this edition of Health*POWER*!. As always – We welcome your feedback.

Jay Shiffler

The Value Argument for Prevention and Patient-Centered Care

Linda Kinsinger, MD, MPH
Chief Consultant for
Preventive Medicine

For the past year or more, the Veterans Health Administration (VHA) has been investing heavily in "transformation" – transforming the way we engage with our Veteran patients and provide health care for them all across the board, from preventive and primary care to specialty and mental health care to long-term and end-of-life care. The goal of these transformational efforts, as stated in the VHA Mission Statement, is to provide "exceptional health care that improves health and well-being." Dr. Gaudet's feature article describes her new office's commitment to patient-centered care and cultural transformation. As she notes, this is a "radical departure from the current system of care," one that will lead to Veterans being "the center of their own healthcare, from beginning to end."

But such major transformation doesn't come without a great deal of financial commitment on the part of VHA. Some may reasonably wonder if spending so much money on this new way of providing health care is a wise investment of limited resources. Taking care of 5.8 million Veterans is expensive and costs are rising. Does it make sense to divert funds to activities that don't seem essential for patient care and may not improve the bottom line? There has been a long-standing debate about whether prevention, in particular, actually saves money, as some claim.

A recent report from the Institute of Medicine takes on this question directly. Entitled *The Healthcare Imperative: Lowering Costs and Improving Outcomes,*[1] the report lists six domains of activity that lead to excess health costs. One of the domains is missed prevention opportunities, accounting for as much as $55 billion in excess costs per year. The report provides rough estimates of how much could be saved by changes in healthcare delivery, including up to $6-9 billion per year by increasing shared decision making. The idea is that involving patients more fully in decisions about their health care, in ways that take into account their needs and preferences, will lead to fewer costly and unnecessary episodes of care. It's a provocative notion that hasn't been completely proven but it's certainly intriguing and worth consideration.

The best discussion that I've come across about whether prevention really saves or costs money is in a paper[2] commissioned by Partnership for Prevention, a non-profit health organization that works to make disease prevention and health promotion a national priority in America. Written by Steven Woolf and colleagues, the paper observes that "the *health* benefits of prevention are intuitive —it is wiser to prevent a disease than to face its consequences at a more advanced stage" but the *economic* benefits of prevention are less clear. Some advocate that prevention is an important means to control health-care spending but others are skeptical, arguing that prevention rarely saves money. Woolf et al. note that "Health is a *good*, and goods—whether they are national security, clean water, or a new car—are not purchased to save money. They are purchased for the nonmonetary benefits they provide." The authors comment that the important factor in health care economics is *value*, the ratio between the cost of a service and its benefits. They state, "Thus the proper question for prevention—and, ultimately, for all of health care—is not whether it saves money but whether it offers good value on the dollar."

One of the challenges to the economic argument for prevention is the fact that many people must engage in a preventive activity for a few to benefit, so the costs of prevention must take into account the expense of providing the preventive service to a large population, not only the savings from the small number who avoid getting the condition. Unhealthy behaviors are difficult to change and the

Continued on page 18

VA's New Office of Patient-Centered Care Represents an Ongoing Commitment to Transform VA's Healthcare Culture

Contributed by
Tracy W. Gaudet, MD
Director
VHA Office of Patient-Centered Care and Cultural Transformation

To underscore its commitment to provide Veterans with world-class health care that is patient-centered and evidence-based, the Department of Veterans Affairs has established the Office of Patient-Centered Care and Cultural Transformation (PCCCT). The goal of this new Office is to transform medical facilities nationwide to patient-centered cultures. The national office will operate out of VA's Washington headquarters and will capture innovation in the field, align and coordinate ongoing initiatives, and demonstrate and deploy new models of care. In partnership with ongoing initiatives, such as those in the National Center for Health Promotion and Disease Prevention (NCP), the staff at the Office of Patient-Centered Care and Cultural Transformation will develop cultural change strategies that include educational training programs to support the nationwide implementation of patient-centered care.

What Does this Mean?

The quality and the commitment of the clinicians and staff who work at the VA and who have dedicated themselves to serving our Veterans are unparalleled. The patient is the entire reason most of us went into the health care field in the first place. So how is patient-centered care a *cultural transformation*?

Here is the central issue: Our existing health care system is not designed with the person at the center. It is actually designed with the problem or the disease at the center. The provider's note starts with "chief complaint," then a problem list, and finally a plan for the problem, but not a plan for the individual. The entire orientation is around the problem; we offer the best possible disease care. While this system typically gets great results with acute issues, it often fails with chronic illness; and moreover, it largely ignores health promotion. The health promotion that is offered in health care today is typically not nearly as effective as it could be because it is offered in a system designed to deliver disease care and not health care.

Seventy-five percent of our health-care dollars are spent on chronic diseases, which are largely affected by health behaviors and lifestyle choices. This burden is part of the driving force to change our system. But how? The problem is that our current system of care lacks a core competency in optimizing health and healing or helping people to truly change their health behaviors. No one on the healthcare team has the responsibility or the training to partner with the patient to really help them change their health and their life. It is not just a matter

Seventy-five percent of our health-care dollars are spent on chronic diseases, which are largely affected by health behaviors and lifestyle choices. This burden is part of the driving force to change our system.

of educating the Veteran. We have a large information-behavior gap in this country. It is easy to find Americans who know that smoking causes cancer and that exercise, good nutrition, a healthy weight, and stress management are good for us, resulting in optimizing our health day-to-day, and allowing us to live longer, happier lives. However, the health of our county and our Veterans continues to decline.

Is this because Americans are inherently lazy or they don't care about their health? NO! It is because we have a Problem-Based Disease Care System when what we really need is a Patient-Centered Health Care System.

How does a Patient-Centered Health Care System Work?

A Patient-Centered Health Care System starts and finishes with the Veteran, with his or her life. It begins with an exploration of what matters to Veterans. Why do they want their health and their life to improve? Many of us haven't given it that much thought. And until we do, our hopes and plans to make difficult changes in our lives and behaviors are likely to remain just that – hopes and plans. This new approach has Veterans at the center and begins with *their* vision of health and *their* goals for health. Created in partnership with their team, the Veteran has a personalized health plan that is based in what matters to them in their lives. We then support Veterans in acquiring the skills and resources they need to succeed in making sustainable changes in their health and life - whether they are young and fundamentally healthy, or whether they are in the end stages of their life. It starts and finishes with the Veteran (see Figure 1).

Radical Departure, Rational Change

This new vision is a radical departure from the current system of care. This approach requires mutually reinforcing behavior change on the part of the system, the health care team, and the patient. What is culture? Culture is individual and collective behavior based in *experience and incentives*. The health care teams need to experience this approach to health care and the system needs to incentivize its delivery. And the patient needs to experience this approach to their health and life, and be incentivized to change. What is transformation? Transformation is profound, fundamental, and permanent change. This kind of change takes years. It takes perseverance and commitment. And in the end, our clinical outcomes will improve and our system will become more efficient and cost effective. And most importantly, our Veterans will be seen, understood, and will be the center of their own healthcare, from beginning to end (see Figure 2).

The Office of Patient-Centered Care and Cultural Transformation will partner with the field through several core implementation strategies. Phase One of the national roll out in this strategy is already underway in partnership with Planetree. Phase I teaches the staff of our health care systems the fundamentals of providing a patient-centered experience. This also serves the vital function of mining the innovation that is occurring every day at the bedside, and creating the system by which these innovations can be understood and assessed for their potential dissemination across the system. While beginning to shift the culture across the systems through Phase One, we must also research, develop, demonstrate, and then deploy the models of care. To this end, we have identified five Centers of Innovation in each of four regions of the country (East Orange, New Jersey; Birmingham, Alabama; Los Angeles, California; and Dallas, Texas) which will serve as our innovation engines. The role of the Centers of Innovation is to help develop and demonstrate these new approaches to care, so that we can learn what will and will not work.

One of the critical goals of these Centers of Innovation is to pilot ways in which the impressive array of new initiatives within the VA can be integrated and aligned at the point of care. The Centers of Innovation and the national roll out will interface seamlessly as each team learns from the other by studying outcomes and then creating education and training to allow the national dissemination of innovations in patient-centered care (see Figure 3). Hearing, informing, and representing the Veterans is at the core of our office, from the Patient Advocacy Program to having a voice at the table of ongoing operations and policies at the national level. The Office of PCCCT must be a living, learning organization that cultivates innovation in our system, learns from these innovations, and translates them across the field in a staged and sustainable strategy.

The Future of Healthcare: A Critical Moment in the History of Medicine

Twenty-first Century Healthcare focuses on the health and healing of Veterans, the care they receive, their partnership with clinicians, and offering respect and commitment. It is

delivered by a great team of people who place our Veterans at the center of all that they do, who address the whole person, and who are world-leading, cutting-edge health care innovators. In fulfilling its responsibility to optimize the health and healing of each and every Veteran, the VHA embraces the opportunity to transform the problem-based disease care system to patient-centered health care. This is an opportunity unparalleled in the history of medicine and a radical departure from our current approach. The need for transformation has never been greater, and the imperatives are professional, financial, and moral. In this way, we will provide the future of health care to our Veterans today. ■

Dr. Tracy Williams Gaudet became the new office's inaugural director on January 18, 2011. She came to VA from Duke University Medical Center, where she was serving as Executive Director of Duke Integrative Medicine, a position she held since 2001. She has been an assistant professor in Duke's Department of Obstetrics and Gynecology since 2004.

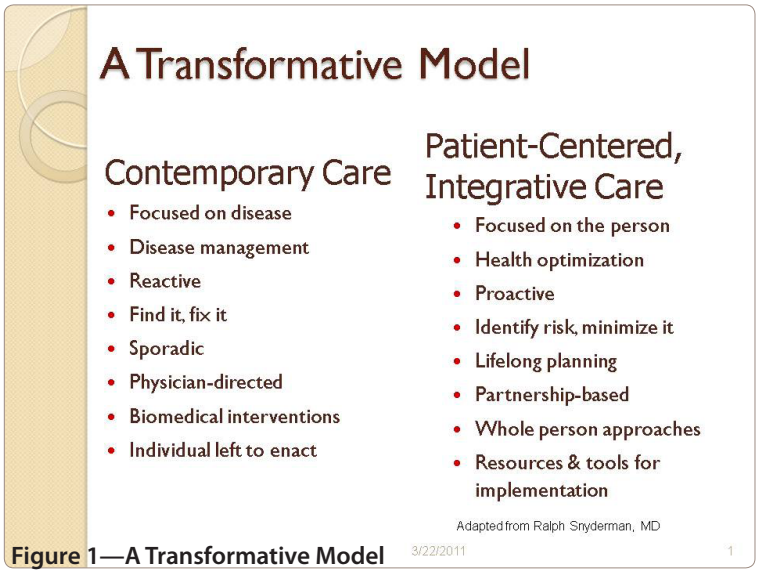


Figure 1—A Transformative Model

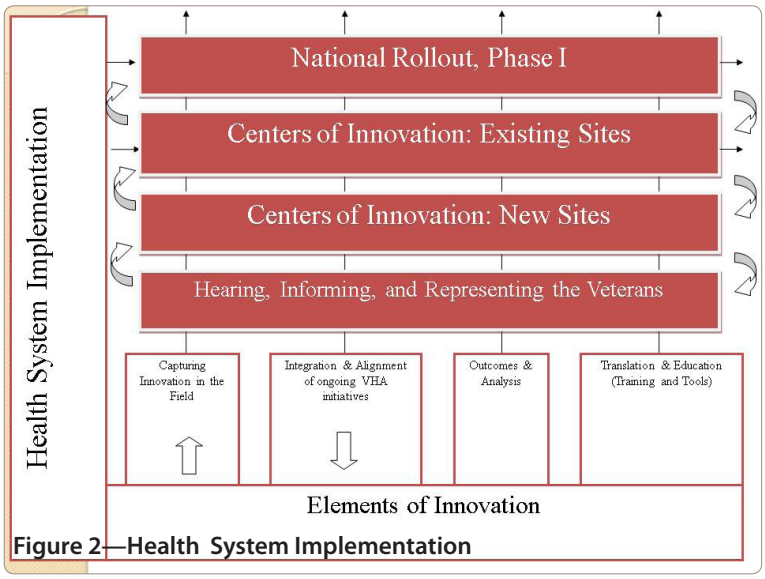


Figure 2—Health System Implementation

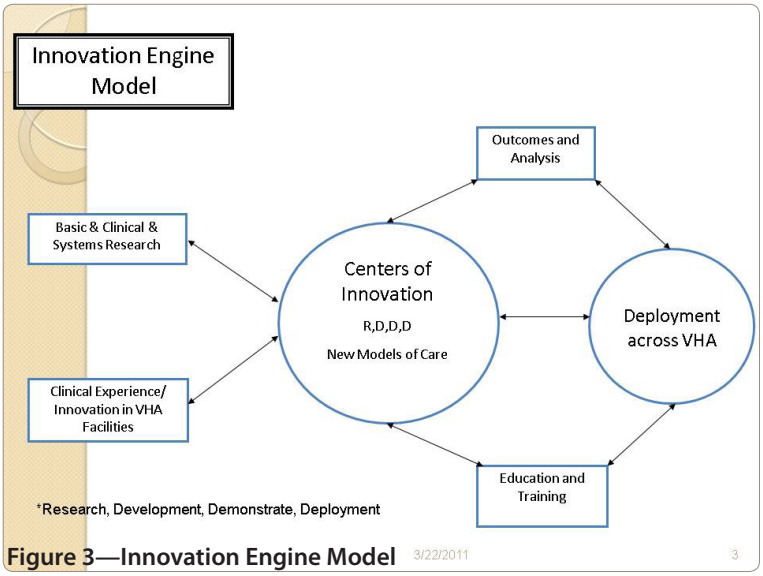


Figure 3—Innovation Engine Model

Communication Skills Training for Patient Aligned Care Teams Spring 2011

Contributed by
Michael Goldstein, MD
Associate Chief Consultant for
Preventive Medicine and

Becky Hartt Minor, MA
Health Educator
Veterans Health Education and
Information

The Veterans Health Administration (VHA) began implementing the patient-centered medical home model now known as PACT (Patient Aligned Care Teams) in the beginning of FY 10. The overall goal of the initiative is to transform our health care delivery system to provide more Veteran-centered care, starting first with primary care. Seamlessly integrating preventive care into primary care and engaging patients as partners are both key aspects of this transformation. NCP is contributing to this effort in a number of ways, including providing PACT staff with training in patient-centered communication skills that are integral to helping Veterans to stay well, prevent illness, and participate in self-management of existing health conditions. *Patient Education: TEACH for Success (TEACH)* and Motivational Interviewing (MI) training are two specific training programs that NCP is utilizing to enhance the Veteran-centered communication skills of PACT staff.

TEACH is a seven-hour, face-to-face experiential educational program that provides PACT staff with evidence-based, Veteran-centered communication skills that enable them to collaborate with Veterans and "coach" them to engage in self-management of chronic conditions, health-behavior change, and healthy living. Classroom sessions use simulated patients and case scenarios to practice strategies and techniques designed for educating and coaching patients in brief encounters. *TEACH* programs are offered by NCP-trained *TEACH* facilitators who include Veterans Health Education Coordinators (VHECs), Health Behavior Coordinators (HBCs), and Health Promotion Disease Prevention Program Managers (HPDP PMs).

MI training provides clinicians with an opportunity to learn the principles, skills, and strategies associated with MI, an evidence-based clinical method that involves guiding Veterans to healthy choices by eliciting and supporting their own motivations to change. Research has demonstrated the effectiveness of MI across a wide range of health behaviors and within a variety of clinical settings. MI training studies indicate that learning MI requires considerable practice and follow-up coaching and support. Thus, MI training for PACT staff will be at least four hours over at least two sessions. NCP plans to train all HBCs in MI.

The FY 11 Transformational Initiative Prevention Program Goal is to reach 20% of all PACT teamlet clinical staff (Clinical Associates,

Providers, RN Care Managers) with *TEACH* training. Over 460 *TEACH* facilitators have been trained by NCP-supported faculty over the last several years, and more than 200 new *TEACH* program leaders have been trained over the first year and a half of the Transformational Initiative. Thus far this fiscal year, *TEACH* facilitators have held over 125 classes for PACT teamlet clinical members in facilities across the country.

MI Training has been disseminated more slowly, as the first group of HBCs was trained by NCP in August 2010. As of February 2011, 80 HBCs have received MI training and training has begun in many facilities. Twenty-five percent of all RN Care Managers have been targeted for MI training in FY 11, though other members of the PACT clinical team, as well as other clinical staff, are also welcome.

As the numbers of *TEACH* and MI facilitators continue to grow, NCP is exploring ways to provide these individuals with additional support to assist them in delivering communication skills training and follow-up coaching to PACT teamlet staff. A workgroup, made up of NCP staff, VHECs, HBCs, and HPDP PMs, has recently been launched to assist NCP with this task. Our charge is to provide *TEACH* and MI trainers with support, guidance, tools, resources, and additional training to enhance their skills as educators, presenters, and clinician coaches. Armed with these additional resources and skills, they will be able to better serve PACT teams and help catalyze the VHA's transformation to more Veteran-centered care. Ultimately, this transformation will assist Veterans to avoid illness and live healthier and more productive lives.

Mark Your Calendar: For those VHECs, HBCs, and HPDP Program Managers not yet trained in MI and *TEACH*, two additional courses have been added for summer 2011. The *TEACH* program will be held July 20–22, 2011, and the MI training will be held July 26–28, 2011.

Tools and Resources for HPDP Communications

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

In the winter 2010 edition of Health*POWER*!, we discussed the nine healthy living messages and included suggestions for discussing these messages with patients. NCP has developed tools to assist clinical staff in communicating the healthy living messages to Veterans.

Clinical Staff Guide to Healthy Living Messages Pocket Guide

This pocket guide is a reference tool for staff that contains evidence-based information about the nine healthy living messages. The purpose of the guide is to help VA clinical staff initiate discussions and/or clarify responses to Veterans' questions. This guide leads staff through the health-coaching steps to ensure effective patient-centered interactions with Veterans about healthy behaviors. The information within this guide includes the key healthy living messages that staff can deliver to Veterans during a brief encounter. The guide also includes expanded messages with more detailed information for interested Veterans. If a Veteran needs more intensive intervention than the clinical staff member can provide, the staff member should refer the Veteran to the appropriate clinical staff, clinic, or program for further education or clinical care by following local referral/consult protocol.

Within this guide, each message has an individually color-coded tab to visually assist staff in finding the message quickly. Staff should use the pocket guide to become familiar with all the messages, so they can respond to Veterans' questions on any of the topics. Staff can share the key message during a brief encounter. Staff also can share the expanded message to interested Veterans with the message tailored to that specific Veteran. The messages are not meant to be memorized and quoted to patients, but instead are meant simply to ensure the staff has evidence-based information when talking with patients. Staff can tailor the expanded messages to the Veteran by giving the right amount of information that is important to the Veteran's need or preferences. Staff can provide the expanded messages to the Veteran over multiple encounters as appropriate.

My Health Choices Patient Handout

The ***My Health Choices*** handout is a practical tool that clinical staff can use to help Veterans choose an area of interest. The handout is a place for setting goals and developing action plans for health-behavior change. The handout includes a "Your Choice" category in case Veterans prefer to discuss a different topic other than those covered by the healthy living messages. The handout provides a place for patients to write down their goals and action plans along with a rating scale for Veterans to assess if they are likely to meet their goals and if they are likely to follow their action plans. Staff can use this scale to identify potential barriers or challenges, and for troubleshooting and problem solving. For example, a patient who answers one through six

The messages are not meant to be memorized and quoted to patients, but instead are meant simply to ensure the staff has evidence-based information when talking with patients.

on a one to ten confidence scale that he/she can meet the goal (one having no confidence and ten being fully confident) may consider modifying the goal or choosing another more achievable goal. The ***Clinical Staff Guide to Healthy Living Messages*** is a companion tool to support staff and/or guide the conversations.

Once completed, Veterans will use the back page of the ***My Health Choices*** tool to document and monitor progress toward their goals. Veterans can photocopy this page with follow-up plans of greater than two weeks. However, in the beginning, it's better to start with a short time frame to keep the interest and motivation at high levels. Use of this tool is also a part of the *TEACH* and Motivational Interviewing staff trainings.

The ***Clinical Guide to Healthy Living Messages*** pocket guide and the *My Health Choices* patient tool may be obtained from the VA Depot through the facility Forms and Publication Officer (FPO). HPDP Program Managers will collaborate with the FPO to place the orders.

Clinical Reminders or template for Physical Activity and Eating Wisely

As Terri Murphy explains in her article, the optional clinical reminders being developed align with the ***My Health Choices*** goal-setting tool and both tools are designed to work well together. The ***Clinical Staff Guide to Healthy Living Messages*** can also be used for support, especially when discussing eating wisely and being physically active.

Clinical Staff Guide to Health Coaching Pocket Guide

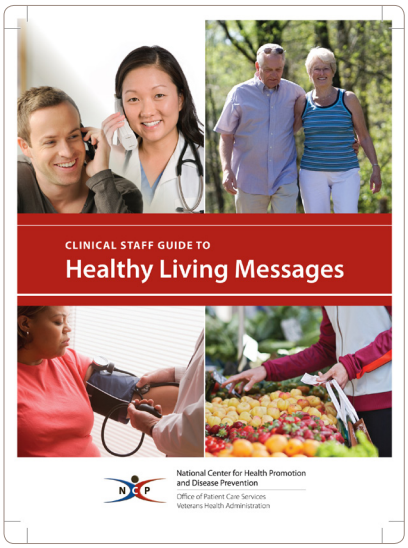
This pocket guide has condensed content found in the ***Patient Education:*** *TEACH* ***for Success*** (*TEACH*) program, relating to the 10 health-coaching steps. *TEACH* participants will receive the guide at the conclusion of the program. The guides are ordered by the local *TEACH* facilitator when preparing to offer a *TEACH* course.

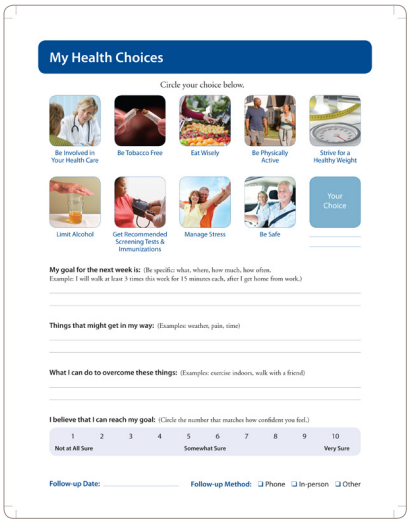
Websites

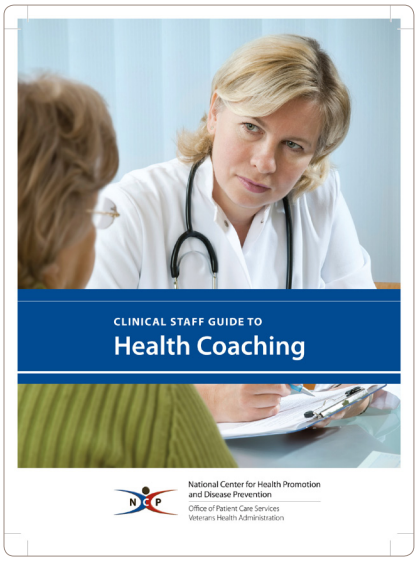
By the end of FY 11, clinical preventive services guidance statements will be posted on the NCP Internet site (**www.prevention.va.gov**) along with a user-friendly search tool for both patient and staff versions. A clinical preventive services guidance statement is a statement that defines VHA recommendations regarding the delivery of individual clinical preventive services to Veterans (e.g., screenings, immunizations). Current clinical preventive services guidance statements are available on the NCP Intranet website for VA staff (**http://vaww.prevention.va.gov**). Links to recommended resources are available for those guidance statements that are not yet posted.

Conclusion

VA has done an excellent job delivering the majority of clinical preventive services to our Veterans, such as cancer screenings and immunizations. Using these tools discussed in this article will enable us to include additional healthy living messages tailored to the Veterans' needs and preferences and to support the effort to become and remain patient-centered.■







"Eat Wisely" and "Be Physically Active" Healthy Living Messages: Development of Optional Clinical Reminders

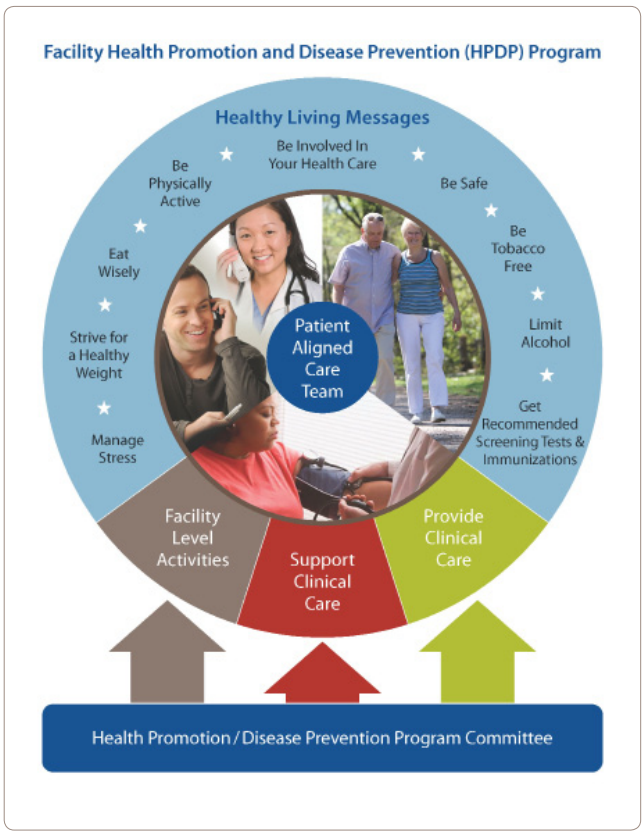
Contributed by
Terri Murphy, RN, MSN
National Program Manager for Prevention Policy

Do you feel confident assisting Veterans in setting goals to eat a healthier diet or to become more physically active?

Do you have a system in place in your clinic to provide Veterans with the follow-up support they need after setting healthy living goals?

This article describes the development of *optional* clinical reminders to support these processes of care.

The Big Picture



We are designing these optional reminders to be user friendly, flexible tools for PACT staff to use when communicating with Veterans about healthy living using a patient-centered, health coaching approach.

This graphic is of a facility Health Promotion Disease Prevention (HPDP) Program. This graphic displays the nine Healthy Living Messages in the blue,

In 2004, a World Health Organization report estimated that at least 80% of all heart disease, stroke, and type 2 diabetes, and more than 40% of all cancers could be prevented if people stopped smoking, started eating more healthfully, and became physically active.

A 'SMART' Goal=
***S**pecific,*
***M**easurable,*
***A**ction-oriented,*
***R**ealistic,*
***T**ime-based*

outer-circle area. These new *optional* clinical reminders will focus on the "Eat Wisely" and "Be Physically Active" healthy living messages.

Why do we need these reminders?

- Evidence shows that healthy behaviors, such as making wise food choices and being physically active, contribute to the delay or prevention of many chronic conditions and diseases. In 2004, a World Health Organization report estimated that at least 80% of all heart disease, stroke, and type 2 diabetes, and more than 40% of all cancers could be prevented if people stopped smoking, started eating more healthfully, and became physically active.
- Facilities will be implementing a communication campaign for patients and staff on all nine healthy living messages. This campaign may prompt questions from patients to clinical staff about what the healthy living messages mean for them.
- VHA has already implemented strong clinical programs and/or performance measures in many of the healthy living message areas, such as cancer screening, tobacco cessation, obesity management, and alcohol screening and counseling. However, at this time there are not any national programs that focus on the "Eat Wisely" and "Be Physically Active" healthy living messages.

What are the goals of these optional reminders?

- Provide PACT staff with user-friendly, flexible tools to use to help communicate evidence-based information to Veterans.
- Reinforce staff use of patient-centered, health coaching approach when communicating with Veterans.
- Help staff focus valuable clinical time on those patients who are interested in eating wisely and becoming physically active.
- Facilitate increased use of staff-Veteran encounters other than face-to-face encounters.

How do these reminders work?

The reminders apply to all PACT Veteran patients except those with terminal illnesses or who are under the care of hospice. Clinicians can also resolve reminders if the topic is not clinically indicated for a specific Veteran for other reasons. The reminders are designed to be used in conjunction with the *My Health Choices* and the *Clinical Staff Guide to Healthy Living Messages* tools. The content in the reminders will also be available as a reminder dialog template that can be used instead of, or in addition to, the reminders.

The first reminder is called **Healthy Living *Discussion***. This reminder guides staff to:

- endorse the importance of eating wisely and being physically active, and then to
- ask the Veteran if he/she is interested in discussing ways to eat wisely or to be physically active.

If the Veteran is interested, share some basic information and ask the Veteran if he/she would like to set a goal. If the Veteran replies yes, then the next step is to assist the Veteran in setting a 'SMART' goal or make arrangements for another clinician to assist the Veteran. To use the health-coaching approach, ask rather than tell the Veteran at each step in the process and coach the Veteran to set achievable goals.

The second reminder is called **Healthy Living *Goal Setting***. This reminder is applicable only if the

Veteran was interested in setting a goal, but the goal was not set during reminder #1 (Discussion). The purpose of this reminder is to build in flexibility to accommodate different clinic workflow processes. For example, a health care tech may identify that the Veteran is interested in setting a physical activity goal, but the RN care manager may work with the Veteran to actually set the goal. Once a goal is set, the RN care manager (in this example) and the Veteran agree on a timeframe for a follow-up.

The third reminder is **Healthy Living *Goal Follow-up*.** This reminder is due based on the timeframe selected in reminder #1 (Discussion) or #2 (Goal Setting). This reminder guides staff to obtain a progress report from the Veteran about the following information:

- Were goals met, partially met, or not met?
- What got in the way, and what helped?
- What are the Veteran's goals going forward?
- What is the timeframe for next follow-up?

Reports will be available that identify which PACT patients are due for goal follow-up so that this activity can be accomplished in a non face-to-face encounter (telephone or secure messaging).

Pilot test of the reminders

The pilot testing of the reminders started in December, 2010, with four conference calls. Staff from 10 facilities participated and provided valuable feedback on the concepts and early prototypes of the reminders. On February 7 and 9, 2011, two kick-off calls were held with the nine pilot sites listed below. Each site received a supply of printed materials for both staff and patients. The actual reminders were sent to the clinical applications coordinators at each site the week of February 14, 2011. The trial will run for approximately two months. Each pilot site has identified an individualized plan for implementation. Many models will be tested including use of the reminders in both individual and group clinic settings.

A huge thank you to our pilot sites and to all of the site coordinators:

- **Ann Arbor, Mich.**, (Kimberlee Buzenberg, APN-BC, HPDP Program Manager and Ashley Clark, MS, RD)
- **Asheville, N.C.**, (Debra Whisenant, MSN, RN, HPDP Program Manager, VHEC)
- **Boise, Idaho**, (Kimberly Bickley, LCSW, HPDP Program Manager and OEF/OIF/OND Case Manager and Kristi Funk, RN Clinical Coordinator Outpatient Department)
- **Chicago, Ill.**, (Tandra Beck, MS, RN, CMSRN, HPDP Program Manager)
- **Perry Point, Md.**, (Patricia Caple, RN, MBA, VAMHCS, HPDP Program Manager)
- **Roseburg, Ore.**, (Elizabeth Ruegg, RN, BSN, Clinic Operation Manager)
- **Saginaw, Mich.**, (Rose Birkmeier, DNP FNP-C, HPDP Program Manager)
- **Salt Lake City, Utah**, (Joan Heusser, RD, CSR, HPDP Program Manager)
- **Tampa, Fla.**, (Kathryn Corrigan, MD, Primary Care Physician, Clinical Reminder Coordinator, Co-Director Southeast Region PACT Collaborative and David P Folds III HPDP Program Manager)

Once we complete the pilot testing, the team at NCP will make revisions based on what was learned during the pilot testing. We plan to make the revised versions more widely available during the fourth quarter, FY 11. We will also work with the National Clinical Reminders Committee for release of these reminders in a patch as optional national reminders in 2012.■

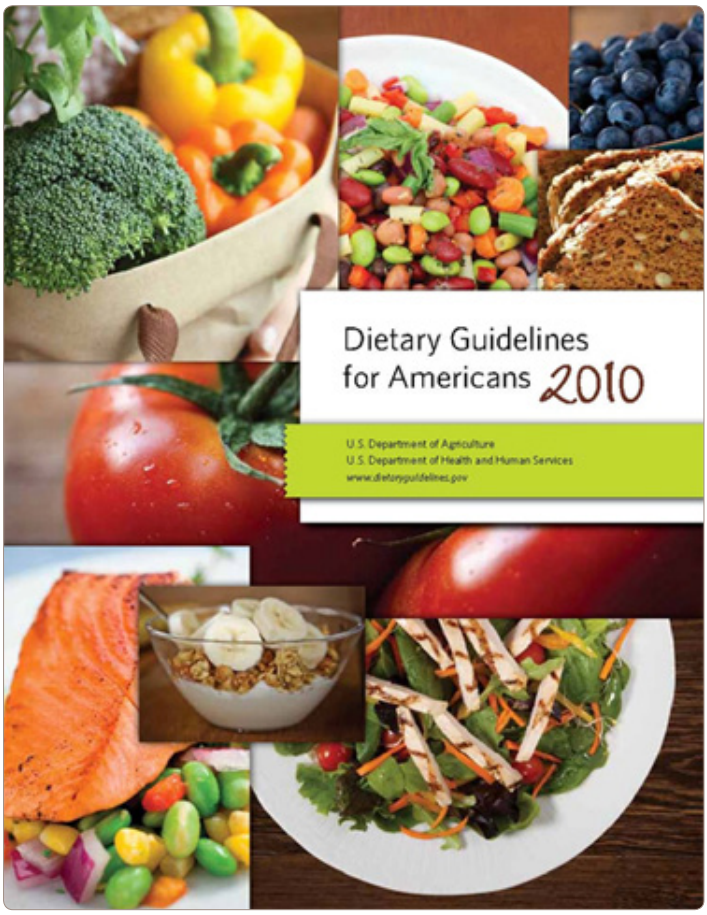
NCP would like to acknowledge and sincerely thank Wilma Fite, Clinical Applications Coordinator from the Asheville, VA who graciously agreed to be detailed for part of her time to NCP for this effort.

The NCP Team that participated in the development of these reminders included physicians (Michael Goldstein, Leila Kahwati, Linda Kinsinger), nurses (Sue Diamond, Terri Murphy, Kathy Pittman), psychologists (Peg Dundon and Ken Jones), a health educator (Becky Hartt Minor), a dietitian (Lynn Novorska), a physical therapist (Sophia Hurley), and a biostatistician (Trang Lance).

Contributed by
Lynn Novorska, RD, LDN
MOVE! Dietitian Program Coordinator

2010 Dietary Guidelines for Americans

March is **National Nutrition Month**®! What a great time to focus on making healthy food choices. It is also the perfect time to take note of the newly released **2010 Dietary Guidelines for Americans** (DGA). The new guidelines, announced by Department of Agriculture (USDA) Secretary Tom Vilsack and Department of Health and Human Services (HHS) Secretary Kathleen Sebelius, offer an evidence-based roadmap to help people make changes in eating plans to improve health.



More than one-third of children and more than two-thirds of adults in the United States are overweight or obese; therefore, the seventh edition of the DGA emphasizes reducing calorie consumption and increasing physical activity.

The *2010 Dietary Guidelines for Americans* include 23 Key Recommendations for the general population and six additional Key Recommendations for specific population groups, such as pregnant women. The Key Recommendations are the most important messages within the DGA because of their implications for improving public health. The recommendations promote shifts in food-consumption patterns and encourage people to eat more of some foods and nutrients and less of others. The *2010 DGA* encourages Americans to eat more:

- Vegetables
- Fruits
- Whole grains
- Seafood
- Low-fat or fat-free milk, yogurt, and cheese or fortified soy beverages
- Vegetable oils, such as canola, corn, olive, peanut, and soybean.

And the *2010 DGA* recommend eating less:

- Sodium
- Added sugars
- Solid fats, including trans fats
- Refined grains

The recommendations provide an integrated set of advice to achieve an overall healthy-eating pattern. To get the full benefit, all Americans should carry out the dietary guideline recommendations in their entirety.

More consumer-friendly advice and tools, including the next generation Food Pyramid, will be released by the USDA and HHS in the coming months.

Dietary Guidelines, ADA, and the National Center for Health Promotion and Disease Prevention (NCP)

NCP's 2011 launch of the healthy living messages for Veterans includes "Eat Wisely," "Be Physically Active," and "Strive for a Healthy Weight" as the critical focus. These messages closely align with the goals and recommendations of the *2010 DGA*. National Nutrition Month®, sponsored by the American Dietetic Association (ADA), has created a 2011 theme which focuses on "Eat Right with Color." This theme supports the release of the DGA consumer messaging campaign and encourages people to strive to consume a colorful palette of foods as a great strategy to add more vegetables and fruits to our diets. Both NCP and ADA are creating brochures and online resources that incorporate DGA messages. Here are additional resources:

The 2010 Dietary Guidelines for Americans
www.dietaryguidelines.gov

Selected Messages for Consumers: Simple and easy to understand nutrition messages based on the 2010 Dietary Guidelines for Americans
http://www.cnpp.usda.gov/Publications/DietaryGuidelines/2010/PolicyDoc/SelectedMessages.pdf

Tips and tools for making healthy eating habits
http://www.healthfinder.gov/prevention/ViewTopic.aspx?topicID=21&cnt=1&areaID=5

Healthy and delicious recipe ideas
http://hp2010.nhlbihin.net/healthy-eating/CategoryList.aspx?linkId=1

Eat more:
- Vegetables
- Fruits
- Whole grains
- Seafood
- Low-fat or fat-free milk, yogurt, and cheese or fortified soy beverages
- Vegetable oils, such as canola, corn, olive, peanut, and soybean.

Eat less:
- Sodium
- Added sugars
- Solid fats, including trans fats
- Refined grains

Veteran Thought He Needed Bariatric Surgery, but Loses 225 Pounds Through MOVE!

Four years ago, Ernie Lohmann asked his team at the Sarasota CBOC of the Bay Pines VA Healthcare System if he should have bariatric surgery. He was suffering from diabetes and kidney failure. "I thought I was going to die." He was enrolled in MOVE! to help him prepare for the surgery, but he was skeptical as he had tried many weight programs in the past. Mr. Lohmann admits that his original goal was to go through the motions with MOVE! so he could qualify for the surgery. Four years later, and without the surgery, he has lost 225 pounds and has been able to discontinue all of his diabetes medications. Mr. Lohmann believes that the multi-disciplinary approach of MOVE! helped him change his lifestyle. The keys to his success have been accountability, keeping a diet log, and thinking about what he is eating. Rather than participating in a formal exercise program, Ernie has dramatically increased his physical activity. He also feels that it has been important to weigh in at each clinic visit and to keep a diet log. "It's like a whole new life." Mr. Lohmann now volunteers with the Sarosota MOVE! program, sharing his story and cheering on fellow Veterans.

Contributed by
Kenneth Jones, PhD
National Program Director for Weight Management

Celebrating the Fifth Anniversary of MOVE!

On March 26, 2006, Dr. Jonathan Perlin signed the MOVE! Handbook formally launching the MOVE! Weight Management Program for Veterans (MOVE!) in the Veterans Health Administration. Through hard work and dedication of staff around the country, MOVE! has become the largest weight management program offered by an integrated health care system.

Some key milestones include:

- MOVE! now available at all VA Medical Centers
- Nearly 100% of Veterans receiving Primary Care services are screened based on their body mass index and offered participation in MOVE! if they would benefit from weight management.
- Over 300,000 patients have received MOVE! care.
- After discovering that copayments presented a barrier to participation, VA worked to remove this barrier.

- Over 300 tons of excess weight have been lost through participation in MOVE!.
- Self-management support has been expanded from group and individual care to care provided through home messaging devices.

NCP's national MOVE! team would like to thank the numerous people who have played a role in building and maintaining MOVE!, for helping Veterans become healthier and for contributing to the tremendous success of MOVE!. We simply would not have the quality program we have without the enthusiastic, knowledgeable, and dedicated team that we have across the nation. We invite you to celebrate with us and share in the success of MOVE! that you helped to create.

We are heartened by the growing number of **success stories** shared by Veterans who have benefitted from MOVE!. Here is a quote from Mr. Thomas Day's story, a MOVE! participant at the Salt Lake City VA.

"The bottom line is that over a period of about 20 months I have lost approximately 70 pounds and now weigh in at roughly 180 pounds. My blood pressure is that of an athlete's and my cholesterol levels are low. Quite honestly, I have never felt so healthy in my entire life. I sleep well, my mind is clear and sharp and I have plenty of energy to sustain my 11 hour work days, 6 days a week." Here is a link to the full story of Mr. Day's weight management journey: **http://www.move.va.gov/tribute.asp**. Congratulations to Mr. Day and the team at Salt Lake!

Thomas Day before

Thomas Day after

Continued from page 3

benefits may take years to become apparent. On the other hand, helping people improve key health behaviors—quitting smoking, becoming more physically active, eating better—adds to health improvements in many chronic conditions, so the benefits can be substantial and long-lasting. Woolf and colleagues conclude: "Preventing people from getting sick has value in human terms that econometrics cannot capture. Even if preventing a disease or treating it after symptoms emerge costs the same amount per QALY [quality-adjusted life years] saved, people prefer the former to avoid the suffering."

To support continued investment by VHA in transforming our healthcare system to one that has a strong emphasis on patient-centered care and prevention, we need to focus on the *value* this approach brings to our Veterans. By striving to achieve "exceptional health care that improves health and well-being," we are being responsible stewards of VHA's health-care dollars and are providing high quality care that matters to Veterans. ■

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2 Woolf SH, Husten CG, Lewin LS, Marks JS, Fielding JE, Sanchez EJ.
The economic argument for disease prevention: distinguishing between value and savings. Partnership for Prevention. 2009.
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Linda Kinsinger

News

Suzanne Bertollo, MD, MPH – UNC Preventive Medicine Residency Program

NCP's affiliation with the University of North Carolina's Preventive Medicine Residency Program continues. Our newest resident, Suzanne Bertollo, is a second-year preventive medicine resident and completed her Masters of Public Health in Public Health Leadership at UNC. She is also board certified in emergency medicine and completed her residency training at Carolinas Medical Center in Charlotte, NC. She earned her MD from the University of Florida and an undergraduate degree from Duke University. Her professional interests include various aspects of health and wellness promotion, and she is a graduate of the University of Arizona's Fellowship in Integrative Medicine.

Update: Clinical Preventive Services Guidance Statements

VA staff can access approved VHA Guidance Statements for Clinical Preventive Services on the following NCP intranet site: http://vaww.prevention.va.gov/Guidance_on_Clinical_Preventive_Services.asp

There are now 13 Guidance Statements posted including:

- Abdominal Aortic Aneurysm Screening
- Aspirin for Primary Prevention of Cardiovascular Disease
- Aspirin or Non-steroidal Anti-inflammatory Drugs for the Primary Prevention of Colorectal Cancer*
  - (*Note: it is important to remember that some of the guidance statements including this one will specify that a particular service is NOT recommended.)
- Chlamydia and Gonorrhea Genital Infection Screening
- Colorectal Cancer Screening
- Hepatitis C Screening
- Herpes Zoster (Shingles) Immunization
- HIV Screening
- Lipid Disorders Screening
- Meningococcal Immunization
- Pneumococcal Immunization
- Seasonal Influenza Immunization 2010-2011
- Tetanus/Diphtheria (Td) and Tetanus/Diphtheria/Pertussis (Tdap) Immunizations

We are currently developing an internet version of the guidance statements, which will include content that is especially targeted to Veterans. We are also developing a more sophisticated search engine for the guidance statements that will allow Veterans and VA clinicians to generate a list of services for an individual based on their age and gender. We plan to launch these new features later this year. Stay tuned!!

Face-to-Face with VISN HPDP Program Leaders

NCP hosted a face-to-face meeting with VISN HPDP Program Leaders February 16-17, 2011. The meeting provided an opportunity for discussion about the status of current programs, successes to date and challenges. NCP provided an update on the overall Preventive Care Program and clarified expectations regarding FY 11 facility HPDP Program goals. Small group work provided an opportunity for the group to collaborate with each other and NCP staff to explore components of "ideal" HPDP Programs and productive collaborations. The meeting ended with planning for FY 12 HPDP Program Goals. Many thanks to all who attended for the great work and for their participation and enthusiasm. It was greatly appreciated.

CALENDAR *of* EVENTS

NCP Conference Call
2nd Tuesday of the month
1:00pm ET
1-800-767-1750, access #18987
• Upcoming calls—April 12, May 10

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 calls—May 10, June 14

Veterans Health Education Hotline Call
4th Tuesday of the month
1:00pm ET
1-800-767-1750, Access Code 16261
• Upcoming calls—April 26, May 24

Health Promotion/Disease Prevention Conference Call
1st Tuesday of the month
1:00pm ET
1-800-767-1750 access code 35202
• Upcoming calls—April 5, May 3

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—April 12

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
Jay Shiffler, Editor

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

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