

Health *POWER!* Prevention News

Spring 2006

In this issue:

American Heart Association Wear Red Day—VAMC Bath, NY.....	Page 9
Employee Wellness Program—VA Black Hills Health Care System	Page 10
Employee Wellness Program Open House—VAMC Martinsburg, WV.....	Page 11
Crystal Methamphetamine: the Up's and Down's.....	Page 12
Diabetes Foot Screening Prevention	Page 14
Religion and HIV: A Review of the Literature and Clinical Implications.....	Page 16

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NCP Mission Statement

The VA National Center for Health Promotion/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



Partnership: A relationship between individuals or groups that is characterized by mutual cooperation and responsibility, as for the achievement of a specified goal.

Webster's definition of partnerships nicely captures the essence of what the Department of Veterans Affairs and the Department of Health and Human Services (HHS) have entered into to address the twin problems of obesity and diabetes among our veterans and their families in the communities in which they live. Secretary Nicholson and Secretary Leavitt have spoken of the need to reach out beyond the usual bounds of our health care facilities into the communities and environments where people live, work, and play in order to address these concerns. While we as health care providers have an important role to play in helping our patients improve their eating and physical activity patterns, we won't be able to solve these problems without also looking to family members and communities as partners in this effort.

Thus a new initiative called HealthierUS Veterans has been born. The name is based on the Presidential initiative called HealthierUS (www.healthierus.gov), which is designed to help Americans live longer, better, and healthier lives. The President's HealthierUS initiative helps Americans take steps to improve personal health and fitness and encourages all Americans to be physically active every day, eat a nutritious diet, get appropriate preventive services, and make healthy lifestyle choices. HHS has developed a program, called Steps to a HealthierUS, to fund competitively selected communities across the nation to implement actions and policies to help people take these steps.

HealthierUS Veterans focuses specifically on veterans and their families, nearly 70 million people (a quarter of the total US population). Working in partnership across the two agencies, VA and HHS staff have developed a set of program activities, including a

communications campaign, collaboration between the Steps to a HealthierUS communities and the VA facilities located within or nearby to them, a volunteer corps of veterans and family members called Fit for Life, promotion of the *MOVE!* weight management program to health care providers outside VA, and a "Prescription for Health" (a paper prescription for a walking program and a pedometer, or for a "rolling" program and wheelchair odometer, for those in wheelchairs).

To encourage fun while trying to lose weight, several groups have set up challenges among their members, to see who can walk the longest distance or lose the most weight. Several VISNs and medical centers have been doing these challenges for a while – the Canandaigua, NY facility has had virtual walks to New Orleans and Hawaii and celebrated with a Mardi Gras and a luau when they reached their goal. This year VISN 2 is walking "back in time," turning the calendar back decade by decade as they accumulate thousands of steps. So far, they're back to 1959 (you remember, *North by Northwest*, Buddy Holly, poodle skirts, and saddle shoes). Several of the Veteran Service Organizations (VSOs) have developed a challenge among themselves to see which group can lose the most weight in the coming year – they're calling it "Down with the Pounds."

There are many ways that you and your facilities can partner with local community groups, such as the YMCAs and YWCAs, the parks and recreation departments, senior centers, and others. If your facility has large grounds, mark off a walking path and indicate the distances along the way, then invite staff and veterans for walks around the campus. Ask local farmers to set up a

(Continued on page 4)

(Continued from page 3)

farmers' market at the facility during the growing season. Offer "walk and roll" events throughout the year to encourage physical activity for both able and disabled veterans and staff. Brighten the stairwells with lighting and artwork and put up signs encouraging everyone who is able to take the stairs, at least for a flight or two. Support healthier food choices in the canteens. I'm sure you all can think of many other ways to make healthy eating and physical activity routine parts of your day.

Partnering with local communities, organizations, and Federal agencies to promote obesity and diabetes prevention and treatment and healthy lifestyle choices is one of Dr. Perlin's "Eight for Excellence" strategies. The National Center for Prevention is the lead office for this initiative, as it is for the HealthierUS Veterans initiative, but we can't make things happen without all of you as our partners. Working together, with *mutual cooperation and responsibility*, we can strive to *achieve a specified goal*, that of healthier living for veterans, their families, and ourselves.

Linda



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

This is a very exciting time for the *MOVE!* team here at NCP as we see the great deal of work you are doing and progress you are making in the field to implement *MOVE!*.

The *MOVE!* Handbook: The *MOVE!* Handbook was signed by Undersecretary for Health, Dr. Perlin, on Monday, March 27. This directs the field to initiate *MOVE!* and provides details on the program and reporting mechanisms.

Staff Training and Discipline Representation in Training: We heard from the field that health care staff frequently reported feeling unprepared to address weight management issues with patients. In collaboration with EES, web-based training was developed to address this need. To date, 1200 staff members have completed *MOVE!* training. Right now we have a ratio of about 1 staff member who has received training to every 8 patients who have completed the *MOVE!*23. As our enrollment increases, we need to insure that primary care and other relevant *MOVE!* team support staff have completed the *MOVE!* training. We at NCP believe that this training is relevant for every Primary Care Team member, and we encourage you to have your colleagues complete the training.

We know that obesity is a multifactorial disorder, there is no single cause and many factors contribute to the problem. *MOVE!* has been developed with a multidisciplinary approach to address as many of these factors as possible within the context of a health care system. The online training is discipline-specific. Here is the breakdown of discipline/staff focus areas of training and number of staff who have completed the modules: Nursing-555, PC providers (Physicians, NPs, PAs)-227, Dietitians-189, Behavioral Health-109, and physical activity-120.

Patient Activity: As of today, 9,431 patients have completed the Intranet version of the *MOVE!*23. With our friends at the VHA Service Support Center, *MOVE!* Data Cube(s) have been developed to provide benchmarking of *MOVE!*-related work. The first of these cubes tracks patient care activity through the *MOVE!* stop codes. In February of last year, we had 538 *MOVE!*-related Stop Code visits for 317 patients. That compares to 6,207 visits in February of this year for 3,417 unique patients. The *MOVE!* Data Cubes are being expanded to include clinical data so that we can track program effectiveness.

(Continued on page 7)

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



NCP Website Update

Work has started on the redesign and format change for the NCP internet website. In current discussions, the new site will have 7 major content areas. Since this is a work in progress, that may change. Our focus for the internet site (www.nchpdp.med.va.gov) is to be a health promotion and disease prevention resource for veterans, non-VA health care professionals and the public. Concomitantly, we are working on redesign and content areas for the NCP intranet site. Our focus for the intranet is to serve as that same health promotion and disease prevention resource for our VA clinical and non-clinical staff. Long-range goals include adding sections for best practices, educational presentations, a repository for documents, information from the field and even a discussion board.

On the current websites, new items are being added on a regular basis. The website is designed to help with your prevention activities. If there are items and information you would like to see added as we continue work on the new site, please send them to me at Pamela.DelMonte@va.gov.

Field Communications Update

Monthly conference calls continue. Mark your calendars for the 2nd Tuesday @ 1pm Eastern (1-800-767-1750 #18987). Monthly topics have been posted for April through June. Topics for July through September include Healthy Aging, Immunizations and Healthy Eating.

Plans are underway for a web-based assessment to evaluate our health promotion and disease prevention program, including the monthly conference calls, the website, and prevention coordinator/VISN preventive medicine leader resources.

We have received many requests from the field about *MOVEmployee!* asking if there is a manual or start-up guide. Several facilities offer *MOVEmployee!* as part of their employee wellness or occupation health program. A *MOVEmployee!* manual is under development and will address methods for administering the program as either part of wellness or occupational health.

Employee Health and Fitness Day is Wednesday, May 17, 2006. NCP is preparing tools for planning, marketing and promoting healthy activities and behaviors which will be available for use on our website. **Don't forget to send NCP a short summary and pictures (jpeg format) of your activities** for the 2006 edition of the Wellness Digest. A template will be available for reporting.

Have you heard about HealthierVA Employees? No? HealthierVA Employees = Employee Wellness. HealthierVA Employees is an umbrella term to capture the varied and numerous wellness activities throughout the VA and utilizes concepts from the Secretary's initiative. HealthierUS Veterans focuses on obesity and diabetes in veterans and their families and *MOVEmployee!*, a multifaceted weight management program (based on the *MOVE!* Weight Management Program for Veterans). The HealthierVA Employees logo will be available for download from NCP's website to be used on Employee Health and Fitness Day materials. Feel free to use it when marketing your wellness program activities.

**National Public Health Week
April 3-9, 2006**

**Designing Healthy Communities
Raising Healthy KIDS
<http://www.apha.org/nphw/2006/>**

Mary Burdick, PhD, RN Program Manager for Partnerships



Lifestyle Interventions for Prevention of Diabetes

One of the National Observances in March highlights diabetes. Because the population we serve in the VA is older, it has a high prevalence of diabetes. The VA and HHS Secretaries' Initiative addressing obesity and diabetes prevention, HealthierUS Veterans, was launched in February this year.

A recent article, *Preventing Diabetes in the Clinical Setting*, JGIM 2006; 21:1, 84-93, reviewed seven recent major diabetes prevention trials in four different countries that used lifestyle changes or medications. The review primarily focused on the four lifestyle intervention trials as they proved more efficacious. The authors looked at the main components of successful interventions and which aspects are most adaptable for use in clinical practice.

The lifestyle interventions encouraged participants to set modest weight loss and physical activity goals. Participants were offered individualized counseling, behavioral contracting and self-monitoring. Families were included and participants were followed up to promote successful outcomes. Participants lost a modest amount of weight, but the reduction in diabetes incidence was quite significant. The review found "prophylactic medication also reduced diabetes risk; however, lifestyle changes were more effective and are recommended as first-line strategy." Based on evidence from this review, the authors suggest that "clinicians should recommend behavior changes for asymptomatic patients at high risk for diabetes."

Here are some of the strategies that may be most useful in clinical settings. High-risk patients can be identified by a combination of "judicious screening by fasting glucose" and clinical characteristics (such as BMI, age, family history, or high-risk minority groups – African American, Hispanic, Native American, and Asian-Pacific Islanders). Important elements from the

strategies used in the diabetes prevention trials can be used in counseling patients on physical activity and dietary change during primary care visits. Family members can be enlisted. "Modest goals for weight loss and physical activity are appropriate; behavioral contracting and self-monitoring may enhance self-efficacy and outcomes for patients." Effective clinician-patient relationships ("coaching relationships") can facilitate patients' behavioral change. The authors noted that, despite implementation across different cultures, "these lifestyle prevention studies demonstrated remarkably consistent outcomes." However, we do need to continue our efforts to tailor diabetes prevention efforts for particular participants and settings. System level innovations that support patient follow-up efforts, feedback to clinicians and healthy lifestyles in the workplace were also strategies that were suggested for translating into organized clinical practice settings. This report suggests that we need comprehensive programs that assist patients in their lifestyle modifications, similar to the *MOVE!* program.

The cost-effectiveness analyses of one of the lifestyle intervention trials, the Diabetes Prevention Program, showed that "diabetes can be prevented by lifestyle modification, at costs generally considered acceptable to society". Because veterans who use the VA are generally in the VA system for the rest of their lives, savings may accrue through prevention or delay of diabetes. The authors suggested that group interventions in clinical settings were less costly and called for further investigation. Many VA staff already have experience in conducting group counseling sessions. **A key take home message is that lifestyle interventions work to prevent diabetes and these interventions can be cost effective.**

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National Primary Care ~ Preventive Medicine Conference

Primary Care – Behind the Lines

July 18 – 20, 2006, Hilton

Alexandria Mark Center,

Alexandria, VA

Telephone: 703-845-1010; Fax: 703-845-7662

This conference is bound to be stimulating for clinical and administrative staff, featuring national experts and many important topics related to patient centered care in the primary care setting. The NCP will host a Prevention Track during the concurrent sessions, highlighting useful strategies for implementing programs including MOVE!, immunizations, colorectal cancer screening and wellness. EES will send the formal call for posters and conference announcement. We hope you will plan to attend and submit posters depicting your successful prevention projects. Funding should be requested at your local facility.

Now Available - VHA Smoking and Tobacco Use Cessation Report

The Public Health Strategic Health Care Group is happy to announce that the final VHA Smoking and Tobacco Use Cessation Report is now available on the Healthcare Analysis and Information Group website at http://vaww.va.gov/haig/smoking/STUC_2005.pdf. The National Smoking and Tobacco Use Cessation Survey was sent to each VA facility in August 2005. The purpose of the survey was to gather data to provide VHA national, regional, and local leaders with a clearer description of the current state of smoking and tobacco use cessation across the VA health care system. The Healthcare Analysis and Information Group (HAIG) provided valuable technical support. If you have technical questions about the survey or report, please contact Marybeth Matthews of the HAIG at (414) 384-2000 ext 42359. If you have comments or questions about the report, please contact Dr. Kim Hamlett-Berry.

MOVE! Update

(Continued from page 4)

Barriers for MOVE! Implementation: The field has clearly identified that the \$15 co-payment for category 7 & 8 patients is a barrier. Our proposal to waive this fee has been reviewed by the Health Systems Committee and will be sent forward to the National Leadership Board for review. As waiving the co-payment requires changing Federal Regulations, this is necessarily a very formal, deliberate process that will eventually require publication in the Federal Register for citizen input. We will keep you posted on the progress.

Weight Management Performance Measures: NCP is working with the Office of Quality and Performance to develop weight management performance measures. Performance measures often drive patient care in the VA, and resources are typically allocated with respect to these measures. As we go forward with proposals, we will seek field input into developing these measures. VHA is already leading the way in treating overweight and obesity. At the same time, we have a long way to go in this process; but NCP will strive to recommend reasonable performance goals that can be phased in gradually.

HealthierUS Veterans: As noted by the Director, promotion of MOVE! is a key element in the HealthierUS Veterans Initiative. Healthcare systems can only do so much to provide self-management tools to our patients. Like our progress in smoking cessation, we will also need cultural/social changes to occur to help focus Veterans and all Americans on improving health and fitness to avoid preventable disease. Clearly, the HealthierUS Veterans campaign is drawing the attention of veterans to this issue as we are now receiving calls and emails from veterans asking for local contact information for enrollment in MOVE!. We are referring patients to the facility MOVE! Coordinators and Physician Champions. Isn't it great that veterans are actively asking for enrollment in MOVE!?

Nominate Prevention Champions!

<http://www.nchpdp.med.va.gov/champ.asp>



MOVE! Program Pilot Feasibility Trials: Final Results

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

The *MOVE!* weight management program was introduced to the field at a weight management training meeting hosted by the NCP in April 2003. Subsequently, medical centers were asked to consider conducting limited feasibility trials of the program. Approximately 40 VA medical centers and community clinics expressed interest, from which 17 sites were selected to conduct trials. Each site was asked to enroll and treat at least 30 patients. The trials were conducted on a staggered basis between July 2003 and December 2004. The intent was to evaluate the feasibility of implementing *MOVE!* Levels 1 and 2 in a primary care setting, identify the barriers encountered, evaluate the adequacy of the patient and staff program materials, and determine patient outcomes. Each site independently obtained approval for the study from their local IRB and R&D Committees. Sites were asked to use the patient materials provided and implement the suggested program protocols to the extent possible in their location. There were no other restrictions.

All study sites were able to implement the program and treated between 30-70 patients, although the methods and strategies utilized varied widely. Staff found the process of enrolling patients time-consuming in many cases, although 41% endorsed it as “easy” or “very easy”, and only 13% reported the process to be difficult. Many patients required assistance with completing the computerized assessment questionnaire, and staff spent from a minute or two to over 15 minutes doing so. Although the process of following up patients by phone resulted in numerous missed connections (60% contact rate), staff ratings regarding the ease of following patients up were relatively normally

distributed. Staff found the *MOVE!* manual to be moderately useful, although parts such as the scripted encounters were used less frequently than others. Informal staff comments on the *MOVE!* patient handout materials were almost universally positive, in spite of the written ratings being mostly neutral.

Staff evaluations of the *MOVE!* Program were largely positive. Thirty-seven percent indicated they were “very satisfied” with the program, 33% were “satisfied”, and 22% were “neither satisfied nor dissatisfied. Similar results were found when staff were asked if they would recommend the program to other health care providers or facilities, with 37% “strongly agreeing” and another 37% “agreeing” that they would recommend it.

Barriers most frequently identified by staff included lack of designated staff time, lack of formal training, and absence of convenient computer access for patients to take the computerized initial assessment questionnaire. Other impediments mentioned were the necessity of assisting many patients with completion of the questionnaire, excessive length of both the questionnaire and the patient and staff reports that are generated based upon the patient’s responses, and not having any method to automatically transfer the web-based computerized staff report into the patient record system (CPRS).

A total of 564 patients participated in the studies, including 482 men and 82 women. Their mean age was 58, and the average initial weight was 258 lbs. Ninety-nine (17.6%) withdrew from the study, five died, six underwent bariatric surgery and were excluded from the analysis, leaving 454 subjects who completed the six month study. Study sites followed some patients by telephone only,

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treated others exclusively in group settings, and some treated patients using both types of contact. The mean number of phone visits was 3, and the average number of group visits was 4.9.

The overall mean weight loss over the six month period was 4.7 lbs. However, there was wide variation in weight loss among patients (standard deviation = 12.3 lbs). Fifty-three percent of patients lost more than 1% of their initial weight, 22% were unchanged (within $\pm 1\%$ of initial weight), and 25% actually gained weight. Of the entire cohort, 35% lost between 1% and 5% of their initial weight, 13% lost between 6% and 10%, and 5% lost more than 10% of their initial weight. Those who were followed by phone lost an average of 3.2 Lbs., whereas those who participated in at least two group sessions lost an average of 6.9 Lbs.

Seventy-eight percent of patients rated their eating habits either “somewhat” or “much” better, 20% were unchanged, and 2% indicated they were worse. Although 32% rated their physical activity level unchanged and 8% worse, 60% rated their physical activity “somewhat” or “much” better. The vast majority of patients intended to continue their improved behaviors, as 91% of them endorsed a “somewhat” or “very” high likelihood of continuing what they had learned in the program. Thirty nine percent said the program “helped a lot”, with their efforts to lose weight, 33% said it “helped somewhat”, and an additional 19% indicated that it “helped a little”.

Twenty-three percent of patients rated their health at the end of the study as “much better” and 36% rated their health “somewhat better”, with 34% unchanged, and 8% worse. Fifty-nine percent rated their quality of life as “somewhat” or “much” better, 35% said it was “about the same”, and 6% endorsed its being worse.

Patient satisfaction ratings were high, with 32% endorsing being “extremely satisfied, 41%

“very satisfied”, 22% “somewhat satisfied, and only 7% being “slightly” or “not at all” satisfied. Ninety-two percent indicated they would recommend *MOVE!* to others, 7% were “not sure”, and only 1% would not recommend it.

In summary, both patient and staff ratings were relatively high and patient outcomes were moderately positive. Staff felt *MOVE!* could be implemented in VA primary care settings if the major barriers were addressed and dedicated staff time could be arranged. Subsequent program revisions have addressed many barriers; work at the local and national levels continues to find solutions to those remaining barriers. A comprehensive national evaluation of *MOVE!* is being planned and will be an ongoing process as implementation proceeds. The results of that evaluation will inform further improvements in *MOVE!* over time.

American Heart Association Wear Red Day VAMC Bath, NY



Put your hand on your own heart... and
make your own promise to be heart
healthy

Submitted by: Cheryl Knowles, RN, BSN, HNC
Women Veterans Program Manager

Employee Wellness Program—VA Black Hills Health Care System Fort Meade, Hot Springs Rapid City and Scottsbluff CBOC

The Black Hills Healthcare System is located in the beautiful Black Hills of South Dakota and we have 3 unique facilities within 75 miles of each other. Each facility has a slightly different program designed for the needs of their employees. The Black Hills is the site for the Creative Arts Festival this year. So many of our members, who also work on this endeavor, are seeing how art plays an important part in health and wellness.

Our VA Wellness Committee is involved in the 2 medical centers and has added the active CBOC at Rapid City this year. Planning to meet the needs at these 3 sites and expanding to another CBOC in Scottsbluff has been our challenge. We met in the fall of 2005 to plan our strategy, set priorities and create workgroups.

The 4 major workgroups are: 1) Health fair, 2) *MOVE!* for employees, 3) Smoking cessation for employees, and 4) Education to include our brown bag sessions, newsletter and looking into the WELCOA program.

A survey was sent out to all employees with about 90 returns. The information on the survey will help us plan educational and program needs.

A health fair was held at 3 sites in February with a modified health fair at Scottsbluff, Nebraska CBOC. Administrative support was evident by offering 1 hour of AA to those who attended and correctly completed the health quiz. Supervisors were encouraged to allow their employees to attend and

because of this, attendance was brisk with over 200 employees attending at Fort Meade and over 100 employees attending at Hot Springs. The health fair theme was "Love Your Heart" and included displays and booths to promote the health of our employees. Some of the booths and displays included: *MOVE!* for employees; Smoking Cessation; Healing Touch; Massage; Chiropractor; BMI; height and weight measurements; B/P and glucose readings; Nutrition; Employee Assistance Program; Worklife Improvement Team; AHA; ACS; My HeathE Vet; Door Prizes; Raffle for donated quilted wall-hanging; Healthy Recipes with samples, cookbooks, and contest.

We chose to purchase the WELCOA program to support our wellness efforts with education material and newsletter availability. We have not yet realized all the benefits but are working towards implementation.



MOVE! for employees is a program we want to offer our staff and the interest has been good. This will take some additional planning and effort on our part as we *MOVE!* with national efforts to provide this program for staff as well as patients.

The smoking cessation group is working at assisting interested employees in smoking cessation. Support groups are planned with March as the implementation goal. They, too, are working with the national efforts to do the same. This is a data driven effort with many benefits for both staff and employer.

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We have held planned fitness programs at least yearly with good participation either individually or in teams. Additional fitness activities include yearly fun runs and participating in the ACS Relay for Life. This enhances the community connection as well.

Members of the Wellness Program have access to annual lab work of glucose, cholesterol screening and colon cancer screening. Free "Road to Health" t-shirts were available for the first 2 years of this promotion purchased with Canteen Funds and approved by administration.

A fitness room has been established at Fort Meade with plans for one at Hot Springs in the near future.

The VA Black Hills Healthcare System has a long history of caring for the health of its employees. The VA Wellness Committee was created in the 80's and is supported by a group of dedicated employees who see health and fitness for themselves and others as an attainable goal. We are excited to see what the future holds now that we have the support of a National Employee Wellness committee.

VA Black Hills Healthcare System
Julie Jones, MS, RN, C Hot Springs, SD
Ellen O'Grady, RDT, Fort Meade, SD
Co-Chairs

**Employee Wellness Program
 Open House
 VAMC Martinsburg, WV**



Crystal Methamphetamine: the Up's and Down's

Ted Canterbury, CMSW
VA San Diego Health Care System



Crystal Methamphetamine, a central nervous system stimulant, is making a fast stronghold among drug users in the United States. This article outlines some basic facts about the substance, user demographics, effects on the body, brain and mental health, and impact on public health. This information can be utilized by clinicians to assess for crystal methamphetamine use among veterans and to aid in the development of effective interventions.

According to the *2003 National Survey on Drug Use and Health*, 12.3 million Americans have tried crystal methamphetamine (crystal) at least once in their lifetimes. In 2004, 6.2% of high school seniors reported use (*Monitoring the Future Study*). Abuse and production continue at high levels in the west and are spreading eastward. Nationally, 42% of users are female, 58% male; the majority are age 18-25 and live in rural areas. Hawaiian and Pacific Islanders are disproportionately affected, but the majority of users are white (*2005 National Survey on Drug Use and Health, US Dep of Health and Human Svc*).

San Diego has been experiencing epidemic crystal methamphetamine abuse for well over a decade where it dominates in the urban, young adult, gay male population. At the VA San Diego's Alcohol and Drug Treatment program, crystal is second only to alcohol as drug of choice for those seeking treatment. In the HIV program, a documented 15% of the current population abuse substances: 54% primary amphetamine, 27% primary alcohol, 13% primary cocaine, and 6% primary opiate. Faced with this epidemic, our clinic is exploring some *avant-garde* steps to reduce individual harm and the impact of crystal methamphetamine use on public health. Through education, it is hoped that the following information will raise awareness for those facing a growing problem of crystal use.

Crystal methamphetamine is known on the

street as crystal, meth, Tina, Crissy, speed, tweak, ice, glass, and the white lady. It was first synthesized in 1919, and was used heavily in WW-II by Japanese, German, and American soldiers. Epidemic addiction is a continuing problem in Japan. It was used medically to treat asthma and obesity in the past and is rarely used in treatment of narcolepsy and depression today. The chemical make-up is similar to amphetamine and adrenaline. It is made in large quantities at clandestine laboratories with the essential ingredients of ephedrine/pseudoephedrine, anhydrous ammonia, lithium, and red phosphorus along with other compounds such as hydrochloric acid, nail polish remover, drain cleaner, rat poison, and lantern fuel. One pound of crystal yields an additional 6 pounds of toxic waste.

Crystal can be smoked in a pipe, snorted, injected, swallowed or administered anally. Smoking produces a rush within 10 seconds. The rush lasts 5-30 minutes and the high lasts 8-24 hours, mainly dependent on the "purity" of the crystal. The half-life is 12 hours. Many users will have one hit every-other weekend, but increasing use can escalate to daily or multiple daily hits. The cost of one hit ranges from \$30 to \$120 depending on location and purity. As a comparison, cocaine causes a 3 minute rush and 30 minute high, has a half-life of 1 hour, and costs \$70-\$150 per hit.

After using, levels of the neurotransmitters dopamine, norepinephrine, and serotonin are increased in the synapse; re-uptake of dopamine is also inhibited. High levels of dopamine are partially responsible for the pleasure experienced during the high. Dopamine levels also affect emotions, pain, and movement, and are thought to play a role in addiction. Research shows that high levels of dopamine are found in people with schizophrenia while low levels are found in those with Parkinson's disease; psychotic and movement disorders can be seen during various stages of crystal use.

Increased serotonin positively affects mood, increases sexual desire, and diminishes appetite, sleep-wake

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cycle, and impulse control; it also affects the GI tract and circulatory system. Problems with serotonin from long-term crystal methamphetamine use can cause amotivation, anxiety and mood disorders, impulsiveness, bingeing, and migraines.

Increased norepinephrine stimulates the sympathetic nervous system, the fight-or-flight system, resulting in increased blood pressure, energy, heart rate, and sexual desire while reducing thirst, hunger, and movement in the GI and urinary tracts. This heightened state, typically reserved for emergency response, is prolonged and adversely affects nutrition, cardiovascular health, and kidney function.

Negative effects while high include paranoia, hallucinations, anxiety, irritability, and loss of impulse control. Overdose can lead to severe chest pain, heart attack, respiratory depression, seizures, vomiting, hyperthermia, stroke, and death. Withdrawal, though not deadly, can cause nausea, vomiting, diarrhea, hyperthermia, sweating, skin ulceration, depression, irritability, and anxiety. The effects of prolonged use on body systems are outlined in the chart located at the bottom of this page.

Psychiatric effects from chronic use are evident long after sobriety. Up to 62% of chronic users experience depressive symptoms 5 years after discontinuing (*Rawson et al, J Addictive Disease, 2002; 21:107-19*). Schizophrenia-like symptoms remain permanent in some individuals (*Sato et al,*

Biol Psychiatry, 1983; Apr 18(4):429-440). Problems with manipulating information, set-shifting, divided attention, psychomotor speed, concentration, learning, and memory can be permanent (*Simon et al, J Addictive Diseases 2002; 21(1):61-73; Sim et al J Addictive Diseases 2002;21(1):75-89*).

The effects of crystal methamphetamine use on public health are numerous. Environmental impact of toxic waste byproducts, diminished workforce efficiency, medical treatment, emergency response, and treatment costs are significant societal burdens. Child abuse, neglect, and endangerment are becoming more frequent as crystal use moves into heterosexual and female populations. Perinatal exposure leads to low birth weight, abnormal reflexes, irritability, learning deficits, and congenital deformities (*SMITH, et al. Effects of Prenatal Methamphetamine Exposure on Fetal Growth and Drug Withdrawal Symptoms in Infants Born at Term. J Dev & Beh Pediatrics. 2/2003;24 (1):17-23*). Violent crime and illegal behavior are highly associated with crystal. The percentage of arrestees testing methamphetamine-positive in 2003 was highest in Honolulu (40% m, 50 % f), Phoenix (38% m, 42% f), and San Diego (36% m, 37% f) (*Community Epidemiology Work Group*).

Sexual behavior with crystal use is a significant problem. Increased frequency, duration, and partner number is common among crystal users,

(Continued on page 15)

Body/Organ/Organ System	Effects of Crystal Methamphetamine
Skin	Welts, itching, tactile hallucination of bugs, static, or sand
Mouth	Reduced blood supply, tooth decay, gum problems, buxism, dry mouth, odor
Kidneys, urinary tract	Filter and excrete crystal; restricted blood supply, lowered urine production, toxins re-enter blood, bladder infections, acute/chronic renal failure, kidney stones
Gastrointestinal tract	Inhibited movement, absorption slowed, appetite and thirst absent, constipation, diarrhea, cramping, malnutrition, anorexia
Heart, circulatory	Increased heart rate, increased blood pressure, decreased blood availability to small capillaries, irregular heart beat, blood clots, endocarditis
Lungs	Additives block blood vessels; reduced ability to exchange oxygen, carcinogenic effects from smoke
Liver	Breaks crystal down but becomes overloaded (especially with other toxins), dangerous drug interactions can lead to drug overdose
Brain	Depleted neurotransmitters; blocked blood vessels; stroke; paranoia, psychosis, anxiety, depression; movement disorders; atrophy, especially in areas responsible for mood, movement, and memory

Diabetes Foot Screening Prevention

By Sharon A. Watts ND, NP, CDE & Jeffrey M. Robbins DPM, BFOPPM



The VA/DoD and American Diabetes Association clinical practice guidelines recommend that all individuals with diabetes should receive an annual foot examination to identify high-risk foot conditions. This examination should include assessment of protective sensation, foot structure and biomechanics, vascular status, and skin integrity (<http://www.oqp.med.va.gov/cpg/cpg.htm>, *Diabetes Care* 27:S63-S64, 2004). Patient education along with screening is thought to improve prevention of amputation; however, the evidence-based data remain limited at this time. A Cochrane



Review titled: *Patient education for preventing diabetic foot ulcerations (The Cochrane Database of Systematic Reviews Issue 4, 2001)* showed that foot care knowledge and patient behavior seem to be positively influenced by education in the short-term, but the goal of education interventions (improving knowledge and behavior) is the prevention of foot ulceration and amputations, and sufficient evidence of this has not yet been delivered.

This important task of preventive diabetes foot screening and education requires an expanded team effort. There are more than 20+ million people with diabetes in the United States (CDC, 2005) today and the numbers continue growing at an alarming rate. Due to these rapidly escalating numbers of patients with diabetes, practitioners at all levels of care can learn to screen and educate veterans with diabetes about foot care prevention. By working together, nurses, certified diabetes educators, primary providers and podiatrists can help mitigate the amputation burden facing our

veterans with diabetes today. To this end, a team of a certified diabetes educator, nurse practitioner, and podiatrist developed a power-point foot screening competency-training program for our staff. This didactic program covers the "basics" of foot assessment and education necessary to provide a foot-screening exam for a patient with diabetes. This program has questions built into the tutorial and includes a post-test. You can view this program at the

AMPUTATION CARE AND TREATMENT (PACT) PROGRAM web page for Primary and Ambulatory Care site. Just click on Foot Screening Competencies for Providers at the following site: <http://vaww.appc1.va.gov/primary/page.cfm?pg=74>.



If patients have been identified as having high-risk feet by screening, they should be referred for more in-depth examination and should be strongly encouraged to participate in their own care. At a minimum this should include:

- Daily home foot checks,
- Proper daily foot hygiene.
- Appropriate shoe gear, including clean socks made from either cotton or wool combined with acrylics.
- How to access the VA (especially if it is emergent) if they discover any abnormal problems.

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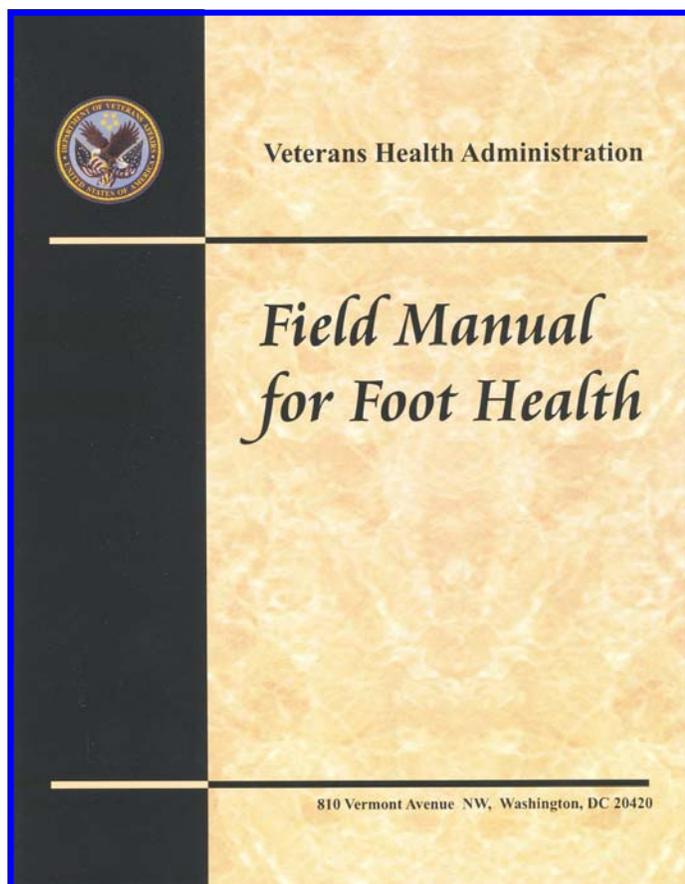
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Patients with high-risk feet should be under the ongoing care of a foot care specialist.

In summary, the guidelines are clear in recommending an annual foot screen for all veterans with diabetes. If we take the initiative as teams of collaborative health-care providers to learn and deliver foot screening, education, and proper follow-up, we can hope to lessen for our veterans with diabetes the potential burden of morbidity and mortality. Patients with diabetes should have their feet examined at every primary care visit. Furthermore, we can substantially improve the quality of life of our vets.

To obtain copies of a Field Manual for Foot Care Publication # 95647, contact your publication officer in the MAS/PCSA Service and ask to order from depot. Your supply officer can also contact Cecil Houston at

cecil.a.houston@hq.med.va.gov



Crystal Methamphetamine: the Up's and Down's

(Continued from page 13)

especially among gay men. Crystal heightens arousal, delays orgasm, increases confidence, and lowers inhibition. Community surveys have found high rates of HIV infection among crystal abusers and high rates of unprotected anal intercourse during drug intoxication (*Urbina & Jones, Crystal Methamphetamine, Its Analogues, and HIV Infection: Medical and Psychiatric Aspects of a New Epidemic, Clinical Inf Dis, 2004;38:890-94*). The impact of this behavior has obvious public health consequences, especially paired with the CDC's estimates that 24-27% of HIV+ individuals are unaware of their HIV status (*CDC HIV/AIDS Surveillance Report: HIV Infection and AIDS in the United States, 2003*). This is one of the areas where our clinic is working to reduce harm by improving prevention interventions for HIV+ individuals.

The crystal methamphetamine epidemic long burdening the western United States is quickly infiltrating mid-western, southern, and eastern regions. With clear information about crystal, clinicians can provide better assessment and intervention at earlier stages of the addiction cycle. Further information can be found at the following websites:

<http://www.oas.samhsa.gov/amphetamines.htm>

<http://www.lifeormeth.com>

<http://www.gmhc.org/programs/crystal.html>

<http://www.tweaker.org>

<http://www.drugabuse.gov/DrugPages/MTF.html>

<http://www.clubdrugs.org>

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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 1

Despite substantive research documenting the connection between various religious dimensions and physical^{1,2} and mental health,³ surprisingly little attention has been given to the study of religion among individuals with the human immunodeficiency virus (HIV). Although initially considered to be a white, "gay man's" disease, today women and ethnic minorities are subgroups that are the most severely affected by the HIV pandemic.⁴ Importantly, these disenfranchised subgroups report greater use of religion in their everyday lives.⁵ A small but growing number of studies conducted mostly within the past few years have recognized the importance of religion in the lives of individuals with HIV.⁶⁻⁹

In particular, research has noted the frequent use of religious coping by men and women with HIV to deal with the loss of their loved ones to AIDS,^{10,11} to overcome their sense of guilt and shame in engaging in risky

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

behaviors,⁸ and to find a renewed sense of purpose in life.¹³⁻¹⁶ However, clinical interventions with persons with HIV have largely neglected religiousness and spirituality as resources for treatment and, to date, few spirituality-based interventions exist that can be empirically evaluated.¹⁷ In this paper, we review the literature on religious coping among individuals with HIV and outline a clinical intervention that incorporates religious issues relevant to this population. We first provide an overview of religious coping.

Framework of Religious Coping

Pargament¹⁸ has developed a transactional model of religious coping wherein religion is viewed as contributing to the coping process by shaping the character of life events, coping activities, and the outcomes of events. Religion can also be a product of coping such that people can increase their religious faith as a result of life events. As part of an individual's general orienting system, religion influences how individuals appraise situations, participate in activities, and develop goals for themselves. In particular, when faced with difficult situations, individuals have reported using a wide variety of religious coping methods, such as benevolent religious appraisals, seeking support from clergy or church members, seeking spiritual support, discontent with congregation and God, negative religious reframing, and expressing interpersonal religious discontent.¹⁸ One parsimonious way of clustering or distinguishing these various coping methods is

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to define “positive religious coping” strategies (eg, seeking God’s love and care, asking for forgiveness) and “negative religious coping” strategies (eg, expressing anger at God, feeling punished by God).¹⁹ Positive religious coping methods rest on a secure relationship with God, a belief in a larger, benevolent purpose to life, and a sense of connectedness with a religious community. Negative religious coping methods reflect a religious struggle that grows out of a more tenuous relationship with God, a more ominous view of life, and a sense of disconnectedness with a religious community. In some sense, negative religious coping occurs when major life stressors pose a threat or challenge not only to physical and psychological health and well-being but also to the individual’s religious and spiritual world view.

In cross-sectional and longitudinal studies, the use of religious coping has been associated with a variety of indicators of mental health (ie, depression, positive affect, life satisfaction), after controlling for the effects of sociodemographic variables, global religious measures (eg, frequency of prayer and church attendance, and self-rated importance of religion), and nonreligious coping measures.^{18,20-22} Importantly, the relation between religious coping and mental health is shaped by the kinds of religious coping methods used by individuals. For example, more use of positive religious coping strategies, such as spiritual support and benevolent religious appraisals of negative situations, has been associated with greater well-being, such as improved mental health status,²³ reduced rates of mortality,²⁴ stress-related growth, and spiritual growth.^{25,26} Conversely, greater use of negative religious coping strategies (alternatively called religious struggles), such as attributions of situations to a punishing God and dissatisfaction with clergy, is tied to

indicators of more psychological distress, such as greater depression and anxiety and poorer resolution of the negative life event.^{14,19,27,28}

Religious coping methods have also been associated with physical health. For example, a longitudinal study by Fitchett et al²⁹ indicated a positive association between anger at God and poor recovery in activities of daily living (ADL). In a recent 2-year longitudinal study conducted by Pargament et al,³⁰ greater religious struggle (eg, demonic reappraisal, spiritual discontent) among elderly ill men and women was associated with increased risk of mortality. Krause³¹ found strong improvements in the self-rated health of elderly residents in deteriorating neighborhoods who reported more positive religious coping. Overall, these studies underscore the multi-dimensional nature of religious coping as well as the importance of studying the role both positive and negative religious coping strategies play in the coping process.

Examples of religious and spiritual coping methods identified among individuals with HIV:

- Spiritual transformation
- Belief in a higher power
- Prayer
- Belief in miracles
- Collaboration between themselves and God/higher power

Religion and Religious Coping Among Individuals with HIV

Surprisingly, fewer studies (mostly qualitative) have attended to the role of religion/spirituality among individuals with HIV.^{16,32-34} Importantly, many studies have observed that much of the religiosity among HIV-positive persons is expressed in terms of a God or a higher power rather than belonging to a religious denomination or attendance of religious services.^{13,14,35} This is not surprising, given the stigma many religious institutions attach to the HIV disease and related modes of transmission.^{13,36,37} However, it is important

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to note that many individuals with HIV still retain their spiritual beliefs and might choose to attend religious services at their church/temple (perhaps disclosing their HIV status to a few members).^{38,39}

Virtually every study on religion and spirituality conducted among men and women with HIV attests to the significance of this construct for these individuals. For example, working with a sample of hospitalized patients with HIV, Kaldjian et al⁸ reported that “religious belief was the rule,” with 98% indicating belief in a divine being called God, 84% expressing a personal relationship with God, and 81% believing in God’s forgiveness. In a study of 125 caregivers of individuals with HIV, Richards and Folkman³⁴ reported that at the time of bereavement, 56% of the caregivers (some of whom were HIV-positive) made spontaneous, explicit references to spiritual phenomena (eg, beliefs in experiences of a higher order). Some studies have shown that those with HIV report greater use of religion and spirituality when compared with similar HIV-negative individuals,^{9,40} with racial/ethnic minority groups and women reporting the most use of religion and spirituality.^{14,41,42}

Several religious and spiritual coping methods have been identified among individuals with HIV. Research with gay men suggests that spiritual transformation³⁷ and belief in a higher power³⁴ are strategies that reportedly help them deal with the challenges caused by their illness as well as their status as a sexual minority. Among inner city, HIV positive drug users, prayer, and belief in a higher power⁶ are common religious and spiritual coping methods. In studies on women (mostly black) with HIV, collaboration between themselves and God/higher power, belief in miracles,⁴³ and prayer^{9,44,45} are coping methods that have been reported. A few studies that have included both men and

women with HIV^{8,14,42} have also noted the use of many of the religious and spiritual coping methods listed above.

Global measures of spirituality have also been significantly associated with positive psychological outcomes. Specifically, among women with HIV, greater engagement in spiritual activities is tied to decreased emotional distress,⁴⁵ lower depression,³⁹ greater optimism,⁴⁴ and overall better psychological adaptation.⁴¹ Ironson et al⁷ found that among men and women with HIV, specific dimensions of spirituality (eg, sense of peace, faith in God) were associated with better immune status (ie, lower cortisol) and mental health (ie, lower anxiety, perceived stress). In a 14-month prospective study of HIV-negative relatives and friends of persons who had died as a result of AIDS, those who professed stronger spiritual beliefs seemed to resolve their grief faster than those with no spiritual beliefs.⁴⁶ In sum, research among both men and women with HIV suggests that spirituality occupies a significant role, often providing them with a context in which they can find meaning in their lives,^{9,13} and stimulating psychological and spiritual growth.³²

As with research on religion and health within other samples, the mechanisms through which religious and spiritual coping exercises its influence on the mental and physical health of individuals with HIV are not well understood. However, a few studies have attempted to elucidate these connections. In their study with Puerto Rican women with HIV, Simoni and Ortiz³⁹ reported that the relation between their measure of spirituality and depression was mediated by self-esteem and mastery. In examining the relation between spirituality and physical health, Ironson et al⁷ found that the “sense of peace” aspect of their spirituality measure was tied to lower cortisol levels, highlighting the importance of subjective aspects of religious/spiritual practices. The sense of

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purpose from spirituality may play another important explanatory role. In their 2-year follow-up of bereaved caregivers of HIV-positive individuals, Richards and Folkman³⁴ found that spirituality increased in 77% of the entire cohort, such that individuals discovered a sense of value and direction.¹¹ As told by one participant in the study of drug users with HIV, “He brought me back for a reason. And then I’m living with HIV. There’s got to be something out there He wants me to do.”⁶ Interview studies suggest a few other potential mechanisms through which religious and spiritual coping methods might be exerting their influence on mental and physical health, such as offering a sense of control, relieving fear and uncertainty associated with death, and facilitating forgiveness of self and others.¹⁶ Finally, it is also important to note that religiousness and spirituality may have direct effects on health; that is, these phenomena may make distinctive, even unique, contributions to health and well-being.⁴⁷

In sum, empiric studies suggest that religious and spiritual resources hold particular value for people with HIV. It is also important to note that religion and spirituality may represent a source of pain and struggle for at least some people with HIV. As yet, researchers have not generally focused on the role of negative religious coping methods among people with HIV. In one exception, Jenkins¹⁴ found that men with HIV who reported more spiritual struggles (eg, anger or alienation from God) experienced more depressive symptoms and loneliness. Given the links between religious struggles and poorer health documented in other groups, the religious stigma attached to HIV, and

Seven issues common to women dealing with HIV/AIDS, and addressed in “Lighting the Way”:

- Healing
- Body and spirit
- Control and surrender
- Letting go of anger
- Shame and guilt
- Intimacy and isolation
- Hopes and dreams

its potential to challenge the individual’s most deep-seated assumptions about the world, people with HIV may be particularly likely to experience spiritual struggles and their potential ill-effects. As one woman with HIV put it: “Before I found out I was HIV positive, I believed in God, I believed in saints, and when I found out I was HIV positive, I lost hope, I lost faith, and I lost my spirit. I was a bad person. A gray person. I thought I was never going to get out of that stage.” Be it a resource or a burden, the spiritual dimension of HIV may carry significant implications for treatment.

From Research to Practice

With the notable exceptions of hospital chaplaincy and pastoral care, spiritual issues have been largely disconnected from health care. In recent years, however, this picture has begun to change. Several books have addressed the integration of spirituality into treatment.⁴⁸⁻⁵⁰ A few investigators have begun to evaluate the efficacy of spiritually integrated forms of treatment, with some promising results.⁵¹⁻⁵³ These treatments draw on a variety of spiritual coping resources: meditation,⁵⁴

prayer and ritual,⁵⁵ reading of scriptures,⁵⁶ spiritual imagery;⁵⁷ forgiveness, and spiritual schemas.⁵⁹ Unfortunately, spiritually integrated programs for treating HIV have not as yet been developed and evaluated. This oversight is particularly striking, given the salience of spirituality as a resource

for people with HIV as well as a source of struggle. What form might a spiritually integrated intervention take for those facing HIV? (End of Part 1)



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