

# Health *POWER!*

## Prevention News

Summer 2006



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## Calendar of Events

### NCP was represented at the following meetings:

April 19, 2006

Linda Kinsinger—HSR&D SOTA (State of the Art) Planning Committee Meeting—Chicago, IL

April 26, 2006

Linda Kinsinger; Ken Jones; Leila Kahwati—OQP Performance Measures Workgroup—Washington, DC

May 6, 2006

NCP Staff—HealthierUS Veterans Roll-Out—Washington, DC

May 9-10, 2006

Ken Jones—VA Women Veterans Health Conference—Orlando, FL

May 13, 2006

Linda Kinsinger; Susi Lewis—HealthierUS Veterans Roll-Out—Seattle, WA

May 16-20, 2006

Ken Jones—CDC Diabetes/Obesity Conference—Denver, CO

May 17, 2006

Linda Kinsinger—VEIN Annual Conference—Richmond, VA

May 19, 2006

Linda Kinsinger; Susi Lewis—HealthierUS Veterans Roll-Out—Boston, MA

June 14-15, 2006

Ken Jones—VISN 10 MOVE—Columbus, OH

June 15-16, 2006

Pam Del Monte—IDPIO Strategic Plan Meeting—Tampa, FL

June 16, 2006

Ken Jones—VISN 6 Lipid Conference—Roanoke, VA

June 26, 2006

Linda Kinsinger—Academy Health Conference—Seattle, WA

June 28, 2006

Linda Kinsinger; Ken Jones—CDC Steps to a HealthierUS Meeting—Atlanta, GA

July 1-7, 2006

Ken Jones—Veteran Wheelchair Games—Anchorage, AK

### NCP will be represented at:

July 17-21, 2006

Linda Kinsinger; Ken Jones; Richard Harvey; Mary Burdick; Pam Del Monte; Rosemary Strickland—Primary Care/Prevention Conference—Alexandria, VA

July 23-25, 2006

Ken Jones—DoD Weight Management Meeting—Alexandria, VA

August 28-29, 2006

Linda Kinsinger; Ken Jones—Senior Management Conference—Las Vegas, NV

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

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**Program Support Assistant, Contractor**—Vacant

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**IT, Contractor**—Tony Rogers

**Deputy Director, Clinical**—Kenneth Jones, PhD

**Assistant Deputy Director (Policy, Research and Training)**—  
VACANT

**Program Manager for Partnerships**—Mary Burdick, PhD, RN

**Program Manager for Field Communications**—

Pamela Del Monte, MS, RN, C

**Program Manager for MOVE!** - Kenneth Jones, PhD

**MOVE! Medical Consultant, Contractor**—

Leila Kahwati, MD, MPH

**MOVE! Project Coordinator/Communications, Contractor**—

Tracey Bates, MPH, RD, LDN

**MOVE! Project Coordinator/Clinical Resources, Contractor**—

Susi Lewis, MA, RN

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## NCP Mission Statement

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

## Linda Kinsinger, MD, MPH Director, VA NCP



Someone once said, "The great thing in the world is not so much where we stand, as in what direction we are moving." Within the National Center for Prevention (NCP) and, indeed throughout VHA, many things in the field of prevention are moving and the direction is clearly forward. I'd like to highlight just a few of the things that we see moving forward.

One important area that is just starting to take a huge step forward is patient health education. Patient health education has long been a focus within VA medical centers and out-patient clinics. Each facility has a designated patient health educator and committee, who develop a wide variety of health education information and materials at the local level. Several national program offices and groups also produce patient education resources in specific content areas (as one example, the VA National Hepatitis C program has a set of patient materials on their website, <http://vaww.hepatitis.va.gov/vahep?page=pt-00-00>.) Here in NCP, we publish a set of patient handouts each month on important common topics (<http://www.nchpdp.med.va.gov/MonthlyPreventionTopics.asp>).

What's been missing, however, is a central resource to coordinate and oversee health education and information across VHA. Dr. Madhu Agarwal, Chief Patient Care Services Officer, recognized the need for such a resource and, through Dr. Michael Kussman, Principal Deputy Under Secretary for Health, charged a task force to assess current health education services, identify areas of improvement, and recommend a plan of action to deliver more effective services. I had the privilege of co-chairing the Task Force, along with Rose Mary Pries, Program Manager for Patient Health Education in EES. Members of the Task Force represented a wide variety of VACO offices and field staff. After taking a close look at many current patient education activities, the Task Force recommended that a new office be established in the Office of Patient Care Services and, specifically, that it be located within NCP. The office will have a Program Manager and Health Educator and will share support staff with NCP. I am very pleased to announce that

Dr. Rose Mary Pries has accepted the position of Program Manager for the new Office of Veterans Health Education and Information and soon will be joining us in Durham. We are thrilled that she will continue to lead national efforts in patient health education, just as she has for many years, but now in a more formal role. The Health Educator position will be posted soon and we expect to have activities moving forward in the next few months.

Another area in which we've made significant forward progress at NCP is the development of the evaluation plan for the *MOVE!* program. Although not quite complete yet, we have taken several substantial steps forward on it. One step has been to collaborate closely with the VSSC (VHA Service Support Center) on putting together a "data cube" (essentially a 3-dimensional spreadsheet) with data on patients who have had *MOVE!* stop-coded visits, thus allowing us to identify and follow those patients to measure utilization of the program. We're working on a clinical data cube that will allow us to follow clinical parameters, such as BMI, blood pressure, certain labs, and so on. This will be a key part of our evaluation of the *MOVE!* program. We're also developing relationships with several groups of VA health service researchers, who will help us answer important questions about *MOVE!*: How many patients is it reaching? How well does it work? For whom? We are also keenly interested in what sorts of local variations in the program lead to better outcomes. This will help us to identify "best practices" that can be disseminated nationally.

Many other areas in which things are moving in the right direction are noted in reports from NCP staff in this newsletter. We're very pleased to be working closely with Primary Care on the upcoming, combined Primary Care/Preventive

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Medicine meeting in July. The agenda is full of interesting topics, great presenters, and timely opportunities to meet with others who share your passions and excitement. The prevention track will include update sessions on colorectal cancer screening and follow-up of positive screens, current and new immunization recommendations, developments in the area of employee wellness, and more things to learn about *MOVE!*

The HealthierUS Veterans initiative, as detailed on pages 8-11, had a very busy month in May and is moving forward on more planning and developing resources for the field. The next major task is to create a facility tool-kit for facilities to use in planning local events and activities. When ready, these resources will be posted on the HealthierUS Veterans website: [www.healthierusveterans.va.gov](http://www.healthierusveterans.va.gov). Dr. Nathan Almond, a Preventive Medicine resident at the University of North Carolina at Chapel Hill and an active duty Navy physician, is working with us this summer on training and guidance for volunteers in the Fit for Life Corps.

It's clear that if you're not moving forward, the world is passing you by. (That's not to say that you shouldn't stop for a deep breath and bit of rest and relaxation once in a while, too!). This is an exciting time for prevention in VHA, with so many things moving forward. We're glad you're along with us, keeping us on the right track and going in the right direction! I hope to see many of you in Alexandria in July for the upcoming conference.

Linda

**The VA National Primary Care and Preventive Medicine Conference will be held July 18 – 20<sup>th</sup>, 2006, at the Hilton Alexandria Mark Center, 5000 Seminary Road, Alexandria, VA.** The conference theme this year is *Patient Centered Care in the Primary Care Setting*.

The Primary Care and Preventive Medicine conference will provide an opportunity for multidisciplinary clinical and administrative staff including primary care providers, prevention coordinators, mental health, women's health representatives, and others to discuss significant VHA issues. This networking should lead to the development of solutions to shared challenges. Dr. Perlin and many other national experts will present important insights on a wide variety of topics including useful strategies for implementing *MOVE!*, colorectal cancer screening, immunizations, wellness programs, poly-trauma centers, seamless transition, OEF-OIF, My Healthy@Vet and other areas of interest.

The planning committee has received numerous practical and useful submissions for the poster session. We expect two hundred and fifty participants to be in attendance who will each earn 15 educational credit hours.

If you plan to attend and haven't registered already, please do so soon. We look forward to seeing you there!

**Funding should be requested at your local facility. There is no national funding for travel.**

To register for the conference, go to: <http://vaww.sites.lrn.va.gov/registration/Default.asp?CourseID=686>

To view the description, brochure and other information about the conference, go to: [http://vaww.sites.lrn.va.gov/vacatalog/cu\\_detail.asp?id=21966](http://vaww.sites.lrn.va.gov/vacatalog/cu_detail.asp?id=21966)

## HEALTHIERUS VETERANS – Get Fit For Life

### 3 Kick-Off Events: Washington, DC; Seattle, WA; Boston, MA

Susi Lewis, Tracey Bates, and Ken Jones (VA NCP)

**HealthierUS Veterans** is a major joint initiative of the Department of Veterans Affairs (DVA) and U.S. Department of Health and Human Services (HHS). HealthierUS Veterans is designed to combat the growing problems of obesity and diabetes in the United States.

[www.healthierusveterans.va.gov](http://www.healthierusveterans.va.gov)

VA is partnering with the Department of Health and Human Services to encourage veterans, their families, and their communities to adopt healthy lifestyles, to eat nutritious foods and limit calories, and to increase physical activity every day. By making good choices such as these, we know that veterans can improve their health and potentially decrease the burden of chronic illness.

Major program components of **HealthierUS Veterans** include:

#### Promotion of the *MOVE!* Program

*MOVE!* is VA's national weight management program. *MOVE!* can help you lose weight, keep it off and improve your health. The *MOVE!* Program is open to veterans who come to our facilities for care. For veterans in the community who have other health care providers and their family members, VA is providing an opportunity to take advantage of the information and resources that *MOVE!* has to offer at [www.move.va.gov](http://www.move.va.gov)

#### Steps to a HealthierUS Programs

HHS funded 40 communities around the country to decrease rates of obesity, diabetes and asthma by improving nutrition and physical activity and decreasing tobacco use. Many VA Medical Centers and Steps Communities are forming partnerships to help veterans, their families and neighbors to lead healthier lives. [www.healthierus.gov/steps](http://www.healthierus.gov/steps)

#### Fit for Life Corps

Veterans, family members, and community volunteers are being recruited to perform a number of duties, both within the medical centers

and in the communities, to help promote **HealthierUS Veterans** and to serve as ambassadors to those we want to reach. [Contact your Voluntary Service for additional information, or go to: \[www.va.gov/volunteer/spotlight.html\]\(http://www.va.gov/volunteer/spotlight.html\).](#)

#### Be Active

Ask your medical provider about a "Prescription for Health" to encourage you to be more active. The prescriptions are an aid for health care providers to work with patients to set physical activity goals. There are separate prescriptions for ambulatory and wheel-chair bound veterans.

#### Healthy Lifestyle and Fitness Challenges

Encourage physical activity through friendly competitions among veteran groups, community groups, VA medical facilities, VA leadership, and others. Your medical center/office/group/club can set up or join a group where you can register and keep track of your individual or group's activity. Take the President's Challenge for fitness at [www.healthierusveterans.va.gov/FitnessChallenges/default.asp](http://www.healthierusveterans.va.gov/FitnessChallenges/default.asp)

#### Learn More

Use My Health<sub>e</sub>Vet as an important source for information about veterans' health and wellness. [www.myhealth.va.gov](http://www.myhealth.va.gov)

Turning the tide of increasing trends in obesity and sedentary lifestyle will require influences beyond our face-to-face patient encounters. Secretaries Nicholson and Leavitt as well as Under Secretary for Health Dr. Perlin and Surgeon General Carmona have developed HealthierUS Veterans to focus attention on these problems and share vital resources in this effort.

Three HUSV national and regional kickoff events have been held across the nation. Read about them on the next few pages.

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## Washington, DC – National Healthier US Veterans Kick-Off—Saturday, May 6, 2006

The HealthierUS Veterans Kickoff Event was held in conjunction with the President's Council on Physical Fitness and Sports on May 6, 2006 at the RFK Stadium in Washington, DC. The national event included dignitaries, celebrities, health organizations, insurance companies and healthcare vendors.

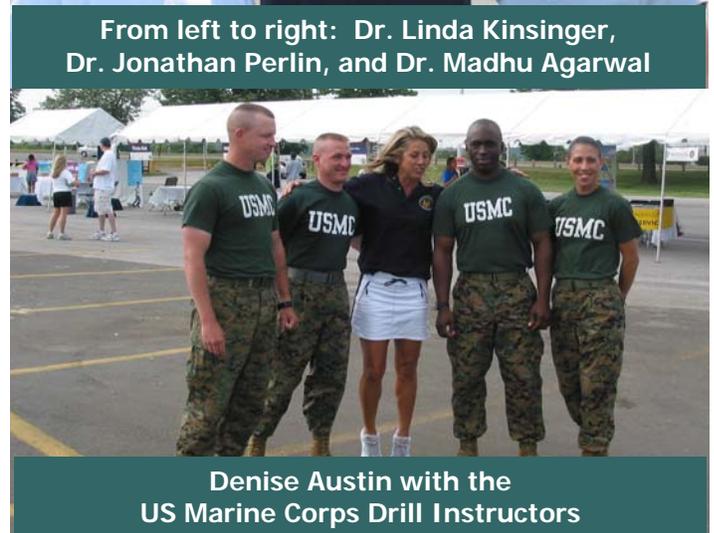
Presentations on the main stage included: the Harlem Globetrotters; US Marine Corps Drill Instructors from Quantico; VA Under Secretary for Health Jonathan Perlin, MD, PhD, MSHA, FACP; HHS Assistant Secretary for Health John Agwunobi, MD, MBA, MPH; Denise Austin; Janell George, Office of Disability, HHS; Kirk Bauer, Executive Director, Disabled Sports USA; John P. Burke, Chair of the President's Council on Physical Fitness and Sports (PCPFS); and Dot Richardson, MD, PCPFS Vice Chair.

The National Center for Health Promotion and Disease Prevention and the Office of Special Projects displayed HealthierUS Veterans and *MOVE!* exhibits complete with promotional give-aways. Staff presented nutrition and fitness interactive sessions. Attendees participated in dance, aerobic, fitness demonstrations and other health and wellness activities.

Demonstration instructors included: Ellen Bosley, MBA, MS, RD, National Director, Nutrition and Food Services, Washington, DC Central Office; Korinne Umbaugh, MS, RD, Registered Dietitian, Lucille Lisle, CTRS, Recreation Therapist, Subrena Utley, Voluntary Service Program Specialist, and Navjit K. Goraya, MD, Primary Care Physician from the Washington, DC VA Medical Center; Sue James, RD, Registered Dietitian, VA Maryland Health Care System; Barbara E. Hartman, MS, RD, LD, Chief, Nutrition & Food Service, Martinsburg, WV VA Medical Center; and Tracey Bates, MPH, RD, LDN, *MOVE!* Communications Coordinator, Kenneth Jones, PhD, *MOVE!* Program Manager & Clinical Deputy Director, Pam Del Monte, MS, RN, C, Field Communications and Susi Lewis, MA, RN, C, CPHQ, *MOVE!* Clinical Resources Coordinator from the VA National Center for Health Promotion and Disease Prevention.



From left to right: Dr. Linda Kinsinger, Dr. Jonathan Perlin, and Dr. Madhu Agarwal



Denise Austin with the US Marine Corps Drill Instructors

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## Seattle, Washington – Regional HealthierUS Veterans Kick-Off—Saturday, May 13, 2006

The Seattle Kick-Off Event, co-sponsored by the VA Puget Sound Medical Center, Steps to a HealthierUS, and the Columbia City Neighborhood, was held on Saturday May 13, 2006. The program name “Step Together! – Joining Together for the Health of the Community” certainly depicted the partnership spirit. The ceremony began on the grounds of the VA Medical Center, complete with a canopy tent, veterans, enthusiastic employees and volunteers, exhibits, and guest speakers. Attendees were able to receive blood pressure readings, blood glucose monitoring, and take a computerized questionnaire (MOVE! 23) to obtain an individualized report addressing nutrition, physical activity and behavioral factors. A track was roped off for those participants who were in wheelchairs. A variety of wheelchairs, a treadmill and stationary bike were displayed.

Timothy Williams, Director VA Puget South Health Care System, provided opening remarks and served as the program moderator. Guest speakers included: Dennis Lewis, FACHE Director, Northwest Network VISN 20, US Department of Veterans Affairs; Patrick O’Carroll, MD, MPH, Regional Health Administrator, Region 10, US Department of Health and Human Services; Terry Duffin, Program Development/Operations Coordinator, Administration on Aging US Department of Health and Human Services, and Laird Harris, Chair Steps to Health, King County Leadership Team.

Following the formal program, participants were divided into 3 groups to prepare for the community walk. Pre-walk stretching exercises were led by Scott Ferris, VA Puget Sound. Pedometer instructions were given. Water, juice, apples, oranges, and granola bars were offered. Approximately 100 walkers took the “walking down the hill challenge” to the Columbia City neighborhood park. Once at the park, the Steps to a HealthierUS leaders introduced King County Executive Ron Sims. A variety of neighborhood entities to include a local gym owner, neighborhood dance group, walk organizers, and merchant owners, participated in the event. Attendees were encouraged to participate in warm up exercises,

take a walk to a nearby park, learn to line dance and visit a local gym. Numerous shop owners and vendors offered free information, health screenings, and give-aways to the community.

The event was a great success with beautiful weather (no Washington State drizzle). It was obvious participants (veterans and their families, VA staff and volunteers, Steps staff and volunteers and members and leaders of the community) supported the goals of the HealthierUS Initiative as they “walked the talk.”



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## **Boston, MA – Regional Healthier US Veterans Kick-Off—Friday, May 19, 2006**

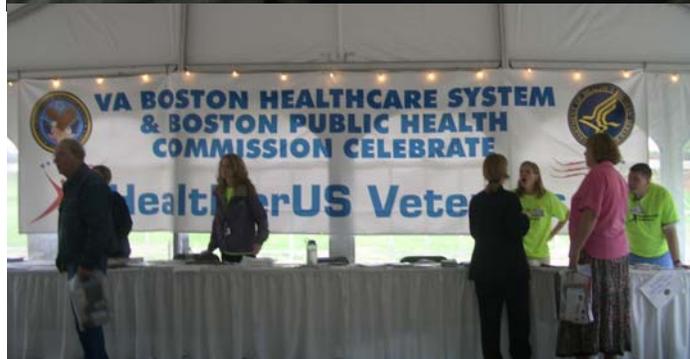
The Boston regional event was held on May 19, 2006 in a huge enclosed tent on the grounds of the West Roxbury VA Medical Center. Veterans and families, staff and volunteers showed their support under rainy and then sunny skies as they participated in the formal ceremony and visited the numerous exhibits and booths. Health information, T-shirts, pedometers, calendars, pens, healthy snacks were available to the approximately 300 attendees.

Medical Center Director Michael Lawson provided opening remarks and facilitated introductions of the guest speakers. The Pledge of Allegiance was led by Kenneth Medeiros, President of the New England Paralyzed Veterans of America. Veteran Peter Connell shared his personal story of overcoming the challenge of losing a leg and making physical fitness a priority in his life. William Sinnott, JD Corporation Counsel, represented the mayor of the City of Boston; Kenneth Moritsugu, MD, Deputy Surgeon General represented HHS; and Jeannette Chirico-Post, MD, Director VA New England Healthcare System provided remarks and represented Jonathan Perlin, MD, PhD, MSHA, FACP, Under Secretary for Health, VA, who was unable to attend due to mechanical problems with his plane.

The sun came out just before the scheduled walk which delighted the enthusiastic supporters of the HealthierUS Veterans event. Attendees took a walk or roll around the VA campus led by the coaches and players of the Boston College Women's Basketball Team.

The attendance at this event, despite the rain, was remarkable. Veterans, family members, volunteers, VA staff and Steps staff made the event successful and memorable.

**On behalf of Dr. Linda Kinsinger, NCP Director, a grateful "thank you" is extended to all staff involved in the DC, Seattle and Boston events. Your hard work for ensuring the success of these HealthierUS Veterans Kick-Off Events is quite noteworthy and greatly appreciated.**



## Pamela Del Monte, MS, RN, C Program Manager for Field Communications



### *NCP Website Update*

We have been diligently at work in updating and revising the NCP website ([www.nchpdp.med.va.gov](http://www.nchpdp.med.va.gov)). By the time you read this, the new site may be available. Major content areas have been redefined. All content areas can be located by using one of the left navigation panes.

Content is broken down into the following categories: What's New; Field Resources; Policy Guidance and Research Info. Links are provided to the *MOVE!*, HealthierUS Veterans and Office of Patient Care Services websites. Field Resources is a large content area and includes: the Monthly Prevention Topics, Education and Training Information, Health Promotion Program Information, Employee Wellness Information, Health*POWER!*, Prevention News, Best Practices (to be developed – see below), Immunization Resources and a Prevention Events Calendar. Policy Guidance will include the Prevention Handbook (to be published imminently), *MOVE!* Handbook, Bariatric Surgery Handbook, links to the VHA's Forms, Publications & Records Management home page and other policy information. Research info will include Handbooks, Directives and Program Guides specific to NCP as well as links to other prevention related documents.

The website is designed to help with your health promotion, disease prevention and employee wellness activities. If there are items and information you would like to see added as we continue work on the site, please send them to me at [Pamela.DelMonte@va.gov](mailto:Pamela.DelMonte@va.gov).

### *Field Operations Update*

**Monthly prevention conference calls** are scheduled for the 2<sup>nd</sup> Tuesday of the month @ 1pm Eastern. Attendance on the calls continues to increase. Dr. Louise Walter was the guest speaker for June addressing her research Relationship of Health Status and Screening PSA among Elderly Veterans. Dr. Rose Mary Pries is the guest speaker in July. She will be addressing health literacy. If there

is a topic you would like addressed on one of the calls, please forward that information to me at [Pamela.DelMonte@va.gov](mailto:Pamela.DelMonte@va.gov). Monthly topics, Healthy Aging, Immunizations and Healthy Choices, have been posted for July - September. Topics for October – December are Depression/Oral Health; Tobacco and Making Changes. Handouts will be posted to the website late August/early September.

A **web-based assessment** to evaluate our health promotion and disease prevention program has been developed and is undergoing final revisions. Some of the elements to be evaluated include the monthly conference calls, the website, resources for facility and VISN prevention coordinators. All persons involved in prevention – VISN Preventive Medicine Leaders, Facility Prevention Coordinators, providers and clinical staff are encouraged to complete the survey. It is brief and should take 10 minutes or less to complete. Stay tuned for more information.

Is your facility having **success**? We all look for that piece of the puzzle that enables us to do things well and efficiently. If you have a process or a procedure that is working for your clinic or facility, please share it with the group. There are many forums to do that, the monthly conference calls, the website and/or submitting to Health*POWER!* One area on the NCP intranet we plan to develop is a section for Best Practices.

**Employee Health and Fitness Day** was Wednesday, May 17, 2006. NCP prepared tools for planning, marketing and promoting healthy activities and behaviors. Many facilities had activities, and pictures indicate that everyone participating had a great time. Thank you to all who submitted a summary and photos your activities. The 2006 edition of the Wellness Digest is being compiled. Copies will be available at the Primary Care/Preventive Medicine Conference in July.

**Prevention Champions** – Activities in Prevention and Employee Wellness continue to grow and flourish. Do

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you know someone who is doing great things, is innovative and/or creative with Prevention or Employee Wellness? Consider nominating them as a Prevention Champion. Nominations are judged in 4 categories:

- Prevention Champion – Clinical
- Prevention Champion – Administrative
- Prevention Champion – Team
- Employee Wellness – Team

The following criteria should be considered when nominating a Prevention Champion:

- *Customer Service & Personal Mastery:* Makes significant contributions in the field of health promotion/disease prevention that make a difference in the lives of veterans (employees) served; inspires and demonstrates a passion for excellence.
- *Interpersonal Effectiveness & Technical Skills:* Works collaboratively to develop innovations that improve health promotion/disease prevention services.
- *Flexibility/Adaptability & Creative Thinking:* Takes initiative and shows innovativeness, creativity, and/or persistence in health promotion/disease prevention activities.
- *Organizational Stewardship & Systems Thinking:* Demonstrates leadership and vision and makes the impossible happen.

The nomination form is on the NCP website at <http://vaww.nchpdp.med.va.gov/champ.asp>.

## *Maintaining Motivation*

Several of us at NCP have been participating in a mock version of the study "Automated step-count feedback to promote physical activity in diabetes" or "Stepping Up to Health."

The purpose of the study is to test and refine an internet-based program to promote walking in people with "type 2" diabetes. We were invited to be test or demo users, even though most of us do not have diabetes. We were given enhanced pedometers that can upload time-stamped step-count information to a website which is converted to graph form, and viewable by month, week or day. Each user is given a goal for the

number of steps to walk each day. Goals are individualized to measured levels of activity and the initial goal is set after a week of steps has been downloaded. Number of steps is uploaded daily and subsequent goals are determined from that. Goal steps are then increased or decreased. In addition to the visual feedback, each participant receives individualized motivational messages. In the study, the different kinds of messages will be compared to see how the participants change their walking patterns.

We are probably no different than the veterans we try to motivate. "Kids in a candy store" summarized our reaction when we received the pedometers and realized their degree of automation. Dutifully, we wore them and uploaded the information. It was interesting to see the differences in how each of us was motivated and our degree of adherence to a walking program. Most of us are still wearing our pedometers. As a group the NCP staff committed to walking together each day and staff members walk individually as well.

For me, this has been an interesting lesson. I looked at the graphs, read my motivational messages and certainly had an opinion on my goals and was meeting them most days. For the past couple of weeks, I have had many days when I walked 15,000 steps or more. After those steps were downloaded, I received a message telling me that my new goal is now 10,000 steps per day. The target has been set and now I am determined to meet it. I do admit that level of determination wasn't there at 6,000 steps. Another participant has been at a 10,000 step goal for several weeks and has been reaching and exceeding her goal. Recently, she has set a goal to walk 10,000 aerobic steps as a goal within a goal!

What lessons have we learned? Each of us has been motivated differently to sustain a walking program. Some of us are motivated by the messages, some are motivated by the graphs, and we all take notice of our activity levels throughout the day. It has been fun.

## STAYING COOL WHEN IT'S HOT

When we are feeling warm/hot, we perspire. The perspiration evaporates and that allows our bodies to cool. If our bodies don't cool correctly or cool enough, we can feel and become ill. There are things we can do to help stay cool.

Dress for it! Wear lightweight, loose-fitting and light colored clothing. Wear a hat or use an umbrella to help block out the sun.

Don't get too much sun! Wear sunscreen when outdoors. Avoid being outdoors during the peak sun hours 10 am – 4 pm. Remember to wear sunglasses.

Drink up! That would be plenty of **water**. Drink even when you don't feel thirsty. Water or 'sports' drinks are beneficial. Avoid alcoholic or caffeinated beverages in the warm weather – they can cause dehydration.

Eat small meals and eat more often! Avoid hot and heavy foods. Try to limit high protein foods. They can increase metabolic (internal body) heat. Eat cool foods such as salads.

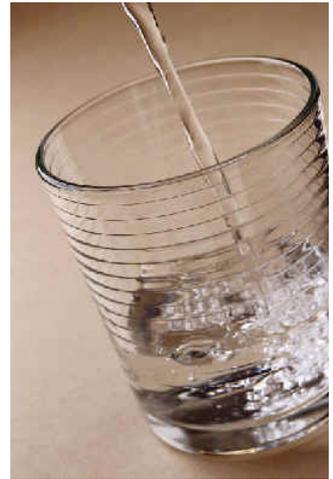
Slow down! Take it easy. If you can, avoid strenuous activity. Not possible? Then do it during the coolest part of the day, usually 4am–7am.

Take a break! Find the shade. Take regular breaks when it is hot.

Stay indoors! When possible, stay indoors and spend more time in air conditioned places. Find a cooling center. Move your exercise indoors. Walk the air conditioned malls.

Shades down/Blinds closed! Blocking out the sunlight will keep indoor temperatures cooler. Do a minimum of cooking. Use the oven only if absolutely necessary.

If you take medications, ask your pharmacist if you need to be extra careful during the warm weather.



The Prevention Topic for June is Summer Safety. To download other Monthly Prevention Topic handouts, visit our website:  
<http://www.nchpdp.med.va.gov/MonthlyPreventionTopics.asp>



## Richard Harvey, Ph.D. Program Manager for Health Promotion

### Employee Wellness Gains Strength

Employee wellness programs in VA Medical Centers have been operating since the early 1980's, if not before. Many facilities currently have such programs in place, and some are quite robust. NCP has championed employee wellness programs for a number of years and plans to do so even more strongly in the years to come. The good news is that wellness programs for VA employees have been the subject of increasing attention from the highest levels of VHA leadership.

As the Program Manager for Health Promotion at NCP, I will be coordinating the employee wellness efforts for NCP. Among other projects, one of my goals is to work with interested employees and established groups throughout the VHA health care system to facilitate the creation of a comprehensive employee wellness "toolkit." The Wellness Advisory Group is already in the process of preparing an employee wellness program "Start-Up" manual. This process was begun as a result of the excellent national wellness conference held in Tampa, Florida in September 2005, organized by Brenda Burdette, a dietitian at the Tampa VAMC. The manual will include information on steps for getting started, designing program components, strategies for implementation and marketing, and program evaluation. Sample materials and a list of resources will be included. Over time, additional resources will be added, such as a stress reduction program, guides for specific wellness events (e.g., health/wellness fairs, physical activity events, healthy cooking demonstrations, farmer's markets), PowerPoint presentations, a compendium of legal opinions regarding wellness programming, a library of brief wellness email messages, and so on. As each component of the toolkit is completed, it will be posted on the NCP website.

VHA employees may soon be able to participate in a version of the *MOVE!* Weight Management Program; some already are. A recent NCP survey

indicated that 12 Medical Centers are currently operating *MOVEmployee!* weight management programs for their employees, and 14 more are actively planning to do so. A *MOVEmployee!* manual designed to assist facilities in implementing an adaptation of *MOVE!* for employees is currently under development by NCP, and should be available by mid-July.

Another exciting development is the recent collaboration between NCP and the Office of Occupational Health in the Public Health and Environmental Hazards Strategic Health Care Group at VA Central Office. NCP and the Office of Occupational Health are together examining possible ways to strengthen and evaluate VA employee wellness programs. There is also interest and participation in these efforts from the VA National Center for Organizational Development. The overall goal is to strengthen employee wellness programs and raise their importance and visibility in the VHA. We can all look forward to the products of this collaboration.



**On June 29, 2006, Dr. Madhu Agarwal visited VA NCP and was given an update on the status of *MOVE!*, including plans for future focus and evaluation.**

## Canandaigua/ROPC Wellness Committee Sponsors "Pounds A Go-Go" to Help Employees Get Healthy

**O**n Wednesday April 5, Medical Center Director Craig Howard and employees from the Canandaigua VA Medical Center and Rochester VA Outpatient Clinic kicked off the "Pounds a Go-Go" program. "Pounds a Go-Go" consists of twenty teams (each team is comprised of five staff members) with the goal to improve health by losing weight. Over the course of a twelve week period, the teams will compete for prizes based on their success with losing weight and body fat.

Each week, the participants will be individually weighed. All participants who lose at least one pound will be eligible for a weekly prize drawing. At the end of the twelve weeks, awards will be presented to the individuals and teams that had the

most success in losing the most percentage of weight and body fat. Throughout the course of the twelve weeks, participants will also be provided handouts and information on exercise, healthy recipes and tips to reduce weight.

The program is being coordinated by the Canandaigua VAMC Wellness Committee under the auspices of the Canandaigua VA Employees Association.

Article submitted by:

**Dan Ryan**  
Customer Service/PAO  
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Canandaigua VAMC participants of "Pounds a Go-Go" program

## Motivational Interviewing, An Approach to Promote Healthier Behavior

Cathy Cole, MSSW, LCSW

VA Medical Center, Durham, North Carolina



Motivational Interviewing (MI) is defined by the authors of the approach, William Miller, PhD, and Stephen Rollnick, PhD, as "a client-centered, directive method for enhancing intrinsic motivation for change by exploring and resolving ambivalence". Ambivalence generally exists when we are being asked to make health behavior changes and is what we often label as 'non compliance'. Exploring ambivalence and allowing our patients to explore reasons for change are the primary ways of using MI.

This is a highly practical and applicable approach with increasing evidence for its efficacy in health behavior change. Medical outcome studies involve increased compliance in managing cardiovascular health following a cardiac event, better control of diabetes, increased HIV prevention behaviors, and increase in fruit and vegetable intake.

While this approach is being utilized by health care professionals, it has also been successful as a peer provided intervention. Body & Soul is a wellness program developed for African American churches. It is based on 10 years of successful programs in African American churches across the country. Two programs were combined to create Body & Soul: "Black Churches United for Better Health" and "Eat for Life," both of which have demonstrated success in improving the eating habits of African Americans, namely by increasing fruit and vegetable intake.

Peer counselors were trained in using an MI approach and ministers promoted the program in church services. The project was conducted in cooperation with the University of North Carolina, Emory University, the National Cancer Institute, and the American Cancer Society.

After six months in the program, participants in Body & Soul consumed significantly more servings of fruits and vegetables than those in the control group, averaging about a half to 1 ½ extra servings of fruits and vegetables per day. Program participants also consumed fewer calories from fat, expressed greater confidence in their ability to eat fruits and vegetables, and experienced an increase in support from friends and family for eating fruits and vegetables.

[http://www.asaging.org/cdc/module7/phase3/phase3\\_3b\\_e3.cfm](http://www.asaging.org/cdc/module7/phase3/phase3_3b_e3.cfm)

What does MI involve? Importantly, MI is considered very appropriate to use in brief medical appointments.

There are several important facets to an MI approach:

- The relationship with the patient is viewed as a partnership.
- Patients are not just told what to do; their ideas about importance and confidence for change are elicited.
- Discrepancy between what is currently happening around health behaviors and what could be possible with change is developed.
- The plan for change is developed with the health behavior practitioner providing information as needed and is tailored to what the client can reasonably commit to.
- You are available to offer your **expertise** but not defining yourself as the **expert, the only one who can make a plan.**
- There are some specific ways to 'elicit change talk'

Here are some examples of Motivational Interviewing methods. The role of a nutritionist is used for the example.

### The Ruler Exercise

The 'ruler' exercise is widely used in Motivational Interviewing to better understand ambivalence and elicit change talk.

Essentially, the interviewer asks the client three staging questions and then uses the answers to facilitate a discussion on the topic at hand.

**"I" is for interviewer; "C" is for client.**

To set the stage: you have a client who is 65, lives alone, uses eating out as a way of increasing social contact. You are the nutritionist focusing on overall health, managing blood pressure, diabetes, and heart disease as risk factors for this relatively healthy person. You already know the client eats mostly in fast food places and consumes foods high in fat and few vegetables; has milkshakes and frozen desserts that are low in cost. She is on a small, fixed income and uses coupons for discounts. You have summarized what you know and, with permission, offered some concern over the high fat, low vegetable diet. The client says she is aware of this information.

You might start the conversation this way:

**I--** 'Thanks for continuing to look at this with me. You are a pretty healthy person and we want to reinforce that. So, just

*(Continued on next page)*

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for us to focus on this in a slightly different way, I'd like to ask you three questions, if that is okay with you. (C says okay).

Here are the three questions and they are on this sheet as well for you to look at; read each one and then come back and put a number to each question:

On a scale of 1-5, when 1 is not important and 5 is very important, how important is it to you to eat in a way that supports your health?

On the same scale, how confident are you that you that you can do this?

And finally, on the scale, how ready are you to do this?

**C--**says 5 on importance, 2 on confidence and 2 on ready.

**I--**Tell me about the 5 on importance.

**C--**Well, I know all the information and I believe it.

**I--**Okay, so you know this is important; so tell me about the 2 on confidence.

**C--**I don't think I can do any better than I am doing, with my fixed income and not wanting to be home alone.

**I--**So you know it is important but your income and need to be around others is important and you don't think you could do better. Okay, we'll come back to this. Why the 2 on readiness...although that seems premature to ask right now.

**C--**Yes, I'd be more ready if I thought I could do better!

**I--**I get it on that! So, back to this confidence area. What would help move that 2 up to just even a 2.5, if you decided to tackle this at all?

**C--**Maybe I could do better if I had a guideline on how to eat at fast food places which are the only places I can afford. And, I don't want to give up all the stuff that tastes so good! Food is a pleasure for me.

**I--**So if you and I looked at some of the menus from these places and did a plan for you that would involve better eating AND keep some of the fun, you would feel more confident.

**C--**That's right and more ready.

**I--**Great idea and we can start that right now since I keep the menus from lots of places. Would you like to do that now?

**C--**Yes.

Now the two of you are partnered on this, the client has generated her own solution and you are ready to lend your expertise to tailor a plan for her.

Pros vs Cons; Advantages vs Disadvantages; Good Things vs Not so Good Things

This method provides a format for assessing both sides of ambivalence. Now let's take the same client scenario and employ this method of eliciting change talk.

You might start the conversation this way:

**I--** 'Thanks for continuing to look at this with me. You are a pretty healthy person and we want to reinforce that. Of course, you will be the only one who can decide on making any changes. So, just for us to focus on this in a slightly different way, what might be some disadvantages for trying a lower fat diet?

**C--**Well, food doesn't taste so good to me now and the burgers, fries, and shakes, I can at least taste!

**I--**So, the higher fat has better taste; and what else, just list all that might be on this side of the list.

**C--**Okay. I have a hard time digesting stuff like salads and I think those things cost more. That's it I think.

**I--**So, disadvantages...taste not as good, digestion harder, and higher cost. And what about advantages for the lower fat diet?

**C--**Hmmm, that is harder. I know it is healthier for me; even though the other, it tastes better, I am more sluggish later and don't stay as active. My daughter would get off my back!

**I--**So, healthier, easier to stay active and your daughter....tell me about that.

**C--**Well, she is always on my case about what a poor example I am to my grandchildren, you know, not wanting them to eat only junk food and then they see Grandma doing it....even at their house..chips, cookies.

**I--**Hmm, so disadvantages are taste, digestion, and cost. And advantages..healthier, more energy/more active and really importantly to you, a good role model for your grandchildren!

**C--**I think the grandchildren are the most important reason.

Note that disadvantages are elicited first then advantages and they are summarized in that order.

Evocative questions about change are just open ended questions that assume ambivalence and help the client explore this.

When you are using MI as an approach, there is fluidity to the interview and a weaving in of the various ways to elicit change talk. In my examples, they are illustrated one by one just for the learning.

Now, back to our client. As you recall, she is 65, lives alone on a fixed income and eats out at mostly fast food places for socialization and for budget. You are the nutritionist focusing on overall health, managing blood pressure, diabetes, and heart disease as risk factors for this relatively healthy person.

**I--**Hmm, so disadvantages are taste, digestion and cost. And advantages..healthier, more energy/more active and really importantly to you, a good role model for your grandchildren!

**C--**I think the grandchildren are the most important reason.

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**I--**So, if you were going to be motivated by anything, it would be for your grandchildren.

**C--**Yes, but I am just not sure I can figure this out.

**I--**Okay, so you are stuck on how to figure this out but you are willing to look at some changes. Where might be a good place for us to start?

**C--**Well, when I go now I know what I am going to order and I don't hold up the line. If I change something, then I'll be standing there trying to figure it out and then people will be upset with me for taking too much time.

**I--**So you need information ahead of time. I have the menus from the usual fast food places if you would like to look at them together.

**C--**Yes, then I could already know what to do and when I am with my daughter and grandchildren, I could set a good example.

From here, the work would be to make choices (a change plan!) and the final part would be eliciting commitment.

**I--**Okay, you have a plan you can follow. When do you think you might start?

**C--**I'm having lunch when I leave; I'll start now.

**I--**Great! And we can check in the next time to see how it is going.

Perhaps this brief overview of how using a Motivational Interviewing approach fits into promoting healthier behavior has peaked your interest! If so, you can gain more information on MI by visiting the MI web site:

<http://www.motivationalinterview.org>.

Two excellent book references are:

Motivational Interviewing, Preparing People for Change, Miller and Rollnick, Guilford Press, 2002

Lifestyle Change, Rollnick and Dunn, 2003 Elsevier Limited, <http://www.elsevierhealth.com>

## **MOVE! Update** **Ken Jones, PhD** **Program Manager for MOVE!** **NCP Deputy Director** **(Clinical)**



Our update this month follows Cathy Cole's excellent article on Motivational Interviewing. We know that lecturing patients and/or ordering them to make lifestyle changes are largely ineffective. In addition, there are actually very few medical "treatments" for weight management. Patients who are successful in losing and maintaining weight loss do this by developing and using self-management skills. The *MOVE!* Weight Management Program is an approach and set of tools aimed at assisting veterans in recognizing the need to manage their weight and assisting them in developing or enhancing their weight related self-management tools. *MOVE!* incorporates motivational interviewing techniques throughout the patient's participation in *MOVE!*, from initial risk appraisal and counseling to ongoing goal-setting to maintenance of gains.

We need to remember that *MOVE!* is based on a self-management support system in which assistance is provided in a patient-centered way. We know that the majority of patients offered *MOVE!* decline participation, at least initially. From a resource perspective, this means that efforts are focused on patients who are ready to make changes. Utilizing motivational counseling techniques, however, we open a door to the future possibility to making changes to improve health.

The primary care team in Tampa is one of the earliest and largest *MOVE!* programs. The Tampa team has found that some veterans who decline care in face-to-face visits and are offered our pamphlet, "So, You Are Not Ready Yet," will call back two to three months later, asking to be enrolled in *MOVE!*. This is a very exciting finding and suggests that the Tampa Staff have been successful in building the discrepancy between what is currently happening around weight management behaviors and the health status patients desire for themselves.

The Clinical Resource Manual, the *MOVE!* web-based training, and discipline-specific *MOVE!* Pocket Guides include guidance on motivational interviewing techniques. *MOVE!* refers to this manner of interacting with patients as "Motivational Counseling" to reflect the ongoing integration of the approach to patient interactions related to weight management.

If you or fellow staff members have not yet completed web-based training for *MOVE!*, please consider doing this now. The *MOVE!* website, [vaww.move.med.va.gov](http://vaww.move.med.va.gov), has links to complete the training.

## National Telephone Quit Line Initiative

Joel A. Simon, MD, MPH  
VA Medical Center  
San Francisco, California



As part of a number of VA Public Health Strategic Health Care Group initiatives to address tobacco cessation as a public health priority, a meeting was held in San Francisco on September 21, 2004, that brought together approximately 90 national experts in smoking cessation from within the VA system and from the broader US tobacco control community. One priority area identified at the meeting was the need to decrease smoking prevalence rates among veterans who live far from VA facilities or who may not wish to participate in group smoking cessation sessions. To address the needs of these veterans, the VA has begun to look at how to make use of promising, evidence-based counseling techniques, such as telephone quit lines. Both research and practical work in this area are already underway.

Since the San Francisco conference, VISN 21 and 22 have been participating in "TeleQuit", an on-going research study led by Dr. Scott Sherman examining the feasibility and effectiveness of quit lines. Dr. Anne Joseph at the Minneapolis VA has recently published the results of a study that found telephone-based care superior to routine health provider care for smoking cessation.

The UCSF Smoking Cessation Leadership Center (SCLC), under the direction of Dr. Steven Schroeder and in collaboration with VA Public Health Strategic Health Care Group, is currently conducting a national VA telephone quit line initiative called "VA 1-800-QUIT NOW". Thirty-one VA facilities will be participating in the project throughout the US.

Veterans who participate in VA 1-800-QUIT NOW will receive a plastic wallet card with a toll-free number for counseling. Calls are received at 1-800-QUIT-NOW in DC and then routed back to their respective state quit lines. For smokers who reside in states without a quit line, calls are routed to the Cancer Information Service of the National Cancer Institute. Veterans will be referred back to their

primary care provider for the prescription of evidence-based pharmacotherapies, specifically nicotine replacement and bupropion. Because this is an education and outreach initiative, the program's effectiveness will be assessed qualitatively.

1-800-QUIT NOW cards are also available to providers at non-participating VAs and can be ordered online via the SCLC website, <http://smokingcessationleadership.ucsf.edu>. Please indicate "VA 1-800 QUIT NOW CAMPAIGN/0406" under the billing address to receive one free order. The maximum order is 500 and *supplies are limited*.

For Prevention Coordinators or others interested in smoking cessation, copies of the Proceedings of the September 2004 conference are still available and may be obtained from Dr. Joel Simon at the San Francisco VA (415-750-2093; <[joel.simon@ucsf.edu](mailto:joel.simon@ucsf.edu)> or <[joel.simon@va.gov](mailto:joel.simon@va.gov)>).

For questions about smoking and tobacco use cessation policies and programs in the VA health care system, please contact Dr. Kim Hamlett-Berry of the Public Health Strategic Health Care Group at <[kim.hamlett@va.gov](mailto:kim.hamlett@va.gov)>.

For further information about the Smoking Cessation Leadership Center and this campaign, please visit <http://smokingcessationleadership.ucsf.edu>

## Interdisciplinary Collaboration for Effective Team Work

Susan Payvar, Ph.D. BCIAC

Edith Takaki, R.D.

Jesse Brown VA Medical Center, Chicago, Illinois

Team collaboration in the area of weight management is the hallmark of *MOVE!* programs and ultimately our effectiveness as a team will translate into quality programs/education for our patients.



Susan Payvar

The following is from our experience in working with an interdisciplinary team within a large medical center. Our work primarily involves facilitating some of the group sessions on a monthly basis for patients/clients referred to *MOVE!* program. We work with other diverse professionals across a range of disciplines, including nursing (the team at our facility is led by a nurse practitioner), endocrinology, pharmacy, and recreation therapy.

We have found it is helpful for team members to agree on the differences between an interdisciplinary versus a multidisciplinary approach in working with their patients. This is ideally done in initial stages of forming a team. Furthermore, defining what works best for the team can be based not only on patient care issues, but also taking into account the needs of members for professional autonomy or clarity of roles (Ivey et al, 1987).



Edith Takaki

In a multidisciplinary team, there is clear differentiation of roles of different professionals. In an interdisciplinary team, however, the roles of the different disciplines may overlap, necessitating clear communication among team members. While each team member understands their unique expertise and represents

the values of their particular profession, they also frequently reinforce the teachings of the other disciplines. This makes the team process more interactive and dynamic. Weight management issues, by virtue of their multi-factorial nature, require more of an interdisciplinary approach.

A monthly meeting, or other opportunities for the staff to get together with an agenda which can include the concerns of all involved disciplines, assures that we can communicate effectively and promotes healthy team dynamics. Identifying and agreeing on mutual goals is essential for optimal care of our patients/clients. Finding out the best ways to deliver our expertise to our patients should be a constant goal. Unfortunately, if a mechanism does not exist for regular communication, this leads to feelings of frustration amongst the staff, which can undermine the efficacy of the team process/relationships, as well as the efficacy of treatment outcomes.

In our program, the psychologist and dietician team up, and the nurse practitioners along with other professionals involved teach topics related to their expertise, including opportunities to address patient's concerns about multiple medical diagnoses. During initial contact/orientation with veterans, we all meet as a group. We strive to find ways to better complement each other's teachings. For example, the psychologist's role is to work with team members in improving patient adherence, including enhancing compliance with self-monitoring, assess potential barriers in compliance, and find ways to overcome problematic adherence.

It is best for the team to be highly mindful of delivering the best practices' approach within a culturally relevant/sensitive context. At our medical center which is in an urban location, we have a large minority population attending our classes. Data indicate that conventional behaviorally oriented approaches might not be as effective with minority populations; therefore, practitioners are encouraged to adopt more culturally sensitive interventions (Foreyt, 2002). A dynamic team is more creative and can readily adapt to implementing changes in teachings consistent with the latest research and improving the outcome of the participants. The monthly team meetings mentioned earlier can be an excellent forum to share such knowledge across disciplines.

### References

Foreyt, J.P. (2002). Weight loss programs for minority populations. In C.G. Fairburn & K.D. Brownell (Eds.), *Eating disorders and obesity: A comprehensive handbook* (pp. 583-587).

Ivey, S.L., Brown, K.S., Teske, Y., & Silverman, D. (1987). A model for teaching about interdisciplinary practice in health care settings. *Journal of Allied Health*, pp. 189-195.

## Author in the Room Series: A Resource for Enhancing Clinical Practice

Mary Burdick, PhD, RN—Program Manager for Partnerships



The Institute for Healthcare Improvement and JAMA have initiated a continuing education series called "Author in the Room," sponsored by the Robert Wood Johnson Foundation. Its purpose is to enhance the translation of published research findings into practice. It involves periodic teleconferences featuring the author of an article, and participants can ask questions and make comments. By discussing the issues involved with applying the article's findings in real world clinical settings, participants have the benefit of the collective wisdom of the group and the author him/herself. Pre-enrollment in this *free* program is required. Continuing medical education credits are available for participating.

The teleconference, held on May 31, 2006, was based on an article in JAMA by William Taylor called "A 71 Year-Old Woman Contemplating a Screening Colonoscopy" (<http://www.ihl.org/IHI/Programs/ConferencesAndTraining/Author+in+the+Room.htm?TabId=14>) The woman had been advised by her primary care physician to have a screening colonoscopy. She was generally healthy, although she had osteoporosis, mild rheumatoid arthritis, mitral valve prolapse, and hypothyroidism. She had no family history of adenomatous polyps or colon cancer, and completed all the usual recommended health screenings including FOBT annually or biannually. Dr. Taylor noted that she was beyond the age when family history is predictive of colon cancer risk. The patient was concerned about having a colonoscopy because of an allergy to tranquilizing medications, and because her husband could not drive her home after the procedure.

Dr. Taylor's article briefly discussed evidence supporting screening for colon cancer and recommendations for annual FOBT, or flexible sigmoidoscopy every 5 years, or colonoscopy every 10 years as effective screening tools for otherwise healthy symptom-free adults age 50 and above. He also noted "that any of these screening modalities is acceptable, and that choice of screening modality should be individualized based on available resources and patient preferences." Issues of "community standard of practice" were also discussed in the article.

Participants on the Author in the Room teleconference held a spirited exchange of opinions and concerns. They discussed the complexity of the issues involved for both the patient and provider in the decision to screen or not screen. They also discussed issues surrounding what seem "nearly impossible demands on primary care clinicians in carrying out the recommendations for

colorectal cancer screening". One person mentioned having difficulty in getting the epidemiological data (numbers to screen and treat to save lives) and determining how to present it to patients in a practical manner. Another caller mentioned the shared decision-making model as an excellent one for discussing colon cancer screening with patients. The overall difficulty with communicating with patients was brought up, including that the decisional process often takes place over several visits (becoming time consuming and hard to track). Standardized documentation and clinical reminders were mentioned. The audience discussed merits of moving more towards electronic communication with patients. One suggestion was to send patients a link to an educational video. One source of patient information is the CDC's "Screen for Life National Colorectal Cancer Action Campaign" which may be viewed at [www.cdc.gov/colorectalancer](http://www.cdc.gov/colorectalancer). Dr. Taylor acknowledged concerns about knowing how to discuss screening with patients, but emphasized the importance of knowing how to effectively make changes in clinical practice system-wide for all eligible patients.

The VHA system is more advanced than the general community in the use of electronic medical records and clinical reminders but several challenges remain, including:

1. All screening involves undertaking some minimal risk now for potential future benefit. How much of the rationale should we try to explain to our patients? Do all providers communicate this to their patients and, if so, how? How can it be facilitated?
2. How should situations such as this one be handled? How much time should be spent discussing the pros and cons in a patient centered/shared decision making conversation?
3. Is there a role for utilizing standard decision aids? Might these aids allow us to simplify our messages, reducing inter-clinician variation in communication and improving patient adherence to the recommendation?
4. What system changes could we implement that would be expected to further increase the screening rate?

These are issues that clinical researchers and health educators in VA are working on. As we learn more about what is effective, we'll share it with you.

# Religion and HIV: A Review of the Literature and Clinical Implications

*Kenneth I. Pargament, PHD, Shauna McCarthy, MA, Purvi Shah, MA, Gene Ano, MA, Nalini Tarakeshwar, PHD, Amy Wachholtz, MA, Nicole Sirrine, MA, Erin Vasconcelles, Nichole Murray-Swank, PHD, Ann Locher, RN, and Joan Duggan, MD*  
Southern Medical Journal,  
Volume 97, Number 12, pages 1201-1209.

## Key Points

- Empirical studies suggest that religion and spirituality can be both resources for people with HIV and sources of pain and struggle.
- Practitioners have begun to develop spiritually integrated interventions for this population.
- "Lighting the Way: A Spiritual Journey to Wholeness" is an 8-session, nondenominational, group program that was designed to help women draw on their spiritual resources and address their spiritual struggles in coping with HIV.

## Part 2

### A Case Example: Lighting the Way

Over the past year, we have developed and begun to test an 8-session group intervention for women who have been diagnosed with HIV. The program entitled "Lighting the Way: A Spiritual Journey to Wholeness" grew out of interviews with poor, urban black women with HIV about the impact of the disease on their spirituality as well as a review of the literature on spirituality, HIV, and spiritually based interventions. There are several distinguishing features of this intervention. First, it is tailored to the critical existential issues commonly faced by women dealing with HIV: healing; body and spirit; control and surrender; letting go of anger; shame and guilt; intimacy and isolation; and hopes and dreams. Certainly these issues could be addressed in secular interventions. What makes "Lighting the Way" distinctive is the weaving of spiritual resources and perspectives into these fundamental concerns. Second, the program is multimodal, drawing upon cognitive, behavioral, affective, and relational levels of experience and methods of change. Third, the program addresses both spiritual resources and spiritual struggles; that is, it taps into a variety of spiritual resources (meditation, prayer, ritual, spiritual support) and engages a variety of spiritual struggles (anger at God, stigma from religious communities, feeling punished by God). Finally, although this program was tailored to urban black women, the

**Because of its length, half of this article (submitted by Hugh Maddry, National VA Chaplain Service) is published in this edition. The first half of this article was published in the Spring edition, minus the references. The entire article, including references, is located on our website: <http://www.nchdpd.med.va.gov>**

program is non-denominational and can be used with people from diverse religious backgrounds in the United States and may also be applicable to people with spiritual interests and concerns who do not affiliate with any religious institution. Below we briefly describe the rationale and content of each of the 90-minute sessions.

## Introduction and healing

Because HIV affects people spiritually as well as psychologically, socially, and physically,<sup>60</sup> the biopsychosocial model of disease and treatment is inadequate to the task of assisting people with HIV.<sup>61</sup> Rather, we adopted a biopsychosociospiritual model that is more inclusive of the needs of this population.

In the first session, participants are introduced to an intervention that addresses the many dimensions of their lives, including the spiritual. This session focuses on the meaning of healing and employs activities that draw upon the metaphor of a journey toward wholeness and healing. Healing is described as a process, one that involves struggles and barriers along the way. Participants identify the specific barriers (i.e., roadblocks) that have interfered with their own personal healing journey, and then identify resources (ie, rest stops) that can help them overcome these barriers. Particular attention is paid to the key role spiritual resources may play in this journey to healing, including spiritual supplies (e.g., prayer, religious support, finding hope, gratitude) as well as other emotional, social, and physical supplies. Participants are also introduced to the critical existential and spiritual challenges (e.g., healing, control and surrender, letting go of anger, shame and guilt, intimacy and isolation, hopes and dreams) that must be faced and addressed if the participants are to succeed in their journey. These existential and spiritual themes are the organizing foci for subsequent group sessions. Finally, the participants take part in an opening prayer/candle ritual that will lend continuity to each session.

## Body and spirit

Individuals diagnosed with HIV often report feeling physically violated; every part of their lives seems to be infected by the disease.<sup>62</sup> One interviewee put it this way, "I

*(Continued on next page)*

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truly thought I had HIV tacked on my forehead. I thought someone could just look at me and see it." The primary goal of this session is to help women identify places within themselves that have not been damaged and aspects of life that remain eternal despite the ravages of the disease. Toward this end, participants begin by drawing pictures of their bodies as they see themselves now with the disease, followed by pictures of their souls. They are then asked to discuss the differences in their pictures and consider whether their spirits and souls transcend disease, pain, and suffering. Participants read from spiritual poetry that reminds them they contain a spark of God and that spark cannot be contaminated by anything earthly.

Another goal of the session is to help participants find effective ways to "feed their spirit." Participants are encouraged to identify unhealthy forms of coping (i.e., "spiritual junk food") that may make them feel good initially but ultimately leave them feeling empty. Spiritual forms of "junk food" include alcohol/drugs, abusive relationships, unhealthy eating, and denial of their disease. Participants are then invited to identify and build a "healthy spiritual food pyramid," with activities such as laughter, prayer and meditation, self-care, and nourishing relationships, including their relationship with a higher power. One woman illustrated this process: "I felt like something was missing in my life. All my life I was looking for something to fill that space. And I never found it. Friends, good friends, didn't fill that space. Drugs didn't fill it. And finally, I met God, and I feel like my whole chest is full of flowers." The session concludes with a ritual in which participants use the Biblical imagery of living water to help them replenish their spirits, followed by a group prayer that summarizes the session.

### **Control and surrender**

Links between a sense of control and psychological health and well-being among individuals with a chronic illness have been consistently reported in the literature.<sup>63</sup> In coping with a disease such as HIV, it may be especially important for people to distinguish between those aspects of life that are controllable and those that lie outside the individual's control. In this vein, Thompson et al<sup>64</sup> worked with a sample of HIV-positive men and found that believing in their ability to manage the daily consequences of a specific stressor (consequence-related control) had a greater impact on psychological well-being than believing that they could control the stressor itself (central control).

Based on this literature, this session helps participants identify and distinguish between those aspects of life that are under their control (e.g., diet, exercise, taking medication, participation in hobbies) from those aspects of life that are beyond their control (eg, final outcome of treatment, how family copes with illness/death). Group members are encouraged to focus on those things over which they have control and actively surrender those things

that they cannot control. One interviewee illustrated this process: "Some things you can deal with, but if you know you can't change something, that's like it's daylight outside. I cannot go and turn daylight into night. So why stress myself out?" Active surrender is not to be confused with passivity, hopelessness, or resignation. Rather, participants can let go or surrender the uncontrollable aspects of their lives to a benevolent external force, such as a higher power or God. After identifying potential barriers to the process of surrender (eg, fear of loss of control, sadness, anger), the group members participate in a guided imagery relaxation exercise in which they are encouraged to surrender those things beyond their control to God. Exercises similar to this one have proven helpful in other programs.

### **Letting go of anger**

Anger is an emotion that often accompanies the diagnosis of HIV<sup>66,67</sup>, anger has also been associated with faster progression to AIDS.<sup>68</sup> Anger at God and distress associated with that anger may be particularly relevant to people who are seropositive. One interviewee described her anger and confusion toward God: "I asked God, why me? I wasn't using drugs, I wasn't drinking, I wasn't in the streets, I was in my house with my kids. Why did you give me this disease? I want to die now, and what about my kids, what's going to happen to them?" Although no studies have specifically examined anger at God among people with HIV, a few studies have demonstrated that anger at God is not uncommon in response to major life crises.<sup>27,69</sup> And, as noted earlier, anger at God and other signs of spiritual struggle, have been associated with declines in physical health and mental health.

The main objective of this session is to validate the participants' experiences of anger, while encouraging them to let go and move beyond it. This goal is approached through a variety of cognitive and experiential activities. First, because anger repression has been associated with poorer health among HIV patients,<sup>70</sup> participants engage in a discussion about adaptive and maladaptive ways to express their anger. Second, participants identify the targets of their anger and are asked to consider whether these targets are appropriate or inappropriate. Third, participants engage in a discussion about anger at God. In this discussion, anger toward God is normalized and validated; participants are reminded that "God is big enough to handle their feelings." Finally, group members participate in an experiential activity in which they draw on their relationship with God to let go of any self-destructive anger they may be harboring.

### **Shame and guilt**

Individuals living with HIV often experience shame and guilt.<sup>71,72</sup> These feelings are all the more prominent among

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women who anticipate leaving their children behind when the illness claims them.<sup>73</sup> Shame and guilt have been associated directly and indirectly with higher levels of depression, avoidance coping, hopelessness, alienation, and loneliness among people with HIV.<sup>74,75</sup> One interviewee described the despair she felt after her diagnosis: "I felt like I wanted to die. I wanted it to happen now. I wanted to throw myself under a car. I wanted to take all the pills and kill myself." Conversely, the disclosure of shameful and guilty feelings may help to alleviate the burden of these emotions.<sup>72,76</sup>

The purpose of this session is to normalize feelings of shame and guilt, explore their impact on healing, and encourage emotional potential messages of shame (e.g., "You are a bad disclosure, self-acceptance, and forgiveness. The first half of the session focuses on identifying person") and guilt ("I am unforgivable"), including spiritual messages of shame and guilt (e.g., "I have let God down").<sup>77</sup> The second half of the session attempts to help the women move toward spiritual and emotional healing. First, to counter the negative internalized messages of shame and guilt, affirming spiritual responses (e.g., "I love you, I accept you as you are, I will not leave you, I forgive you, I want you to be whole, I am always with you, I know you and I think you are beautiful") and potential barriers to these affirming messages are presented and discussed. The women engage in a two-way journaling exercise in which they write a letter to God about their true feelings and listen for God's response. If they receive a response they are asked to write about that as well. Then, in an exercise intended to encourage disclosure, the women are guided through a visualization in which they imagine shedding the weights of shame and guilt by immersing themselves in a healing lake.<sup>57</sup> Participants are encouraged to disclose their feelings of shame and guilt to God, to safe figures in their lives, to themselves, and to seek forgiveness.

### Isolation and intimacy

Empiric studies suggest that the stigma associated with HIV can lead to punitive and prejudicial thoughts and actions by others.<sup>78</sup> Women, particularly black women with AIDS, are even less likely to be supported by families, partners, and friends.<sup>79</sup> One of our interviewees spoke powerfully of this stigma: "In people's book you're dirty. Yeah, that's what you're living with. It makes you feel dirty. People don't know how you received HIV. They speculate, just assume. They treat you like nothing." According to another interviewee: "A lot of people with HIV deeply in their hearts want to talk about it. Their experiences, their traumas, their glories, and

they don't have a chance. They die and they don't have a chance for anyone to listen to them. I wish everybody has that chance." Stigma and the lack of social support can lead to declines in preventative behaviors (e.g., condom use), higher rates of depression, and even suicidality.<sup>78,80</sup>

This session is designed to promote social intimacy and support by normalizing the experiences of isolation, identifying the risks and benefits of intimacy, exploring the disconnection from God that can result from living with HIV, and beginning to move toward greater closeness with others. Group members begin by discussing their own feelings of isolation, including feelings of abandonment from God. Nevertheless, the need for intimacy remains. Participants are encouraged to talk about their fears that accompany reaching out to others for greater intimacy. For people with HIV, interpersonal closeness comes with the risk of stigma and rejection. Thus, it takes a "leap of faith" to connect with other people in the hope that they can be there for them. Group members read stories of people who have been successful in garnering social intimacy. They also generate a list of potential sources of spiritual as well as interpersonal support. One woman described the support she found from talking with God: "When I am in the street, I am always whispering to myself. But when I'm whispering to myself, I'm really talking with the Lord, asking Him to stay with me. Wherever I'm going, I'm asking Him to guide me back safe." Through a group activity in which participants pass a ball of yarn to each other, they are reminded of how they have become interconnected with each other. The session concludes with a prayer to thank God and ask for His presence in the participants' journeys to healing and connectedness.

### Hopes and dreams

Research on the impact of HIV has neglected the importance of hope in the face of this pervasive life-altering event.<sup>81</sup> However, it is important for people to sustain a sense of meaning and hope during this traumatic time.

One woman we interviewed illustrated how spiritual resources can play an important role in the movement toward hope. She stated: "I know He's looking at me, and He's going to make a better day each day. He's going to make it better and better. Because He's alive and He's right here, everywhere. We do everything through him."

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Social intimacy and support is promoted by:

- Normalizing the experiences of isolation
- Identifying the risks and benefits of intimacy
- Exploring the disconnection from God that can result from living with HIV
- Beginning to move toward greater closeness with others

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The challenge for people grappling with HIV is to acknowledge their limitations while simultaneously realizing that hope and meaning remain a part of their lives.<sup>81</sup> In this session, participants acknowledge and discuss the dreams that have been lost as a result of their infection, including dreams that they held sacred (e.g., watching their children grow up; being part of a community of faith). They are then encouraged to identify dreams that are still possible despite their illness. Participants are asked to distinguish possible dreams from false dreams (i.e., those that cannot be achieved or those that can lead them in destructive directions). To illustrate the experience of dangerous dreams and hopes, they watch a clip from a movie that describes a depressed and lonely woman who becomes involved in an abusive relationship. Finally, the women identify new dreams that are sacred in character; that is, dreams that allow them to see God's purpose and meaning in their lives. They read and discuss the true story of a young woman who became a quadriplegic after an accident and was able to find a new spiritual purpose for herself over time. The women are then asked to consider how God might help them change and pursue their own dreams.

### **A review of the journey**

The final session reviews the journey to healing. Participants are given symbols to remind them of the barriers they have addressed and the resources they have been able to access. They are also given "travel kits" so they can be reminded of their resources by referring to their symbols when they face difficult times in the future. The symbols are: a compass to remind them of the need to find a true direction along the path toward wholeness and healing; a cup to help them recall that they can replenish themselves with living water when their spirits become dry; a card containing the serenity prayer to recall the importance of distinguishing the controllable from the uncontrollable; a rock to remind them how anger may seem strong and powerful at first but becomes a burden over time that can be released; an umbrella to help participants remember the sheltering function of God's love in the face of feelings of shame and guilt; a piece of yarn to remind them of their connectedness to God and each other; and a dream catcher to remind participants that despite their illness they still have sacred dreams that can provide them with meaning and purpose in their lives. The program ends with a prayerful poem entitled, "Somewhere Within," that illustrates an individual's growth through the various seasons of life.

### **Conclusion**

A small but growing body of empirical evidence indicates that religiousness and spirituality play an important role in the health and well-being of people living with HIV. Further studies are needed that examine the longer-term impact of religiousness and spirituality, the specific coping resources and burdens that contribute to the positive or negative effects of these phenomena, and the mechanisms through which religiousness and spirituality affect health status. Nevertheless, the data are sufficiently compelling to suggest that we can begin to move (albeit cautiously) from research to practice. Researchers and practitioners have begun to design, implement, and evaluate spiritually integrated forms of intervention for people dealing with a variety of physical and emotional problems.

It is time to extend this work to people facing HIV. "Lighting the Way: A Spiritual Journey to Wholeness" is not the only spiritually sensitive program that could be designed for people with HIV. It does, however, illustrate how spiritual coping resources and spiritual struggles can be addressed within the context of the major existential issues so commonly raised by the encounter with this disease. We believe the program could be helpful to people from a variety of religious traditions and also those with spiritual interests and concerns who are not affiliated with any particular religion. However, the program would be contraindicated for those who have no interest in talking about spiritual matters, those who would prefer a program linked exclusively to one religious tradition, and those with serious physical or psychological problems that would preclude their ability to attend or participate meaningfully in a group (eg, alcohol/drug abuse, dementia, active psychosis). Clearly, the next step in this evolving area of research and practice involves empirical evaluations of the efficacy of spiritually integrated treatments, such as "Lighting the Way." Are spiritually integrated interventions for people with HIV helpful? Do they add a valuable component to existing models of treatment? Are they particularly helpful to specific groups? These are some of the exciting questions that grow out of the attempt to integrate the religious and spiritual dimension more fully into our efforts to understand and treat people confronting HIV.

In the hopes and dreams session, participants acknowledge and discuss the dreams that have been lost as a result of their infection, including dreams that they held sacred.



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