

# Health *POWER!*

Prevention News • SPRING 2009



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Linda Kinsinger, MD, MPH  
Chief Consultant for  
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*Thanks to all our women Veterans who have served so well and who deserve our best care.*

**W**omen have a long and proud history of serving our country in the military. A report entitled *Women Veterans: Past, Present and Future*, on the Center for Women Veterans web site ([http://www1.va.gov/womenvet/docs/WomenVet\\_History.pdf](http://www1.va.gov/womenvet/docs/WomenVet_History.pdf)), provides a nice summary of the role of women in the military from the Revolutionary War to the present day. In addition to what many may think of as “traditional” roles, such as nurses, cooks, and caregivers, women have served in a variety of unconventional roles, including “acting as spies, saboteurs, and couriers.”

It wasn't until World War II that women were given full military status, with the establishment of the Women's Army Corps by Congress in 1943. In addition to the Army, other branches of the service, including the Navy, the Marines, the Coast Guard, and the Air Force, set up women's units, which significantly supported the war effort. The report notes that, “during the Korean Conflict (in 1951), the Defense Department Advisory Committee on Women in the Services was established by then-Secretary of Defense, George C. Marshall, to provide advice and recommendations on matters and policies relating to the recruitment and retention, treatment, employment, integration, and well-being of professional women in the Armed Forces.” The Committee is still in existence, providing input and direction to the Department of Defense.

In describing more recent conflicts, the report states that, “beginning in the early 1990s, women flew combat aircraft, manned missile placements, served on ships in the Gulf, drove

convoys in the desert, and assumed other roles making exposure to combat more likely. In the 2001 National Survey of Veterans, 12 percent of women veterans reported having served in a combat or war zone. Nearly one-quarter reported contact with dead, dying or wounded compatriots during their military service.” At the end of September, 2005, the number of women on active duty was more than 202,000, making up nearly 14 percent of the active duty armed forces.

Focusing on women Veterans as the theme in this issue of *HealthPOWER!* is therefore quite appropriate. As Drs. Patty Hayes and Mandy Krauthamer, of the Women Veterans Health Strategic Health Care Group in the Office of Public Health and Environmental Hazards, point out in their commentary, providing the same high quality care to women as we provide to men requires some new ways of thinking and interacting with our patients. For reasons that aren't clear, we are not doing as well in delivering core clinical preventive services to women Veterans

as we are for men. Understanding the reasons for this discrepancy and making changes to eliminate it will require careful and thoughtful analysis of our systems of care.

Several of the articles in this newsletter note a few demographic differences between men and women Veterans seen in VHA. According to the report on women Veterans mentioned above, women Veterans, on average, are younger, with a median age of 47, compared with a median age of 61 for men. They are more likely to be persons of color (31% vs. 19% for men) and to have higher educational achievement (72% with at least some college education, compared to 57% for men).

Based on data from the 2000 Census, more than 70% of women Veterans aged 25-64 are employed. The report also notes that “in FY 2006, the top three diagnostic categories for women Veterans treated by VHA were post traumatic stress disorder, hypertension, and depression. Nearly 80,000 women veterans were in Priority Categories 1 and 2, which include veterans with service-connected disabilities.”

The report concludes, “Women will make up a larger share of the Veteran population, add to its diversity, and require veteran services geared to their specific needs. The debt owed to all our Veterans and to women in particular demands nothing less than full attention and action.” Well said! Thanks to all our women Veterans who have served so well and who deserve our best care. ■

*Linda Kinsinger*

# Enhancement of Care for Women Veterans

In the next five years, the number of women using the VA for health care services will double. In 10 years, one in every seven enrollees in the VA will likely be a woman. Women are changing the landscape of care in the VA, and not by their numbers alone. Women Veterans of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) are younger than women Veterans of the past. As seen in Figure 1, nearly 90% of OEF/OIF women Veterans who are enrolled in VA health care are between 20 and 40 years old (i.e., of child-bearing age). These women are much more likely to be balancing work, motherhood, and transition to civilian life. Like all of our Veterans, these women will rely on the VA to provide care that is of the highest quality while also being age- and gender-appropriate.

The challenge of a rapidly increasing population of women Veterans presents tremendous opportunities to improve the provision of preventive care. Women and men wear the same uniforms and salute the same flag, but the health care they require can be drastically different, in ways other than gender-specific health care like Pap smears and breast cancer screenings. For example, posttraumatic stress disorder (PTSD), a common diagnosis among both men and women Veterans who receive care in the VA, may be treated with

medications that increase the risk of birth defects. Additionally, many commonly prescribed medications can decrease the effectiveness of oral contraceptives. For a woman Veteran of child-bearing age using any of these medications, alternative medications, initiation of oral contraception, or an alternative contraceptive method must be considered.

This isn't the only way that you, as a health care provider, need to think differently about the Veterans who walk into your facility. Reproductive and sexual health issues should be incorporated into every visit. Women in their reproductive years will be thinking about family planning and, as their physician, you should be talking with them about sexual risks, pregnancy, and prenatal care.

The change in demographics allows us the opportunity to begin forming healthy life strategies earlier with our women Veterans. Cardiac disease is the leading killer of women. The earlier you start talking with women about the relationship of high blood pressure, cholesterol, weight management, smoking cessation, exercise, and nutrition to cardiac disease, the better the chances of prevention. Breast health and osteoporosis are other common preventive topics to focus on with women Veterans of all ages.

Meeting the benchmark of highest quality will require more than having the right conversations at the right times. It also will require recognizing the differences in women's health care and focusing on women Veterans' unique needs. Although VA facilities score higher than the private sector in most performance measures, a consistent difference persists between men and women Veterans on

Contributed by

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**Figure 1. Age Distribution of 102,126 Female OEF/OIF Veterans**

(Data from 2002 through 3rd Qt FY 2008)

Age Group	Frequency	Percent
Under 20 years	9,177	9.0%
20–29	59,009	57.8%
30–39	19,266	18.9%
40 and over	12,493	12.2%
Unknown	2,181	2.1%

measures that are common to both as seen in Figure 2. To eliminate gender differences on quality measures, we need to focus on the way we deliver health care to our women Veterans.

The VA Under Secretary for Health has asked facilities to ensure that every woman veteran has access to a VA primary care provider who can meet all her primary care needs—both gender-specific care and acute and chronic illness, preventive, and mental health care—in the context of an ongoing patient–clinician relationship. This one-visit, one-provider model—the predominant model for men in VA primary care—is the goal for delivery of care to women Veterans as well. This task presents a challenge: some VA providers lack training in women’s health and 67% of VA sites provide primary care to women Veterans in a multi-visit, multi-provider model. This current model of care means women receive primary care at one visit and gender-specific primary care (Pap smears, breast exams) at another. But the challenge is also an opportunity to set the standard by which all women’s health care will be measured and to provide a higher level of comprehensive preventive care to women Veterans.

The Women Veterans Health Strategic Health Care Group is collaborating with VA facilities and other VA Program Offices to assess and evaluate the delivery of primary care to women throughout the VA system. We stand ready to assist you in planning and implementing improvements to health care for women Veterans to raise the VA standard and provide the best care anywhere.

For more information please contact the Women Veteran Health Strategic Health Care Group at 202-461-7174 or email [mandy.krauthamer@va.gov](mailto:mandy.krauthamer@va.gov). ■

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**Figure 2. 2007 Quality of Care Indicators**

Clinical Process	Percentage of eligible population receiving clinical process			
	VA Women	VA Men & Women	Private Health Insurance	Medicaid or Medicare
Cervical Cancer Screening (Pap)	91%	–	81%	65% Medicaid
Breast Cancer Screening (mammography)	86%	–	69%	50% Medicaid
Colorectal Cancer Screening	74%	80%	55%	50% Medicare
LDL <100 in diabetic patients	51%	64%	44%	47% Medicare
BP <140/90 in diabetic patients	71%	77%	61%	56% Medicaid
Pneumococcal Vaccination (ages >65)	51%	69%	N/A	67% Medicare
Influenza Vaccination (ages 50-64)	60%	72%	49%	72% Medicare

*Office of Quality and Performance, Steven Wright, Elizabeth Yano, Michelle Lucatario unpublished report: An Analysis of the Quality of Care Provided to Men and Women in the VA Health Care System, July 2008*

# Osteoporosis

**O**steoporosis (extreme bone loss) causes bones to become thin and fragile, increasing the chance of fractures resulting from even minor injury. Women are four times more likely than men to develop osteoporosis. Lower estrogen levels brought on by menopause cause the body to lose more bone than it can replace, which can lead to osteoporosis. Some chronic health conditions and long-term use of some medications, such as corticosteroids, can also lead to osteoporosis. Symptoms include back pain or tenderness, a loss of height, and a “hump” of the upper back, but many people with osteoporosis don’t have any symptoms at all.

According to the U.S. Preventive Services Task Force (USPSTF), one-half of all postmenopausal women will have an osteoporosis-related fracture during their lives. Fractures can have devastating consequences for the individuals who suffer them, as well as for their family members. For example, people with hip fractures have an increased risk of death: up to four times greater among patients with hip fractures during the first 3 months after the fracture, compared with individuals of similar age without a fracture. For those who do survive, these fractures often are the start of a downward spiral in physical and mental health that dramatically impairs quality of life. Thirty years ago, osteoporosis and the fractures that go along with it were thought of as an inevitable part of old age because relatively little was known or could be done about the disease.

We now know that many of the physical, emotional, and financial costs of bone disease and fractures can be avoided. However, much of what could be done to help reduce this burden is not being done, largely due to a lack of awareness of the problem and the failure to apply current knowledge. Many in the public, and even the medical community, still believe that osteoporosis is a natural, unavoidable

consequence of aging.

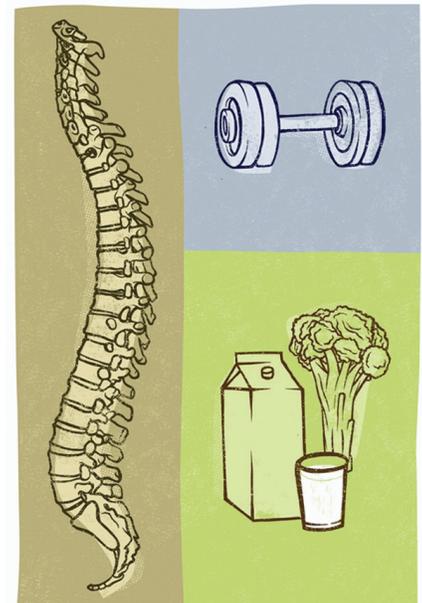
The key is to prevent bone loss, because it is hard to replace bone once it is lost. The evidence clearly suggests that individuals can do a great deal to promote their own bone health. Prevention of bone disease should begin early and continue throughout life. Although most cases of osteoporosis occur later in life, making a lifelong commitment to exercise and healthy nutrition in one’s youth may reduce the risk of developing this condition in later life. For women, weight-bearing exercise increases bone mass before menopause and helps to reduce bone loss after menopause. Weight-bearing exercises include walking, low- or high-impact aerobics, and tennis, to name a few. While non-weight-bearing aerobic activities, such as swimming and biking, have good cardiovascular benefits, they are not as effective as weight-bearing activities at increasing and maintaining bone structure and strength.

An adequate calcium intake is essential in the promotion of bone health and the prevention of osteoporosis. Good sources of calcium include low-fat dairy products, leafy green vegetables, nuts, and seafood. Most women get only about half of the calcium they need every day, so taking a calcium supplement is often advisable.

Contributed by

**Kathy Pittman, RN, MPH**

Program Manager for Prevention Practice



*Women are four times more likely than men to develop osteoporosis.*

The best form of calcium for preventing bone loss is calcium carbonate. A total calcium intake of 1,200 to 1,500 mg per day (through diet, supplements, or both) is recommended for all postmenopausal women. Premenopausal women need a minimum of 1,000 mg of daily calcium. Vitamin D is necessary for the body to absorb calcium, and one of the best sources is low-fat milk fortified with vitamin D. Sunlight also is an excellent source of vitamin D: being in the sun for just 15 minutes a day helps the body produce and activate vitamin D.

Early detection of osteoporosis, before symptoms occur, is also an effective prevention strategy. The risk for osteoporosis increases steadily and substantially with age. Risk factors for fracture or low bone density other than age include: low body weight or body mass index (BMI), white or Asian ethnicity, history of fracture, parental history of hip fracture, history of falls, low levels of physical activity, smoking, excessive alcohol or caffeine use, low calcium or vitamin D intake, and the use of various medications such as steroids. The risk for osteoporosis is similar among Hispanic women and white or Asian women; African-American women are at less risk than white women, but their risk also increases with age.

Screening for osteoporosis involves measuring bone mineral density (BMD). BMD testing is painless, quick, safe, and relatively inexpensive. Several methods are available, but dual-energy X-ray absorptiometry (DEXA) is the method recommended for routine use, because it is the most reliable and accurate. The USPSTF recommends that women aged 65 and older be screened routinely for osteoporosis. Screening should begin at age 60 for women at increased risk for fractures due to osteoporosis. A history of fractures related to a minor injury in a postmenopausal woman strongly supports a diagnosis of osteoporosis, regardless of BMD.

Once osteoporosis has been identified, a comprehensive management plan should be put into place. This may include:

- Counseling to avoid smoking and excessive alcohol intake, as these behaviors have been linked to greater fracture risk.
- Encouragement and assistance for patients to engage in regular physical activity, specifically weight-bearing and resistance exercise. These activities are associated with increases in BMD.
- Adequate calcium and Vitamin D intake to prevent further bone loss.
- Medication to increase BMD and/or mitigate further bone loss. Providers should discuss with patients the benefits

and risks of the various options available for the treatment of osteoporosis.

The good news is that, with appropriate nutrition and physical activity throughout life, women can significantly decrease their risk of osteoporosis and fractures in later life. Health professionals can help by actively encouraging good nutrition and physical activity behaviors during childhood and beyond, and by routinely screening older women for osteoporosis.

For more information about routine screening for osteoporosis, check out the U.S. Preventive Services Task Force website: <http://www.ahrq.gov/clinic/uspstf/uspstf.htm>.

#### SOURCES:

Office of the Surgeon General, U.S. Department of Health and Human Services. *Bone Health and Osteoporosis: A Report of the Surgeon General 2004*. [http://www.surgeongeneral.gov/library/bonehealth/Executive\\_Summary.html#ExecutiveSummary](http://www.surgeongeneral.gov/library/bonehealth/Executive_Summary.html#ExecutiveSummary)

U.S. Preventive Services Task Force. *Screening for Osteoporosis in Postmenopausal Women: Recommendations and Rationale*. <http://www.ahrq.gov/clinic/3rduspstf/osteoporosis/osteorr.htm>

Rosen, CJ. *Clinical Practice: Postmenopausal Osteoporosis*. *New Engl J Med*. 2005;353:595-603.

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# VA, DOT and DoD Partner to Reduce Deaths from Motor Vehicle Crashes

Contributed by  
VHA Office of Communications

## “Home Safe. Drive Safe. Stay Safe.” Initiative Seeks to Save Veterans’ Lives

Motor vehicle crashes are the leading cause of death among Americans aged 15 through 44. Many of our Nation’s newest Veterans are in this age group. More young Veterans die from motor vehicle crashes than from suicide.

Crashes are also the leading cause of death among Veterans in the early years after they return from combat deployment. This was true of Veterans who served in Vietnam and in the first Gulf War, and is proving to be true among Veterans now returning from Iraq and Afghanistan.

To reverse this trend, the U.S. Department of Veterans Affairs (VA), the Department of Defense (DoD) and the U.S. Department of Transportation (DOT) are partnering in a new driving safety initiative, called “Home Safe. Drive Safe. Stay Safe.” to educate Veterans and their families on ways motor vehicle deaths can be avoided. VA will help DOT spread the word about two major safety initiatives: “Drunk Driving. Over The Limit. Under Arrest,” designed to reduce impaired driving, and “Click it or Ticket,” designed to encourage seat belt use.

The three agencies will also jointly work with researchers to better understand what can be done to prevent vehicle fatalities following deployments. Every VA hospital



will appoint a Safe Driving Coordinator to educate patients and VA staff about the issue and to distribute DOT and DoD materials and posters. The Coordinator will also conduct a Safe Driving Rally for patients, their families and the community sometime during 2009. In addition, VA medical staff will be educated about the potential of high-dose, long-acting sleep medications to raise the risk of automobile and motorcycle accidents, and encouraged to seek alternatives to these medications whenever possible.

Here are some simple rules Veterans should remember to reduce their own risk of becoming involved in a fatal crash:

- If you are planning to drink alcohol with friends, designate a sober driver before going out and give that person your keys;
- If you’re impaired, call a taxi, use mass

transit or call a sober friend or family member to get you home safely;

- Use your community’s Sober Rides program;
- Promptly report drunk drivers you see on the roadways to law enforcement;
- Wear your seat belt while in a car or use a helmet and protective gear when on a motorcycle as these are your best defenses against an impaired driver;
- And remember, if you know someone who is about to drive or ride while impaired, take their keys and help them make other arrangements to get to where they are going safely.

For more information, visit VA’s new Safe Driving Website at [www.safedriving.va.gov](http://www.safedriving.va.gov), or see the Safe Driving Coordinator at your nearest VA hospital. ■

# News



## 2009 Prevention Forums

NCP, in collaboration with the Employee Education System (EES), will offer two conferences on "Clinical Prevention Practice: Delivering the Best Preventive Care Anywhere." The conference will be held April 29–30 in the Washington, DC area and July 21–22 in the western part of the country (specific location to be determined). The target audience will be VISN Preventive Medicine Leaders, Facility Prevention Coordinators, and others interested in prevention issues. Both conferences will offer the same content.

## Meet Rex Dancel, MD – UNC Preventive Medicine Residency Program

Over the last few years, the NCP has had several medical students, public health students, and preventive medicine residents rotate with the Center as part of their practicum requirements. We are pleased to have established a formal relationship recently with the University of North Carolina (UNC) Preventive Medicine Residency Program. Through this arrangement, the VHA will be supporting a 0.5 FTE resident position in the UNC program and will have two or three second-year preventive medicine residents rotating at the NCP in 8- to 12-week blocks. During their NCP rotation, residents will take on a "mini-project" and will be exposed to a broad range of the Center's activities and programs. The first resident under this new agreement began rotating with us in January.



Rex Dancel is a second-year UNC preventive medicine resident from Fayetteville, NC. He is already a board-certified family physician, having completed his family medicine residency training in Charlotte, NC. He was born in the Phillipines and grew up in a military family (his father is a retired US Army Colonel and is also a family physician). Rex did his undergraduate work at UNC at Chapel Hill in chemistry and graduated from medical school at Wake Forest University. He is currently completing his master's degree in Public Health at UNC. His professional interests include primary care, chronic diseases, and underserved populations.

## Agency for Healthcare Research and Quality (AHRQ)

AHRQ has released the Guide to Clinical Preventive Services 2008, which highlights recommendations from the U.S. Preventive Services Task Force. In addition to previous recommendations, this year's Guide provides new Task Force recommendations released during 2007 on the use of aspirin or nonsteroidal anti-inflammatory drugs for the primary prevention of colorectal cancer; screening for carotid artery stenosis; counseling about proper use of motor vehicle occupant restraints and avoidance of alcohol while driving; and screening for illicit drug use.

The Guide contains evidence-based



## UPCOMING CONFERENCE CALLS

### VHA Monthly Prevention Call 2nd Tuesday of the month

1:00 pm ET

1-800-767-1750, access #18987

- April 14, May 12, June 9

recommendations that have been adapted for a pocket-size book. Complete recommendation statements and supporting systematic reviews are available on the AHRQ Web site. The Clinical Guide can be downloaded from the AHRQ Web site at <http://www.ahrq.gov/clinic/prevenix.htm>. A print copy of the guide is available by sending an e-mail to [AHRQPubs@ahrq.hhs.gov](mailto:AHRQPubs@ahrq.hhs.gov).

## Advisory Committee on Immunization Practices (ACIP)

In October 2008, ACIP approved the Adult Immunization Schedule for 2009. The Recommended Adult Immunization Schedule — United States, 2009 can be found at [http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5753a6.htm?s\\_cid=mm5753a6\\_e](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5753a6.htm?s_cid=mm5753a6_e). No new vaccines were added to the schedule. Several new indications were added for the pneumococcal polysaccharide vaccine, including persons who smoke cigarettes and persons with asthma; clarifications were made to the footnotes for human papillomavirus, varicella, and meningococcal vaccines; and schedule information was added to the hepatitis A and hepatitis B vaccine footnotes.

# Women Veterans' Health: What Do We Know?

contributed by

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The face of the woman Veteran is changing, as are the numbers of women Veterans for whom the VHA will provide a continuum of health care. It is useful to understand the demographics of our women Veterans and review their special health care needs. The following VHA Offices and Centers provide information about women Veterans.

## Center for Women Veterans, Department of Veterans Affairs

Located at: <http://www1.va.gov/wom-envet/> on the Internet, also a parallel intranet site with additional resources for VHA staff.

The primary mission of the Center for Women Veterans is to review VA programs and services for women Veterans, and assure that they receive benefits and services on a par with men Veterans; encounter no discrimination in their attempt to access benefits and services; and are treated with respect, dignity, and understanding by VA service providers. Facts, statistics, and policies related to health care and other benefits for women Veterans can be found here.

## Women Veterans Health Strategic Health Care Group, Office of Public Health and Environmental Hazards, Veterans Health Administration

Located at: <http://www1.va.gov/wvhp/> on the Internet, also a parallel intranet site with additional resources for VHA staff.

The Women Veterans Health Strategic Health Care Group coordinates policy related to Women Veterans' Health Care. This Group promotes the health, welfare and dignity of women Veterans and their

families by ensuring access to timely, sensitive, quality health care. Additional reports, statistics, and tools specific to women Veterans' health care experiences and needs can be found here. Directives and policies related to women Veterans' health care and a listing of all VHA Women Veterans Program Managers can be accessed on the internet site.

## Women Veterans Health Research Agenda—Useful Resources & Information

The VHA has an active Women Veterans Health research agenda, developed to inform VA healthcare policy and services to ensure accessible, quality care for women Veterans. Check out the following resources and information:

- An introduction to women Veterans' health research, including a 4-minute video by two VHA women Veterans health researchers, Drs. Becky Yano and Donna Washington: [http://www.research.va.gov/programs/womens\\_health/default.cfm](http://www.research.va.gov/programs/womens_health/default.cfm)
- Special supplement to the Journal of General Internal Medicine in March 2006 focused exclusively on women Veterans health: <http://www3.interscience.wiley.com/journal/118582951/issue>

*It is useful to understand the demographics of our women Veterans and review their special health care needs.*

- Abstracts from two selected “in progress” studies:
  - Pilot Study of Reintegration and Service Needs for Women Veteran Mothers: [http://www.hsrd.research.va.gov/research/abstracts.cfm?Project\\_ID=2141698773&UnderReview=no](http://www.hsrd.research.va.gov/research/abstracts.cfm?Project_ID=2141698773&UnderReview=no)
  - Women Veterans Ambulatory Care Use Project, Phase II: [http://www.hsrd.research.va.gov/research/abstracts.cfm?Project\\_ID=2141696839&UnderReview=no](http://www.hsrd.research.va.gov/research/abstracts.cfm?Project_ID=2141696839&UnderReview=no)
- Recently published findings on women Veterans and military sexual trauma: <http://www.ajph.org/cgi/content/abstract/97/12/2160>

# News



## 1st Quarter VHA Performance Measurement

The VHA Office of Quality and Performance (OQP) has released 1st quarter FY09 performance measurement data. All 21 VISNs met or exceeded target on the following prevention-related measures:

- Screening and counseling for obesity
  - Cessation counseling provided to smokers
  - Cessation medications offered to smokers
  - Women age 50–69 screened for breast cancer with mammography
- Check out the OQP intranet website for a complete listing of facility and VISN-level prevention-related performance measures and health system indicators.

## New Composite Measures

New this FY, OQP is now reporting out composite measures for several various domains including “prevention.” A composite indicator is a measure derived from a set of individual quality indicators. Composite measures have been proposed as a way to gauge an organization’s underlying culture of quality, but they tend to be less “actionable” than individual component measures in terms of driving improvement in any one specific area. On the other hand, composite measures have the potential to serve as a catalyst for broader system changes that could have an impact on multiple indicators, as opposed to a constant shifting of improvement expertise and resources to temporarily address deficiencies in individual indicators from year to year or quarter to quarter.

The following measures are combined into the Prevention Composite:

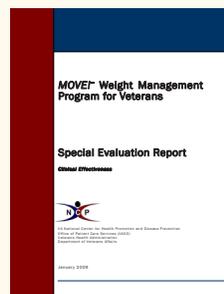
Mnemonic	Measure Description
p6nh	Pts age 50–75 receiving appropriate colorectal cancer screening
p4h	Women age 21–64 screened for Cervical cancer in the past 3 yrs
p3h	Women age 50–69 screened for breast cancer with mammography in the last 2 years
p1	Pneumococcal immunization (Nexus Cohort)
mov5	Outpt screening for obesity and offering treatment if appropriate

For 1st quarter FY09, one VISN scored exceptionally well (above 2 standard deviations) and the remaining VISNs all scored within acceptable parameters. Although this reflects only one quarter’s worth of performance data, it certainly suggests a culture of quality in the area of clinical prevention. Keep up the good work, VHA!

For access to all VISN and facility-level performance measurement data, go to the VHA Office of Quality and Performance’s intranet website or consult with your local facility quality manager.

## MOVE! Special Evaluation Report Now Available

The NCP is pleased to announce that the final report for the MOVE! Special Evaluation—Clinical



Effectiveness is now available at the MOVE! intranet website.

This was a retrospective evaluation of a sample of patients (N=1,012) who had at least 6 or more MOVE!-related visits at VHA facilities between Oct. 1, 2004 and March 1, 2007. The evaluation used medical record review to track changes in participant weight over time. The primary outcomes were changes in weight and body mass index at 6, 12, and 18 months, and the percentage of patients losing 5% or more body weight at those time points.

### Key findings from this evaluation:

- 22% of men and 24% of women achieved a body weight loss of 5% or more at 6 months. The average weight loss at 6 months was 5.8 lbs. The average percent body weight loss was 2.1%.
- Overall, 75% of both men and women either lost or maintained their weight at 6 months.
- Women were more successful at continuing to lose or maintain their weight loss. By 18 months, 32% of women lost 5% or more of their body weight compared with only 19% of men.
- Patients with diabetes or impaired fasting glucose were twice as likely to achieve a body weight loss of 5% or more than were patients without these diagnoses.

A major limitation of this evaluation was that facility implementation of MOVE! was not measured or accounted for. Future evaluations should use robust measures of implementation to better understand why and under what circumstances MOVE! works.

# Health Education for Women Veterans

Contributed by

Rose Mary Pries, DrPH

Program Manager for Veterans Health Education and Information

In the lead article of this issue, Drs. Hayes and Krauthamer emphasize that VHA encourages every woman Veteran to have a primary care provider who can meet all her primary care needs. As VA facilities move to this model of health care delivery for women Veterans, they need to build in health education and information programs, services, and products to meet women Veterans' specific needs.

## An Example: The Alaska VA Healthcare System

As it moves to this model of women Veterans health care, the Alaska VA Healthcare System is applying lessons learned in delivering health care and health education programs in locations that are challenged by time, distance, and weather. In addition to the facility in Anchorage, Community-Based Outpatient Clinics (CBOC) are located in Fairbanks and Kenai. A new CBOC is slated for Wasilla and a new VA Outreach Clinic for Juneau. The Women Veterans Program is led by Yvonne Stevenson, FNP/CNM. Her training as a Family Nurse Practitioner and Certified Nurse Midwife gives her a unique perspective, which is especially important when dealing with the reproductive health and education needs of new, young women Veterans.

## Program Planning

This issue's lead article also identifies clinical priorities for women Veterans. Because cardiovascular disease is the leading cause

of death for women over age 65, the Alaska VA Healthcare System promotes risk reduction in all areas. Women Veterans are encouraged to participate in smoking cessation classes, MOVE! program and cholesterol class. Alaska VA health education programs emphasize the importance of appropriate screenings and education about breast, ovarian, and cervical cancer.

The Alaska VA Healthcare System is sensitive to women Veterans' reproductive health education needs, especially for younger OEF/OIF Veterans. Clinicians stress the importance of preconception counseling. Using resources from the March of Dimes, women Veterans receive education about the importance of folic acid intake or supplementation. Another important health issue for women Veterans is to know which prescription drugs may be harmful during pregnancy or when breastfeeding. Alaska VA has instituted a "blue line warning" to alert providers about these medications. When health technicians or nurses access the screen to enter vital signs at a clinic visit for women Veterans between the ages of 18 and 55, a local electronic clinical reminder prompts the health technician or nurse to ask for the date of the patient's last menstrual period (LMP), is she pregnant, or breastfeeding. When providers open the visit note, the information regarding LMP, pregnancy, or lactation is on that note for their review. All clinics have this note available to them, including Social and Behavioral Health, Surgery, Dental, and Specialty Clinics. The reminder can be turned off if the woman no longer has childbearing capacity. These data are tracked in CPRS, and the Women Veterans Program Manager reports the



*Planning and implementing health education is most effective when education and information for patients and clinicians are developed in parallel. Alaska VA's successes and strategies provide valuable lessons for other facilities.*

data on a quarterly basis to the pharmacy and therapeutics committee to monitor compliance to this important health issue for women Veterans.

Program planning involves providers and team members assessing women Veterans' health education needs, selecting educational strategies and counseling and communication techniques, and standardizing programs.

Stevenson emphasized that assessing clinicians' needs related to health education is also an important part of planning health education programs for women Veterans. As Women Veterans Program Manager, she communicates frequently with primary care providers and teams. Anchorage primary care providers meet weekly, and as a part of the Primary Care team, she can regularly update providers on women's healthcare issues. The meetings help her identify new health education needs for women Veterans and inform clinicians about new health education services or programs. These meetings can address educational needs of clinicians and patients. For example, Alaska VA permits primary care providers to administer the human papillomavirus (HPV) vaccine (Gardasil). At her meetings with providers and other clinicians, Stevenson can discuss the need to educate women Veterans about the benefits of the vaccine and the requirement to schedule the second and third doses.

### Program Implementation

Time, distance, and weather affect the type of health education programming possible in the Alaska VA Healthcare System. Currently, clinical staff rely on traditional health education delivery methods, such as one-on-one education and counseling in clinic visits, along



with print materials. They also frequently contact patients by telephone and advise patients on reliable health information websites so that patients can obtain instructional materials to meet their individual needs. Alaska VA's orientation program for new patients includes specific information about women Veterans' health services and education, and promotes use of My HealthVet. In-person authentication is offered to Veterans at the Anchorage Outpatient Clinic, and the Fairbanks and Kenai CBOCs. In the future, to minimize weather and distance problems, Alaska VA hopes to expand health education classes at their CBOCs and clinics via videoconferencing. Topics for classes will include group learning experiences on menopause, heart health for women, and healthy lifestyles.

The Alaska VA Women Veterans Advisory Board is fortunate to have as a member a woman Veteran who is not a VA

employee. This ensures input and immediate feedback on the design and delivery of health education programs and services from a member of the patient population being served. A member of the facility's Patient Education Committee also serves on the Advisory Board. The close collaboration and effective communication among Stevenson, providers, clinicians, and the facility Patient Education Committee is also important.

Planning and implementing health education is most effective when education and information for patients and clinicians are developed in parallel. Alaska VA's successes and strategies provide valuable lessons for other facilities.

For more information, contact Yvonne Stevenson, FNP/CNM, Women Veterans Coordinator, Alaska VA Healthcare System, (907) 257-4950 or [yvonne.stevenson@va.gov](mailto:yvonne.stevenson@va.gov). ■

# News



## Resources on VHEI's Intranet Website

Have you visited the VHEI intranet website, [http://vavw.prevention.va.gov/Veterans\\_Health\\_Education\\_and\\_Information.asp](http://vavw.prevention.va.gov/Veterans_Health_Education_and_Information.asp) recently? You'll find resources to assist your facility and VISN to develop effective health education programs at the VISN, facility, patient population, and patient-clinician levels.

- A Model for Health Education Programming discusses assessment, program planning and implementation, and evaluation at the facility-wide, patient population, and individual patient-clinician levels. The Model includes objectives, outcomes, participants, and decision makers for assessment, planning, implementation, and evaluation at each of the three levels.
- VAMC Multifactorial Health Education Needs Assessment suggests data and other information sources, as well as assessment questions to identify health education needs at the facility, program, and patient levels.
- Responsibilities of VAMC Veterans Health Education Coordinators identifies core and suggested functions for Coordinators.
- Responsibilities of VAMC Veterans Health Education Committees identifies functions for a facility Health Education Committee.
- Responsibilities of VISN Veterans Health Education Committees identifies functions for a VISN Health Education Committee.

As you use these website resources, please share your experiences with us. They may provide success stories and case studies that can help your colleagues. We would also be interested in your suggestions about other useful kinds of resources. Please send your input to Dr. Pam Hebert, [pam.hebert@va.gov](mailto:pam.hebert@va.gov), (919) 383-7874 ext 249.

## Patient Education: TEACH for Success

Interested in offering the continuing education program, "Patient Education: TEACH for Success," at your facility? VHEI offers TEACH in collaboration with the Employee Education System (EES). TEACH is an experiential learning program that helps clinicians use evidence-based health education, counseling, and communication skills with patients and their caregivers. "TEACH" stands for: Tune in to the patient; Explore the patient's concerns, preferences, needs; Assist the patient with behavior changes; Communicate effectively; and Honor the patient as a partner. The TEACH program has two implementation levels: VAMCs select staff who will be trained at a national conference to serve as local TEACH facilitators; facilitators then conduct "Patient Education: TEACH for Success" at their facilities.

VAMCs and VISNs provide the travel funds to attend the national conference. EES funds travel for the TEACH master faculty attending the national train-the-facilitator conference, and also provides all facilitator and local participant

## UPCOMING CONFERENCE CALLS

### VHEI Patient Education Hotline 1st Tuesday of the month

1:00 pm ET

1-800-767-1750, access #16261

- April 7, May 5, June 2

### VHEI Patient Education Conference Call

4th Friday of April, July, October

1:00 pm ET

1-800-767-1750, access #19360

- April 24

learning manuals along with all the additional resources needed to conduct TEACH at the local level.

The date and location for the national TEACH train-the-facilitator conference in 2009 will be the week of either May 18 or June 1. It will either be held the week of May 18 or June 1. If your facility needs additional or new TEACH facilitators, or if you would like to begin to offer TEACH, this will be your opportunity. For additional information about TEACH, please contact Barbara Snyder, Health Educator, VHEI, at (919) 383-7874 ext 228, [barbara.snyder2@va.gov](mailto:barbara.snyder2@va.gov). For administrative questions about TEACH, contact Lauren Elliott, EES Project Manager, at (314) 894-6457, [lauren.elliott@va.gov](mailto:lauren.elliott@va.gov).

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

## Women and Wellness

Lots of women are interested in personal wellness. Is wellness for women any different than it is for men? Most of us would probably say No. The wellness lifestyle for all of us includes frequent physical activity, eating a healthy diet, maintaining a healthy weight, minimizing life stresses, having a positive attitude, avoiding tobacco, and using alcohol in moderation, if at all.

However, women may have some advantages when addressing personal wellness. Relative to men, women are often thought to be more aware of and responsive to health needs. Do proportionally more women engage in a healthy lifestyle? We don't know, but women may be more likely to explore ways to improve their health and well-being and follow through by implementing recommended health behaviors. Indeed, informal observation suggests that women have great interest in wellness programs in the VHA and elsewhere. Without a doubt, heightened health awareness and motivation to be healthy go a long way toward adopting a healthy lifestyle!

The vast majority of participants in organized aerobics, yoga, and other similar classes are females. Such settings may afford more comfort for women than exercising in other settings. There are also physical activity events targeted specifically for women, such as the "Run for the Cure," which supports breast cancer research and the American Heart Association's "Wear Red Day," which promotes heart health. In any case, opportunities for physical activity in comfortable venues are readily available. This may also be true for wellness-related classes such as healthy cooking, stress management, and others.

Women can also benefit from emotional support provided by friends, family members, and acquaintances. We know that people who have strong social support networks often enjoy better health than others, and also that strong support from others makes difficult things easier to accomplish. Adopting a wellness lifestyle is often easier with meaningful support from others. In fact, one good way to engage in wellness activities like exercise or stress reduction classes is to do those things with a friend. Each person can provide companionship, support, and encouragement for the other.

To the extent that the usual family scenarios hold true, women do the majority of meal preparation. This allows some degree of control over the family diet, and provides the opportunity to include healthy foods. Healthy foods may be introduced slowly over time, so that family members have time to accommodate the changes. Women can serve as change agents in the family and, if nothing else, can influence other family members by being wellness role models.

Overall, women and wellness make a very good fit! Serving as a role model for others can provide a motivating example not only for family members and friends, but for the worksite as well! Of course, men can serve as role models and change agents too. The message for all of us is to adopt and promote a wellness lifestyle for ourselves, for our families and friends, and for the benefit of our patients and the VA organization. Together we can make a difference! ■



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

# News



**The National Employee Health and Fitness Day** will be celebrated on Wednesday, May 20th, 2009. Facilities are encouraged to have "Be Active Your Way VA" physical activity events, as well as relevant displays, wellness fairs, and related health-enhancement activities. This comes in the middle of the Champions Challenge and gives us a great opportunity to reinforce participation in the challenge, as well as promoting the new 2008 Physical Activity guidelines for Americans available at <http://www.health.gov/paguidelines/>. Materials will be available on the NCP website well in advance of May 20th.

**Go Red for Women** is a national campaign initiated by the American Cancer Society to raise awareness that heart disease is the number one killer of women. February 6 was designated as "National Wear Red Day."



*Catherine Austin, Chief of Nutrition & Food Service and Henry Smith, Supervisor of Environmental Management, Memphis*

## UPCOMING CONFERENCE CALLS

**General Employee Wellness**  
Every other month, 4th Tuesday

2:00 pm ET

1-800-767-1750, access #63047

• April 28, June 23

*engage in physical activity • eat a healthy diet • maintain a healthy weight • minimize life stresses • have a positive attitude*  
*• avoid tobacco • use alcohol in moderation*

# News



## BE ACTIVE YOUR WAY VA!

The National Center for Health Promotion and Disease Prevention (HealthierUS Veterans and MOVE!) and Veterans Canteen Service (VCS) are partnering to sponsor the **2009 Champions' Challenge**. The 2009 Champions' Challenge is a physical activity challenge designed to increase awareness of the 2008 Physical Activity Guidelines for Americans recently

released by the US Department of Health and Human Services. The goal of the 2009 Champions' Challenge is for participants to complete 150 minutes of moderate-intensity physical activity each week for at least 8 of 12 weeks between **March 29, 2009 and June 20, 2009**. NCP and VCS launched the 2009 Champions' Challenge at the National Disabled Veterans Winter Sports Clinic (WSC) in Snowmass,

Colorado on March 29, 2009. Veterans Canteen Service will provide prizes for participants at enrollment and at completion of 3 weeks and 8 weeks. All participants who complete the Champions' Challenge will be eligible for entry into a national prize drawing sponsored by VCS. The challenge is designed primarily for Veterans and VA employees; however anyone is welcome to participate.

Registration and participation in the

### UPCOMING CONFERENCE CALLS

#### HealthierUS Veterans National Call

**3rd Tuesday of the month**  
3:00 pm ET

1-800-767-1750, access #35202

• April 21, May 19, June 16

#### Champions' Challenge Coordinators

**April 24**

3:00PM ET

1-800-767-1750, access #35202

Champions' Challenge is being offered **on-line only** at [www.move.va.gov/challenge.asp](http://www.move.va.gov/challenge.asp) beginning March 29, 2009. Participant instructions are also available at this web link.

Additionally, VCS will be partnering with General Mills to salute twelve gold medal winners of the 2008 National Veterans Wheelchair Games. During the "Challenge," the twelve athletes will be honored at their local VA Medical Centers and will sign sports cards with their pictures. The twelve gold medal winners will also appear on boxes of Cheerios that will be sold in military markets and the VCS retail stores around the country.

**Be ACTIVE Your Way VA!**  
**2009 Champions' Challenge**  
**March 29, 2009-June 20, 2009**

**Register Online:** [www.move.va.gov/challenge.asp](http://www.move.va.gov/challenge.asp)

**Goal:** Complete **150 minutes** or more of moderate intensity physical activity for at least 8 out of 12 weeks during the challenge.

Earn milestone prizes along the way. All participants who complete the challenge will be eligible for entry into a national prize drawing sponsored by Veterans Canteen Service

HealthierUS Veterans logo, MOVE! logo, and VA logo are included at the bottom of the graphic.

Visit [www.move.va.gov/challenge.asp](http://www.move.va.gov/challenge.asp) to register for the 2009 Champions' Challenge!

## Move! Weight Management and Women

Since the initial development and implementation of MOVE!, NCP has paid close attention to the enrollment and special needs of women Veterans. In this MOVE! update we describe what we know about women and MOVE!: weight and nutritional needs, suggestions about physical activity, and description of a MOVE! program specifically designed for women.

### Women and MOVE!

Whether through a healthcare system, a stand-alone clinic, or commercial programs such as Weight Watchers or Take-off-Pounds Sensibly, weight management services outside of VA tend to be used predominately by women. In fact, much of the research on weight management is based on mostly female samples of patients. VA serves a predominantly male patient population and most patients receiving MOVE! care are men. Women, however, participate in MOVE! at a higher level than we would expect, given their enrollment in VA. For example, approximately 8% of patients receiving health care from VA last year were women, but 13% of patients participating in MOVE! were women. This appears to indicate that women are more likely to accept assistance with weight management than their male counterparts. In general, we know that women Veterans tend to be younger, more highly educated, and more likely to be single, working, and also single parents than men Veterans. It follows, then, that women who participate

in MOVE! are younger and more likely to be single than their male counterparts. From data collected on the MOVE!23 Patient Questionnaire, we also know that women Veterans are more likely than men to be a members of a minority groups than the men. Recently, NCP commissioned a study that used methodology similar to the external peer review process to examine outcomes for a sample of male and female MOVE! patients who had workload evidence for six follow-up encounters (telephone, face-to-face, or group). Note that this was not a longitudinal study, but we were able to look at outcomes at 6, 12, and 18 months after entering MOVE!. Although men and women showed similar patterns of weight loss for the 6- and 12-month intervals, the percentage of women who lost more than 5% of their initial weight was higher than men at 18 months. Although these are observational findings, we plan to continue to monitor the experience of women Veterans. In summary, women are using MOVE! to manage their weight, they appear to accept this assistance more readily than men, and their outcomes appear to be comparable to men in initial weight loss and show a better response to weight management in the long term.

### Women, Weight, and Nutrition

Nutrition is a topic that is always of great interest to women, but many are surprised to learn that obesity is the #1 nutritional problem for women in the United States. Although the prevalence of overweight and obesity has increased for both genders and across all races, ethnicities, and age groups, disparities do exist. Among women, overweight and obesity are more prevalent

Contributed by

The MOVE! Team

Contact: Kenneth R. Jones, PhD  
National Program Director for  
Weight Management



among members of racial and ethnic minority populations than among non-Hispanic white women. These statistics are alarming, indicating nearly 50 percent of all Hispanic-American and African-American women are overweight. Obesity risk is greater among women with less education, poorer economic circumstances, and lower occupational status. Obesity, especially abdominal obesity, is central to metabolic syndrome and is strongly related to polycystic ovary syndrome in women. Obese women are particularly susceptible to diabetes and cardiovascular disease and have an increased risk of several major cancers, especially postmenopausal breast cancer and endometrial cancer. Obesity can also affect medical care. Too much fat can obscure imaging tests, such as X-rays, CT scans, ultrasound, and magnetic resonance imaging. Too much body fat can make it harder for a doctor to make a medical diagnosis and treat a patient.

MOVE! can be a great place for women

to start achieving and maintaining a healthy body weight. Today's women burn the candle at both ends, whether they are out in the workforce or working full-time in the home. After active military duty, and after children arrive, it can be exceedingly difficult to take control and lose the extra pounds that result from a healthy pregnancy or from increased inactivity. Our busy daily lives can make healthy eating a difficult task. Aging, too, presents its weight control issues, and weight gain later in life can have serious implications.

MOVE! recognizes that eating is one of life's great pleasures. Many foods and many approaches can help to build a healthy lifestyle—there's lots of room for choice. A good place to start is with the basic ABC's for health:

- **A**im for fitness. Check out the MOVE! Activity handouts on the **MOVE! website** (<http://vawww.move.med.va.gov/OUT.asp>).
- **B**uild a healthy base. Introduce women to the food guide pyramid as well as the variety of nutrition handouts available on the MOVE! website.
- **C**hoose sensibly. Individuals need to discover the diet that's best for their overall health. Choosing a particular eating plan is less important than sticking with the one you choose! Safe and effective weight-loss programs should include these components:
- Healthy eating plans that reduce calories but do not rule out specific foods or food groups, and
- Slow and steady weight loss of about 1-2 pounds per week.

### Women, Weight, and Physical Activity

The benefits of physical activity for adults over the age of 18 are numerous, and include a lower risk of early death, heart disease, stroke, type 2 diabetes, high blood pressure, adverse blood lipid

profile, metabolic syndrome, and colon and breast cancers. Additionally, physical activity can help prevent weight gain and falls (by improving balance and muscle strength), improve cardiorespiratory and muscular fitness, reduce depression, and improve cognitive function. Women who are physically active on a regular basis may also benefit from improved sleep quality, increased bone density, lower risk of hip fracture, and lower risk of lung and endometrial cancers.

The recently released **2008 Physical Activity Guidelines for Americans** (<http://www.health.gov/paguidelines/>) recommend that all people participate in some physical activity on a regular basis and that more physical activity is better. The guidelines recommend at least 150 minutes of moderate-intensity or 75 minutes of vigorous-intensity physical activity per week. Episodes of activity should be at least 10 minutes in length and ideally spread out during the week. Muscle strengthening activities that involve all the major muscle groups should be performed on 2 or more days per week.

For healthy pregnant and postpartum women who are not already doing vigorous-intensity physical activity, at least 150 minutes of moderate-intensity aerobic activity per week is recommended. Women who regularly engage in vigorous-intensity aerobic activity or high amounts of activity can continue this activity, provided that their condition remains unchanged. Pregnant women should communicate regularly with their health care providers about appropriate activity levels.

Although the numerous benefits of physical activity are well known, there is no ideal, prescribed way to deliver or guide physical activity specifically for women. One consideration when designing a physical activity program for women may be to focus on topics of concern for many women, such as osteoporosis, breast

cancer, postmenopausal hormonal imbalances and treatment options, and urinary incontinence. Conversations with women should detail the positive impact physical activity can have on many of these important health concerns. By addressing these topics, clinicians can assist women Veterans with what may be an otherwise awkward conversation, and encourage follow-up as needed with providers.

### An Example of Women-Specific MOVE! Care

The VA Pittsburgh Healthcare System will soon be offering a 10-week program specifically focused on women's healthcare needs and also addressing weight management. They plan to sponsor a spring fling for women Veterans, "MOVE! for a Healthier You" day on April 29, 2009. Festivities will include a healthy breakfast; healthy-eating and physical activity giveaways; guest speakers addressing women-specific topics; 15-minute exercise sessions; and a fashion show with VCS clothing, modeled by VA staff. Here's their promotional flyer. ■

**SPRING FLING for WOMEN VETERANS**  
 MOVE! for A Healthier YOU  
 BREAKFAST, SEMINAR, & FASHION SHOW

WEDNESDAY . APRIL 29, 2009 8:00 AM - 12:30 PM  
 VAPHS HIGHLAND DRIVE . BLD 8 . REC HALL

8:45am	Registration, healthy breakfast
8:45-9:00	Welcome, opening remarks Deborah Mitchell RN, Melodie Erskine RN
9:00-9:30	Eating for good health: Allison Morell RD
9:30-10:00	Healthy aids: Anita Williams NP
10:00-10:30	Let's get physical: Susan Dielanko MT
10:30-10:45	Opening: Melodie Erskine RN
11:00-12:00pm	Fashion Show featuring Veteran Cafeteria Service apparel
12:00pm	Busiest rally/ give-aways

Please RSVP before April 22 to **Melanie Erskine** at 412-954-4309.

This program is brought to you by the **MOVE! team** at VAPHS:  
 Melanie Erskine, MOVE! Coordinator  
 Allison Morell, MOVE! Dietitian  
 Susan Dielanko, MOVE! Kinesiotherapist  
 and Women Veterans Program/Deborah L. Matsumo, Manager  
 Voluntary Service/Deborah Goral, Voluntary Program Specialist

Portions of the program are made possible by the continued partnership of the Veterans Center for Services.

VAPHS  
 VA Pittsburgh Healthcare System

# News



## Dr. Deborah Tate joins the NCP Team as a Consultant

Dr. Tate is a clinical psychologist with primary research interest in interventions for the prevention and treatment of



obesity. She holds a joint appointment as an Assistant Professor in the University of North Carolina at Chapel Hill School of Public Health in the Departments of Health Behavior and Health Education and the Department of Nutrition and the Lineberger Comprehensive Cancer Center. The focus of Dr. Tate's programmatic line of research is in developing public health alternatives to standard clinical treatments for obesity, incorporating technology and informatics. She also has an interest in developing health communications about dietary and physical activity changes for weight loss and maintenance. Her research, funded by the National Institutes of Health, is an extension of her work in developing and evaluating Internet behavioral weight loss programs that incorporate new technology such as diet and physical activity monitoring on a handheld computer and online chat support. She is also the principal investigator

of a study funded by the US Courts to develop an Internet component for weight loss for adolescent girls. She is part of a research team recently funded by the CDC to examine the effectiveness of Internet weight loss programs combined with incentives for weight loss in worksites. Dr. Tate will advise the MOVE! team in the development of TeleMOVE! Care, which will include regional telephone coaching centers and Internet-based self-management tools.

### Training Conference

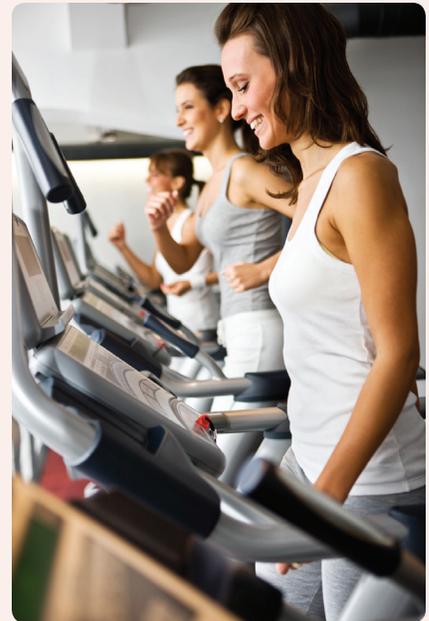
Mark your calendars for our "MOVE! Forward Together Training." This will be held for VISNs 1–10 on May 5–6 and VISNs 11–23 on July 23–24. Target audiences include VISN and Facility MOVE! Coordinators, Physician Champions, and others contributing to MOVE!. We will provide more details as they become available.

### Champions' Challenge

Please encourage patients and staff to participate in the Veteran Canteen Service/HealthierUS Veterans Champions' Challenge—Be Active Your Way VA. The Champions' Challenge promotes the new HHS Physical Activity Guidelines, which encourage moderate exercise for a minimum of 150 minutes per week completed in blocks of at least 10 minutes. Go to [www.HealthierUSVeterans.va.gov](http://www.HealthierUSVeterans.va.gov) for details.

## UPCOMING CONFERENCE CALLS

**MOVE! VISN and Facility MOVE! Coordinators Call**  
**2nd Tuesday of the first month of each quarter**  
 3:00 pm ET  
 1-800-767-1750, access #59445  
 • April 14



# CALENDAR *of* EVENTS

## PREVENTION CONFERENCE

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

April 29–30 in Arlington, VA

July 21–22 in the western part of the country (location TBA)

## MOVE! CONFERENCE

**“MOVE! Forward Together Training”**

May 5–6: for VISNs 1–10 in Boston, MA

July 23–24: for VISNs 11–23 (location TBA)

## PREVENTIVE MEDICINE FIELD ADVISORY COMMITTEE

April 28: Meeting at VACO in Washington, DC

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

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

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Visit our website at:

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



Department of  
Veterans Affairs

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

Office of Patient Care Services

Suite200 3022 Croasdaile Drive Durham, NC 27705

## NCP MISSION

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.

