

HEALTH *POWER!*

PREVENTION NEWS

SUMMER 2008

THEME:

PATIENT SELF-MANAGEMENT SUPPORT

In this newsletter, you'll find:

- From the Chief Consultant *p2*
- Implementation of Patient Self-Management into Routine Care in the Veterans Health Administration (VHA) *p3*
- Employee Health and Wellness *p5*
- HealthierUS Veterans (HUSV) Initiative *p7*
- *MOVE!* Weight Management Program for Veterans *p8*
- Prevention Practice and Policy *p11*
- Research and Evaluation *p14*
- Veterans Health Education and Information (VHEI) *p17*

WWW.PREVENTION.VA.GOV

From the Chief Consultant

The theme of this issue of HealthPOWER Prevention News is patient self-management support. Although patient self-management is an idea that's probably obvious to most patients, healthcare providers have come to accept and embrace the idea only relatively recently. Recommended care for many common chronic conditions now includes an approach that is more patient centered and that encourages patients to take a more active role with their healthcare team, in order to make decisions that are in keeping with their values, preferences, and goals. Patients and providers alike now recognize that nearly all chronic disease care occurs not in the medical care setting but at home and at work. Similarly, healthy lifestyle behaviors are learned and maintained by people as they go through their every day lives, not just when they're in the medical clinics for appointments. As Dr. Adam Darkins points out in his commentary, the Chronic Care Model includes patient self-management support as one of the six key elements that are to be integrated in a patient-centered way for healthcare to be successful. VHA Strategic Initiative 3.1 calls for VHA to "develop methods for advancing patient self management competency that enables patients to share in decision making and improve health outcomes."

Clearly, patient self-management is a concept that is worthy of a great deal of attention and effort within VHA. Several articles in this newsletter highlight the activities of NCP sections in support of patient self-management. The MOVE! Weight Management Program, Health Promotion/Employee Wellness, Veterans Health Education and Information, HealthierUS Veterans, Prevention Practice, and Research and Evaluation sections all are engaged in promoting and supporting patient self-management in various ways. It's a core component of "prevention."

The old saying in quality improvement of "what gets measured, gets done" is applicable to patient self-management. Currently performance measures, both in VHA and in non-VHA settings, focus mostly on clinical process and

intermediate health outcomes (for example, was the BP checked? was it below the target level? were lipid levels checked?). But we don't usually measure how well our patient self-management strategies are being done. The Society for Behavioral Medicine recently called for adding patient self-management measures for patients with diabetes, such as whether self-management goals were recorded, how well patient-centered care was delivered, and so on (www.sbm.org/policy/diabetes.asp). Incorporating such measures in our quality improvement system would certainly indicate that VHA considers these activities to be critical to high quality patient care.

As with all other aspects of health care, we need to carefully study and understand not only the benefits of patient self-management but we also need to be open to potential downsides, as well. Several recent studies have found, for instance, that self-monitoring of blood sugar by patients with type 2 diabetes who are not taking insulin not only doesn't lead to better health outcomes but actually is associated with greater self-rated depression and reduced quality of life.¹ The reasons for this surprising finding aren't entirely clear but it may be that some patients become overly concerned with their blood sugar readings and don't pay as much attention to other areas of their health. More research to look for potential harms of patient self-management is needed, so that we can be sure that we're providing our patients with care of proven value.

Working to keep our veteran patients "well and well-informed" is a goal of NCP and all of VHA. Helping patients to do what they can to manage their health behaviors and chronic illnesses themselves is an important strategy to achieve that goal.

Linda

¹ Gulliford M. Self monitoring of blood glucose in type 2 diabetes may not be clinically beneficial or cost effective and may reduce quality of life. *BMJ*. :1139-40.

"Clearly, patient self-management is a concept that is worthy of a great deal of attention and effort within VHA."

Implementation of Patient Self-Management into Routine Care in the Veterans Health Administration (VHA)

Incorporating *Patient Self-Management* (PSM) into health care services is important to the future of health care delivery. PSM has its underpinnings in translating the concept of patient centered care into how health services for patient populations with chronic conditions are developed. Patient-centered care was highlighted in the 2001 Institute of Medicine (IOM) publication *Crossing the Quality Chasm*. IOM defined patient-centered care as "care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions". By this definition PSM supports patient-centered care and improves care for patients with multiple chronic conditions, patients whose care requires coordination between multiple providers. Wagner's Chronic Care Model¹ provides a framework whereby PSM is incorporated into patient-centered care because it addresses the management of patients with multiple chronic conditions and includes the concept of the "activated patient" who is involved in his or her own disease management.

VHA, as other health care organizations, faces the challenge of meeting the needs of a patient population that is aging and affected by multiple chronic conditions for which PSM is an appropriate strategy. Influenced by both the IOM's *Crossing the Chasm* and the Wagner Model of Care, VHA identified PSM as one of its strategic priority areas in FY 2005. VHA's Office of Patient Care Services (PCS) led the initiative to realize the translation of this strategic priority into the delivery of routine services. Within PCS, Care Coordination Services (CCS) convened an expert panel to focus on Patient Self-Management. Between 2005 and 2007 this diverse and representative panel of clinicians, administrators, educators and researchers collaborated, reviewed evidence and made recommendations

that identified and crafted appropriate and effective PSM information and tools for staff, patients and caregivers. This work included feedback from focus groups of patients, caregivers and clinicians from across the nation to confirm these tools resonated with patient, caregiver and clinician experiences in direct care settings. The materials generated are incorporated within VHA's Patient Self-Management Toolkit that is available at: <http://vaww.carecoordination.va.gov/topics/psm/> (this toolkit contains the names and affiliations of the expert panel).

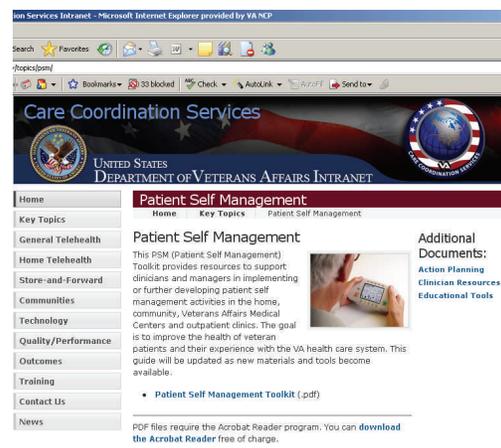
This toolkit is a resource for individual Veterans Integrated Service Networks (VISNs) to implement Patient Self-Management as an element of clinical services. The toolkit includes evidence-based definitions for PSM in VHA.

"Patient Self-management enables the individual to partner in an on-going trusting relationship with the healthcare team in activities and programs to: understand, actively participate and take responsibility for his/her condition(s)".

The above was an initial definition that was relevant to clinicians delivering routine care through input from focus groups of clinicians. However, this definition did not resonate with focus groups of patients and their caregivers. A patient specific definition of PSM was therefore created that was: "Patient Self-management allows you, your caregiver/family and healthcare team to work together to:

- Learn about your condition(s).
- Learn how you and your family can help.
- Learn what skills you need.
- Learn what help and resources are available.

This month's feature article was contributed by Adam Darkins, MD, MPH, FRCS—VHA Chief Consultant for Care Coordination



(Continued from page 3)

- Learn what you can do.
- Improve access to your healthcare team.
- Help you do what you want and need for your health and life.”

Both patient and clinician definitions of PSM are short and user friendly which is important from a patient/clinician communications perspective. Building on this communication, the intended implementation of PSM is based upon a model of patient and clinician working together on an individualized treatment plan which takes into account the identified needs/goals and preferences of the patient, caregiver/family and healthcare team. The anticipated outcomes of PSM are that it develops and enhances skills and uses resources that support adapting and living with acute and chronic problems, as well as protecting and promoting health and quality of life. The recommended strategy for the initial measurement of these outcomes is monitoring the levels at which PSM is incorporated into treatment plans.

As with all new programs, communication and marketing are vital components in the recipe for

success. An appropriate and relevant national slogan was selected to promote patient self-management among VA clinicians, patients and families. The most popular slogan of 5 that were proposed and the one adopted was:

My Life, My Health, My Choices

This slogan has been placed on buttons for individuals to wear. These buttons are intended for patients and clinicians with the expectation they will facilitate PSM in individual clinical encounters and promote this activity more widely. Buttons have already been mailed out to each Network and are available through the VISN Lead for Care Coordination for sharing with clinicians locally. They are also available from the CCS's Sunshine Training Center in Lake City, FL. The Sunshine Training Center has developed on-line training materials for patients, clinicians and caregivers to ensure PSM is consistently implemented and achieves the ultimate goal of ensuring that care is:

“Respectful of, and responsive to individual patient preferences, needs, and values, and ensures patient values guide all clinical decisions.”

¹Wagner, E.H. (1998). Chronic disease management: what will it take to improve practice? *Effective Clinical Practice*, 1(1): 2-4.

My Life
My Health
My Choices

The theme for the next HealthPOWER!
Prevention Newsletter is Motivational
Counseling Strategies

What? Manage Myself?

Jn caring for patients, we spend a good bit of our time “managing” our patients by advising them what to do to improve or maintain their health. After all, that’s why patients come to us. Of course, in the end patients have to manage themselves once they leave the healthcare setting, and they do so with varying degrees of success. But what about us? We all know what we need to do about our own health. Who will “manage” the caregiver? Therein lies the rub!

Managing our own behavior is hard. Far too often we find ourselves failing to do what we know we should do to optimize our own health and well-being. We know we need to eat a healthy diet with lots of fruits and vegetables, exercise on most if not all days of the week, maintain a healthy weight, not smoke, minimize our stress, and so on. So what’s the problem? Is the problem all the usual culprits, such as “I don’t have enough time,” “It costs too much money,” “I’m just too tired today,” “I have too many other things to think about,” “I don’t have any support from my family,” “I just have to get through (insert event) and then I’ll start,” “I’m under too much stress,” and so on? Of course not! For the most part, those are just our excuses. Unfortunately, we humans seem to have an endless capacity to rationalize our shortcomings, often to our own detriment.

So what is the answer to “managing” ourselves? Basically, much of our health and well-being (at least the behavior-based part) is “all in our heads.” Our thoughts, whether conscious or not, always precede our behaviors. If we could control what we think, we could control what we do. What a concept! In fact, we *can* control what we think. We just have to “Get the stinking out of our thinking.”

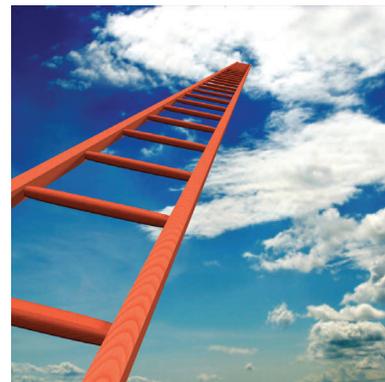
But where do we start? First, we can pay attention and recognize any thought that’s a rationalization, an exaggeration, unrealistic, a trumped-up excuse, and/or self-defeating in some way. Then neutralize such a thought by replacing it with a thought that’s more realistic, positive, and promotes our best interest. For example, if we think that we don’t have time to do any

physical activity, we can neutralize that thought by thinking, “I may not have time every day, but on some days I could rearrange things to make time. And I will absolutely feel better, have more energy, and have a better outlook when I do that. Now, what can I rearrange?” In other cases, we can think to ourselves, “Wait a minute! That’s not right. The situation is really (insert real situation) and I can deal with that.” In every case, it pays to think positive thoughts. We can deal with just about anything if we focus on it and have a positive “can-do” attitude.

Some things help us keep our thoughts positive. One is posting notes to ourselves where we will see them. Write positive statements, such as “Think positive! Life is good!” or “You’re on the right track now—feel proud!” or “I take care of myself because I’m worth it!” Another such tool is to keep an accurate and honest record of our physical activity, our weight, what we eat each day, what stresses we’re dealing with, or whatever we are working on. Completing entries on a daily basis keeps the target fresh in the mind and leads to productive thinking. Setting goals is also helpful, as long as they are daily or short-term enough to be relatively achievable, and are very specific. An example might be, “I will walk at least 30 minutes each and every day this week.” Meeting our goals strengthens our thinking about how to keep meeting those goals.

We always do better with “managing” our health behavior if we have support and encouragement from others. Joining a mall walkers’ group can encourage physical activity, joining a healthy cooking group can encourage healthy eating, and don’t forget to ask family and friends for

(Continued on page 6)



Employee Health and Wellness (cont'd)

(Continued from page 5)

words of encouragement. Having the opportunity to report our progress to others, such as family members or friends, provides accountability and motivation to continue.

Finally, we all need reinforcement for our good behavior. We can reinforce ourselves (and get a good stretch!) by patting ourselves on the back each time we make our thoughts positive or do something good for ourselves. And when we meet a goal, we should do something pleasurable. For example, if we manage to walk for at least 30 minutes a day for a week we might treat ourselves to a movie on the weekend, get a massage, go to the

park, plan a day trip, or whatever else will please us. The rewards reinforce both the behaviors and the thoughts that precede them.

Remember: the key to a healthy lifestyle is to have healthy, positive thoughts. A healthy mind leads to a healthy body. Although we cannot avoid some of life's unpleasant experiences, we can make ourselves aware of our thoughts and keep our attitudes positive. Let's all get our minds "right"!

Contributed by: Richard Harvey, PhD

I will walk at
least 30
minutes each
and every
day this
week.



Upcoming Conference Calls

General Employee Wellness
August 26th—2:00pm ET
1-800-767-1750 #63047
August 26, October 28,
December 23



Employee Health and Wellness News

Wellness Toolkits

Toolkits on various wellness-related topics, prepared by the NCP Wellness Advisory Council, have been posted on the NCP intranet website at http://vaww.prevention.va.gov?A_Cache_of_Wellness_Topics.asp

National Employee Health and Fitness Day

The 2008 National Employee Health and Fitness Day was celebrated on May 21st this year. VHA Medical Centers throughout the country hosted "Walk and Roll" or similar events and participants selected valuable health and wellness information from attractive display tables. A great deal of creativity went into these celebrations as evidenced by the reports and pictures pouring into NCP! It is clear that a good time was had by all! The reports and photographs will be featured in the 2008 Wellness Digest to be published soon. Look for the announcement in your email in August or September!

Helping Veterans “Get Fit for Life”

Developing resources to support physical activity was identified as a high priority early in the HealthierUS Veterans Initiative. One idea that surfaced was the development of an exercise video/DVD especially for veterans who are sedentary. A work group was established and the end result is “**Get Fit for Life**,” a comprehensive beginner’s exercise DVD that includes follow-along exercises, helpful tips, and inspiring stories from veterans. It is formatted so that veterans can use it in the privacy of their homes or in a group format. Exercises on the DVD include a warm-up, aerobics, cool-down, strength and balance, stretching, and intermediate strength training. Along with the DVD, veterans get a 16-page accompanying booklet with additional

information and a tear-out physical activity log. If veterans are just getting started with physical activity, then this DVD is for them.

Each medical center was sent several hundred copies of the DVD. Many of the local *MOVE!* programs are already using the DVD. Overall, veteran response to the DVD has been very positive. Additional copies of the DVD are available for facilities to order at:

http://vaww.sites.lrn.va.gov/vacatalog/cu_detail.asp?id=23847



Contributed by Pam Del Monte, MS, RN-BC



HealthierUS Veterans (HUSV) Initiative News

Staff Update

The NCP is happy to announce the addition of a new staff member, **Sue Diamond, RN, MSN**, as the new Program Manager, Community Health. Sue earned her BSN from Creighton University in Omaha, Nebraska, in 1984 and her MSN with specialty as an Adult Nurse Practitioner and Oncology Clinical Nurse Specialist from Duke University, Durham, North Carolina, in 1999. Her most recent position was as a Nurse Practitioner at the Durham VAMC where she was a Nurse and Midlevel Provider recruiter. She also has been involved in system redesign and leadership projects and served as chairperson of the Nurse Professional Standards Board for several years. Sue holds a Clinical Associate Faculty appointment at the Duke University Graduate School of Nursing. She will be coordinating NCP’s efforts with respect to the HealthierUS Veterans initiative. Sue can be reached at 919-383-7874, ext. 244 or at sue.diamond@va.gov.

HealthierUS Veterans Mini-Grants Program

This year the HealthierUS Veterans initiative solicited applications from facilities to

conduct HUSV-related projects. Forty mini-grants of \$2,500 each plus one group grant were awarded. The purpose of these grants is to help facilities fund original ideas, projects, materials, and/or products for use with veterans to promote the goals and key message of the initiative: Be Active, Eat Healthy, Get Fit for Life.

The NCP received more than 160 applications with descriptions of unique and innovative ideas. Each VISN was awarded at least one mini-grant. Projects target a variety of veteran groups (e.g., women, OEF/OIF, older veterans) in urban, rural, and suburban locales at facilities and community-based outpatient clinics. As the projects move forward, periodic updates will be given on the HealthierUS Veterans monthly conference calls (3rd Tuesday of the month at 3:00 PM ET), on the HealthierUS Veterans website (www.healthierusveterans.va.gov), and the HealthPOWER! newsletter. A heartfelt “thank you” goes to the HealthierUS Veterans VISN Points of Contact and the team of reviewers for all their hard work in the grant application and selection process.



Upcoming Conference Calls

Beginning with the July 15, 2008 HUSV monthly conference call, we will open the calls to HUSV facility coordinators and HUSV mini-grant recipients. We look forward to hearing about the progress of the mini-grant projects as well as other facility-level HUSV activities.

HealthierUS Veterans National Call

3rd Tuesday of the Month,
3:00 PM ET
1-800-767-1750, Access
Code #35202
July 15, August 19,
September 16, October 21

MOVE! Weight Management Program for Veterans

Patient-Centered Self-Management Support and MOVE!

The MOVE! Weight Management program for Veterans is designed to support patients in self-management of weight-related health. We have many information tools to help members of the healthcare team support patient self-management. These tools include guidance on how to open the discussion of weight issues, how to offer the support of MOVE! to patients, and techniques for helping patients set goals to develop action plans and work towards making healthy behavior a lifelong habit.



Screening and Initial Discussion

The VA/DoD Clinical Practice Guideline for Obesity recommends that clinicians screen patients at least annually using the body mass index (BMI). The risks of excess weight should be discussed with all patients. Patients who are obese (BMI ≥ 30), are overweight (BMI 25-29.9) and have a weight-related disease, or have excess abdominal adiposity (waist circumference >35 " for women and >40 " for men) are targets for a discussion about weight management and the availability of MOVE! care. The MOVE! team has developed several tools to facilitate this discussion, primarily using motivational interviewing approaches. These tools include our [online training](#), [our discipline-specific pocket guides](#), and guidance from our [MOVE! Clinical Reference Manual](#). Because most overweight or obese patients have already attempted to manage their weight and have had some successes and failures, that's a good place to begin the discussion. Here's a good approach: "I can see from your height and weight that you're carrying excess weight. We know that this can damage your health and affect your life. I'll bet that you've already done some things on your own to try to work on your weight.

Tell me what you have tried."

MOVE! is designed to assist patients who are "ready" to work on their weight. Two key issues in the decision to attempt to regulate weight are the perceived *importance* of addressing these issues and patients' *confidence* in their ability to make changes in eating, physical activity, and behavior that leads to better weight management. Motivational counseling and other health communication approaches can assist the patient in clarifying these issues and making a decision to address excess weight.

Making and Carrying Out an Individually Tailored Action Plan

Unlike many rigid weight management programs, MOVE! is designed to be patient-centered and tailored to the individual. Although patients have a choice of individual or group treatment, both forms of care support patient self-management. To identify individual patient needs, we developed the [MOVE! 23 Patient Questionnaire](#). The MOVE!23 helps identify personal barriers to changing eating, physical activity, and other behaviors. Again, our tools include guidance for patients and staff to form viable plans to facilitate weight management. For patients we have [handouts](#) that address barriers and assist with creating action plans, including those barriers identified in the MOVE!23. For example, the handout [Change Your Behavior](#) focuses on how to make a plan. For staff assisting patients in developing plans, guidance is available through our [online training](#), [MOVE! Clinical Reference Manual](#), and [Group Session Materials](#). Good plans include the following: setting reasonable goals, formulating a plan with details (who, what, when, how), self-measurement of key elements, establishing rewards for success, and incorporating periodic review of progress and revision of the plan, as needed.

(Continued on page 9)

MOVE! Weight Management Program for Veterans (cont'd)

(Continued from page 8)

Behavioral Maintenance: Making Healthy Behavior a Habit

As Mark Twain said, "Quitting smoking is easy. I've done it a thousand times." Although making healthy behavior change is good, making healthy behavior a *habit* is the key to long-term risk reduction. Our initial focus in implementing *MOVE!* was to establish the program and begin treatment. As those of you working in *MOVE!* already know, many patients drop out of care and return later. This is to be expected, and suggests that we are communicating to patients that they are welcome to come back and try again, even if they encounter difficulties. Again, our tools include assistance to support patients in making weight management a healthy habit. These include handouts such as [Yes, You Can Keep that Weight Off!](#) and the previously mentioned training and reference materials. Even if patients achieve success in initial weight loss, we know that they will probably need to self-manage their weight-related behaviors for the remainder of their lives. To this end, many facilities are providing periodic group sessions to support maintenance of weight management. Our revised Group Session materials include guidance on conducting a [maintenance group](#). Even the most successful patients will need annual reassessment of their weight. Patients should be encouraged to maintain rewards for the hard work they are doing, and to establish a threshold for weight re-gain (e.g., 10 pounds) to serve as a signal to ask the healthcare team for help.

With *MOVE!*, we have attempted both to give patients as much information and encouragement as possible to create a self-management plan that works for them and to give clinicians guidance to support patients throughout this process.

Yes! You Can Keep That Weight Off!

You have been managing your weight successfully for a long time. GREAT!!

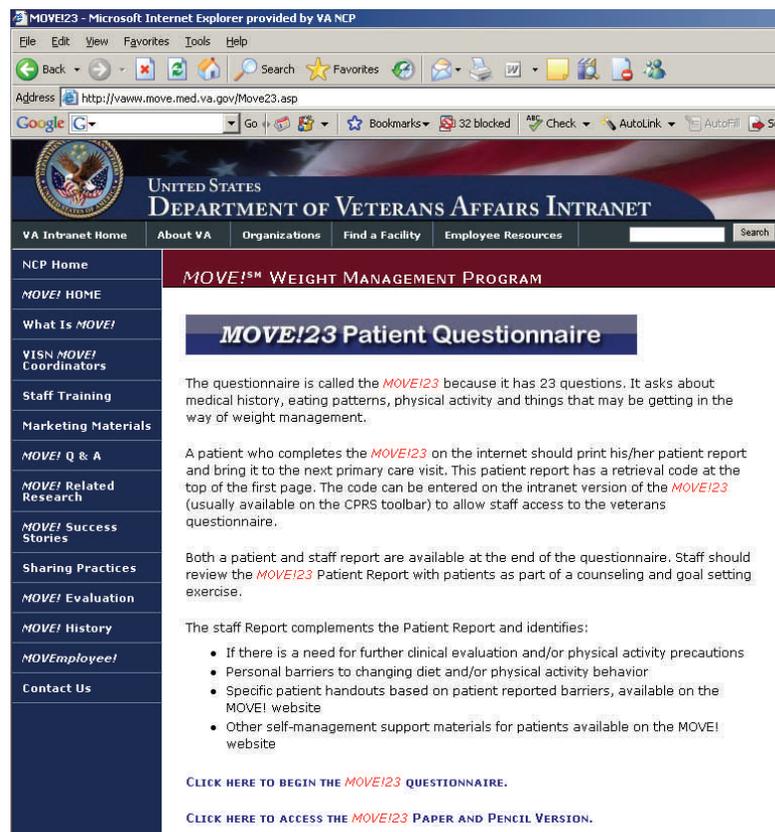


Here are some tips to help you keep going:

- Now that you know what works for you – keep it up!
- Write down all the reasons you wanted to lose extra weight in the first place. Look at these carefully, and think about how far you have come.
- Take credit for your success and hard work. Continue to reward yourself often!
- Plan for people, places, and events that might trip you up.
- Keep your thinking POSITIVE.
- Maintain your network of family and friends to provide encouragement and support. Let them know how much their ongoing support is helping you.
- Plan ways in advance for you to deal with difficult situations.
- Find new ways to cope with stress.
- If you do "slip-up", get right back with your program. Give yourself lots of praise for doing that.

MOVE! 806 Version 3.0
www.move.va.gov

Contributed by: **Kenneth Jones, PhD**



The screenshot shows a Microsoft Internet Explorer browser window displaying the VA Intranet page for the MOVE!23 Patient Questionnaire. The browser address bar shows the URL: <http://vaww.move.med.va.gov/Move23.asp>. The page header includes the United States Department of Veterans Affairs Intranet logo and navigation links. The main content area features a red banner with the text "MOVE!23 Patient Questionnaire". Below the banner, there is a section titled "MOVE!23 Patient Questionnaire" with the following text:

The questionnaire is called the *MOVE!23* because it has 23 questions. It asks about medical history, eating patterns, physical activity and things that may be getting in the way of weight management.

A patient who completes the *MOVE!23* on the internet should print his/her patient report and bring it to the next primary care visit. This patient report has a retrieval code at the top of the first page. The code can be entered on the intranet version of the *MOVE!23* (usually available on the CPRS toolbar) to allow staff access to the veterans questionnaire.

Both a patient and staff report are available at the end of the questionnaire. Staff should review the *MOVE!23* Patient Report with patients as part of a counseling and goal setting exercise.

The staff Report complements the Patient Report and identifies:

- If there is a need for further clinical evaluation and/or physical activity precautions
- Personal barriers to changing diet and/or physical activity behavior
- Specific patient handouts based on patient reported barriers, available on the MOVE! website
- Other self-management support materials for patients available on the MOVE! website

At the bottom of the page, there are two links: "CLICK HERE TO BEGIN THE *MOVE!23* QUESTIONNAIRE." and "CLICK HERE TO ACCESS THE *MOVE!23* PAPER AND PENCIL VERSION."



MOVE! Weight Management Program for Veterans News

Staff Updates

Please join us in welcoming two new members to the *MOVE!* staff.

Sophia Hurley, PT, former Patient Education, Employee Wellness, and *MOVE!* Coordinator at the Miami VAMC, joined our staff as *MOVE!* Physical Activity Coordinator on April 27. She has a background in general physical therapy and in promoting physical activity to foster wellness and weight management. Sophia will serve as our official liaison with the national Rehabilitation Services Office. She can be reached at 919-383-7874, ext. 225, or at Sophia.Hurley@va.gov.

Lynn Novorska, RD, was selected as our *MOVE!* Dietitian Coordinator. Lynn also began work with NCP on April 27. Most recently, Lynn was the Asst. Chief, Nutrition and Food Service at the Durham VAMC, where she was also the *MOVE!* Coordinator. Lynn was an early contributor to *MOVE!*, as she participated in the pilot program. Lynn has also held positions at the Tampa and Pittsburgh VAMCs. She will serve as our official liaison with the national Nutrition and Food Services Office. Lynn can be reached at 919-383-7874, ext. 245 or at Lynn.Novorska@va.gov.

Other News

MOVE! Counseling Exempt from Co-payment

Effective June 16, 2008, all *MOVE!* Counseling, whether provided to individuals or groups, is exempt from co-payments. Here are the details:

- *MOVE!* visits coded with DSS Identifier/stop codes 372 (individual)

and 373 (group) are automatically exempt from co-payment via a Business Office software patch.

- By policy, *MOVE!* visits should have already been coded in this manner.

DSS Codes Identifiers contain two 3-digit codes (primary and secondary), and the exemption will be credited if the *MOVE!* code is in either the primary or secondary position.

VISN MOVE! Leadership Changes

Linda Cameron, MBA, VISN 1 *MOVE!* Coordinator, retired from VA service on May 22. We thank Linda for her contributions to *MOVE!* and wish her well in her retirement. Congratulations, Linda!

Peg Dundon, PhD, VISN 2 *MOVE!* Coordinator, has accepted the leadership position for the VISN 2 Center for Integrative Health. We will miss her leadership of *MOVE!* in VISN 2, but we are excited about planned collaborations with the Center and *MOVE!*. Congratulations, Peg!

Screening for Obesity Performance Measure

At the recommendation of the VHA Performance Management Workgroup, the VHA Office of Quality and Performance has elevated the current obesity screening supporting indicator (mnemonic "MOV5") to a performance measure for FY09. Complete details about this measure can be found on the *MOVE!* website under "Administrative Tools".



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 Code #59445
Next call: July 8

Self-Management to Enhance Clinical Preventive Services

Self-management is not only for improving chronic disease, but can also be applied to preventive health care. Patients that are informed and active participants in their own preventive care is the goal. Listed below are several recommended screenings and immunizations for men and women. Each has a brief explanation and some questions to anticipate and encourage patients to ask.

Screening for Hypertension: The VA/DoD Clinical Practice Guideline for Hypertension (http://www.oqp.med.va.gov/cpg/HTN04/HTN_base.htm) recommends screening all adults in the VA healthcare system. Questions to anticipate and encourage patients to ask:

- ⇒ What is my blood pressure?
- ⇒ What should my blood pressure be?
- ⇒ What can I do to keep my blood pressure under control?

Screening for Dyslipidemia: The VA/DoD CPG for Dyslipidemia (http://www.oqp.med.va.gov/cpg/DL/DL_base.htm) recommends screening men 35 and older and women 45 and older for dyslipidemias. Screening is also indicated for younger patients with cardiovascular disease or risk factors. Questions to anticipate and encourage patients to ask:

- ⇒ What are my cholesterol numbers?
- ⇒ What should my cholesterol numbers be?
- ⇒ What can I do to keep my cholesterol under control?

Screening for Colorectal Cancer: VHA Directive 2007-004 "Colorectal Cancer Screening" (http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1530.) addresses both appropriate colorectal cancer screening tests and recommendations for optimizing colorectal cancer screening in practice. Questions to anticipate and encourage patients to ask:

- ⇒ When should I start screening?
- ⇒ How often should I be screened?

- ⇒ Which screening test is right for me?

Influenza and Pneumococcal

Immunization: Veterans aged ≥ 50 should receive an annual influenza vaccination (http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1613) and those aged ≥ 65 should receive a one-time pneumococcal vaccination (<http://www.cdc.gov/mmwr/preview/mmwrhtml/00047135.htm>). Vaccination of younger patients may also be indicated depending on the patient's health status. Questions to anticipate and encourage patients to ask:

- ⇒ Should I get a pneumonia or flu shot?
- ⇒ Where can I get my pneumonia or flu shot?
- ⇒ What side effects can I expect from getting vaccinated?

For Women

Gender-specific care for women is described in the VHA Handbook 1330.1 "VHA Services for Women Veterans" (http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1117).

Screening for Breast Cancer: Of all breast cancer screening strategies that have been studied (clinical breast exam, self breast exam, and mammography), only mammography has been shown to be effective in clinical studies. Women aged 40 and older should have a mammogram every one to two years. Questions to anticipate and encourage patients to ask:

- ⇒ When should I start screening?
- ⇒ How often should I be screened?
- ⇒ When should I stop getting screened?

Screening for Cervical Cancer: Women should be screened for cervical cancer every 1–3 years beginning at age 21, or three years after onset of sexual activity, whichever comes first. Routine screening in women who have had normal screening exams and are not at high risk can stop

(Continued on page 12)



Encourage patients to be active, well-informed, knowledgeable partners in their preventive health care



Prevention Practice and Policy (cont'd)

(Continued from page 11)

at age 65. There is no clear advantage among the various screening tests (conventional PAP smear versus liquid based cytology) or strategies (cytology plus/minus HPV testing) that are currently available. Questions to anticipate and encourage patients to ask:

- ⇒ How often should I be screened?
- ⇒ Do I still need to get screened if I got the HPV (human papilloma virus) vaccine?
- ⇒ Do I need to get screened if I have had a hysterectomy?

For Men

While gender-specific cancers in men (prostate and testicular cancer) are somewhat common, the evidence is less conclusive about the net benefits of screening for these cancers.

Screening for Testicular Cancer: No studies have evaluated whether screening either by clinical examination or by teaching men to perform self-examination has any morbidity or mortality benefit. While screening asymptomatic individuals may not have any benefit, prompt evaluation of testicular symptoms (pain, swelling, and/or mass) is always warranted given that testicular cancer often presents similar to benign testicular conditions.

Screening for Prostate Cancer: While tests are available for prostate cancer screening, the evidence is less conclusive about the benefits of early prostate cancer detection. Thus, the United States Preventive Services Task Force (USPSTF) does not make any recommendations for or against routine screening. Thus, clinicians are urged to use shared-decision making so that patients can have a reasonably good understanding about the risks and benefits of screening and make an informed decision about getting screened for prostate cancer. An updated recommendation from the USPSTF is expected in July 2008.

Contributed by Pam Del Monte, MS, RN-BC and Leila Kahwati, MD, MPH

Clinical preventive services resources for patients from the Agency for Health Care Research and Quality:

Men: Stay Healthy at Any Age, Your Checklist for Health <http://www.ahrq.gov/ppip/healthymen.pdf>

AND

Women: Stay Healthy at Any Age, Your Checklist for Health <http://www.ahrq.gov/ppip/healthywom.pdf>



Prevention Practice and Policy News

Staff Updates

Pam Del Monte, MS, RN-BC, Prevention Practice Program Manager since September 2005, has accepted a new position at the Durham VA Medical Center. Pam began her work as the Associate Chief Nurse for Ambulatory Care in mid-June. We wish her the best of luck in her new role.

Terri Murphy, RN, MSN, joined NCP as Prevention Policy Coordinator in April 2008. She came to NCP after 16 years at the Durham VA Medical Center, where she was most recently a Clinical Applications Coordinator. Terri, a Clinical Nurse Specialist by training, has a

background in Geriatrics and Spinal Cord Injury and has worked in various roles and a number of projects during her VA tenure. Terri is an Illinois native, happily transplanted to North Carolina in 1976. She obtained her BS in Nursing from Northern Illinois University and her MSN from the University of North Carolina at Chapel Hill. Terri is working with the newly formed Preventive Medicine Advisory Committee and other stakeholders to coordinate clinical preventive service policy for the VHA. A large part of her new job will be to develop content for a portion of the NCP web site, so that it can serve as a one-stop shop for

(Continued on page 13)

Prevention Practice and Policy News (cont'd)

(Continued from page 12)

VHA clinical preventive service policy and resources for implementation. Terri can be reached at 919-383-7874, ext. 243 or at AnnTerri.Murphy@va.gov.

Other News

NEW! VHA Preventive Medicine Advisory Committee Formed

NCP has convened a Preventive Medicine Advisory Committee (PMAC) composed of representatives from the VISN Preventive Medicine Leader group, other VHA program offices that have a prevention focus, and field-based subject matter experts. The group's first face-to-face meeting was on June 12, 2008 in Washington, DC.

The purpose of the PMAC is to:

- Advise NCP on clinical and administrative issues related to VHA health promotion and disease prevention services and activities;
- Assist in the assessment of new clinical techniques and preventive medicine advancements, the formulation of individual clinical preventive service policies, and the monitoring of VHA prevention program performance; and
- Help NCP identify field preventive medicine challenges, priorities for improvement, and opportunities for disseminating best prevention practices.

Experts Needed

The Guide to Community Preventive Services at the Centers for Disease Control and Prevention (www.thecommunityguide.org) is seeking experts in health communication or health marketing to serve on either the coordination or consultation teams for a new series of systematic reviews on the effectiveness of interventions in these areas, to begin soon. Coordinating team members actively participate in the development and execution of the systematic reviews, whose findings form

the basis for recommendations from the Task Force on Community Preventive Services. Consultation team members serve as consultants and expert reviewers throughout various stages of the systematic review process. If you are interested, please contact Dr. Leila Kahwati (Leila.kahwati@va.gov), your VA liaison to the Task Force on Community Preventive Services, for more information.

US Preventive Services Task Force: Recently Issued Recommendation for Adults

Screening for Chronic Pulmonary Obstructive Disease
The USPSTF recommends **against** screening adults for chronic obstructive pulmonary disease (COPD) using spirometry. The USPSTF assigned a grade of D to the evidence it evaluated in its systematic review of the use of spirometry to screen for COPD. This means that there is moderate to high certainty that the service has no benefit or that the harms outweigh the benefits. Therefore, the use of this service should be discouraged. For complete details, see: <http://www.ahrq.gov/clinic/uspstf/uspscopd.htm>.

Have You Visited the NCP Internet Site Lately?

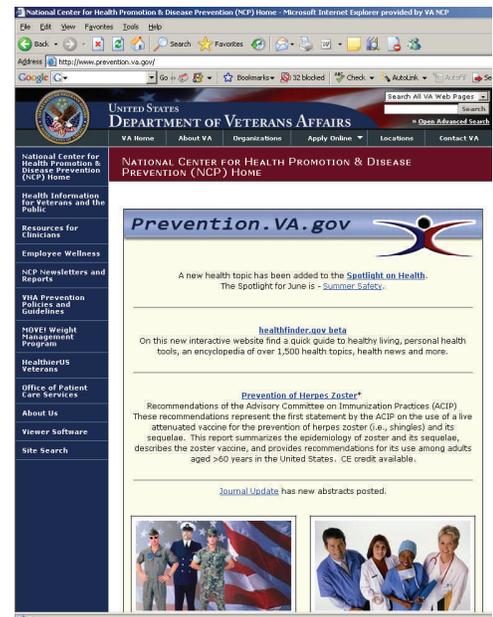
We continue to add to and improve our Prevention Internet Website (www.prevention.va.gov). On this site you'll find a variety of resources both for you and your patients. Encourage veterans to visit the Spotlight on Health, where a new health topic is posted each month. Also, check out the "Journal Update" page. Each month, NCP staff highlight relevant articles for clinicians interested in preventive health care. You'll also find quick links to the *MOVE!* website, the HealthierUS Veterans website, and a section for tools and resources for Employee Wellness.



Upcoming Conference Calls

VHA Prevention Call
2nd Tuesday of the Month,
1:00 PM ET
1-800-767-1750, Access Code #18987
July 8, Aug. 12, Sept. 9, Oct. 14

VISN Preventive Medicine Leaders Call
1:00 PM ET
1-800-767-1750, Access Code #18987
September 2



Research and Evaluation

Patient Self-Management Support: What is an Effective Program Design?

Various chronic disease self-management support models, programs, and services have been designed, used, and studied throughout the U.S. healthcare system. While an evidence base is starting to accumulate for these programs, many questions still remain for developers, purchasers, and policymakers as to how to design and structure these models of care and what benefits (both in terms of health and costs) are likely to be observed.

In November 2007, the Agency for Healthcare Research and Quality (AHRQ) issued a report prepared by RAND Health that summarized an evaluation of patient self-management support programs.¹ The purpose of this report was to identify structure and features to be considered by developers of such programs, including measures by which to judge program effectiveness. This report was based on a comprehensive review of the literature supplemented by interviews with experts. Key findings from this report are as follows:

1. Programs should aim to change patient behavior.

Self-management support programs often include multiple objectives and multiple endpoints for possible evaluation. However, their primary purpose is to help patients succeed in managing a chronic disease, by changing and maintaining behaviors. We know that providing information *alone* is insufficient to change patient behavior. Patients also need encouragement, skills, confidence, and help with problem-solving to be successful with behavior change. The case for self-management support programs is strongest when good evidence links changes in patient behavior to improved patient health outcomes. The report identified several effective self-management program components for two common chronic conditions—diabetes and asthma—as shown in the table.

Self-Management Strategy	Diabetes	Asthma
Self-monitoring	X	X
Group-based education	X	
Patient collaboration	X	
Regular reinforcement	X	
Additional contact time between educator and patient	X	
Computer-assisted patient education/ health communication applications	X	
Written action plans		X
Individualized plans		X

2. Several options for program design and location exist. Optimal design and location depends on the goals of the program, the patient population, and staffing requirements.

Major design decisions include the program elements listed in the sidebar. The location of the program often guides subsequent design decisions. Options for location include: within the primary care practice/clinic, elsewhere within the

Elements of Program Structure

- Location
- Degree of personal interaction
- Staffing
- Content of support
- Patient population served
- Information support
- Protocols for delivery of support
- Staff training
- Communication with patients
- Communication between primary care providers and self-management support staff

(Continued on page 15)

(Continued from page 14)

healthcare system, or outside the healthcare system (e.g., an external entity or commercial vendor). Each location has advantages and disadvantages and no one model is clearly superior.

3. "Health coaching" is an element that distinguishes effective self-management support programs.

Programs without any direct, personal patient contact (e.g., programs that rely entirely on written materials or are computer-generated and/or use scripted websites, e-mails, or robo phone calls) are very different from programs that rely on personal contact with patients, either face-to-face or by telephone. The ability for a self-management support program to respond to an individual's needs and priorities in a patient-centered, compassionate way generally requires considerable personal interaction. Many program's content and protocols emphasize knowledge that patients must acquire for successful behavior change, rather than the "health coaching" required for patients to successfully utilize that knowledge.

4. The most effective "health coaching" staff may not be easily identified by background or educational qualifications.

Staffing for self-management services are typically delegated to non-physician staff, but no particular type of staff or qualification is optimal. More important than discipline or education are the interpersonal skills and attributes suitable for the role of "coach". These include teaching skills, compassion, and the ability to reflect on patients' priorities and needs.

5. A variety of communication modalities exist for patients, primary care physicians, and self-management support program staff.

The Internet is used increasingly to communicate with patients participating in self-management programs. The web allows a one-stop portal for self-

monitoring, education, and contact (through e-mail or live chats). Group visits, individual visits, and telephone are most commonly used when the program is based within the primary care clinic. Communication between primary care provider and self-management support staff varies, depending on the location of the program. Externally based programs are at higher risk of poor communication with the primary care provider. On the other hand, supporters of externally based programs argue that it is exactly this lack of connection to the primary care provider that may result in more independent patients, who, through coaching, are better equipped to communicate with their physicians.

So, as you can see, no one program design can be considered "effective." An effective program is one that successfully achieves the outcomes determined by its implementers. The final section of the AHRQ report briefly outlines how to approach evaluating self-management support programs, along with a number of outcomes and end-points that could be considered. The key evaluation principle is to align outcomes with program goals and to use a measurement timeframe that is consistent with the program's timeframe.

¹Pearson ML, Mattke S, Shaw R, Ridgely MS, Wiseman SH. Patient Self-Management Support Programs: An Evaluation. Final Contract Report (Prepared by RAND Health under Contract No. 282-00-0005). Rockville, MD: Agency for Healthcare Research and Quality; November 2007. AHRQ Publication No. 08-0011. <http://www.ahrq.gov/qual/ptmgmt/>.

Contributed by: Leila C. Kahwati, MD MPH





Research and Evaluation News

MOVE! Evaluation Reports Released

For the second year, NCP has prepared and distributed reports summarizing the status of the *MOVE!* Weight Management Program for Veterans. The FY07 reports were released in April and include a VHA national report along with 21 VISN-specific reports. This year's reports are organized along the five RE-AIM domains (Reach, Effectiveness, Adoption, Implementation, and Maintenance) and are based on data obtained from the *MOVE!* Annual Reports submitted by facilities and data obtained from the VHA National Patient Care Databases and External Peer Review Program. The reports can be accessed at: <http://vaww.move.med.va.gov/Reports07.asp> (link is only accessible behind the VA firewall).

2Q FY08 Prevention Performance Measure and Supporting Indicator Data Available

Performance measure and supporting indicator data for second quarter FY08 is available from the Office of Quality and Performance. Starting with this quarter, the Executive Briefing Book is now accessible via a ProClarity Data Cube. Data is also available via the Measures Master Reports. These data are available at the OQP Performance Data Warehouse: <http://vaww.pdw.med.va.gov/>.

MOVE*VETS Research Study Kicks into Full Gear

A collaborative study between the VHA and the University of North Carolina at Chapel Hill is now underway. The study's objective is to examine the impact of two enhancements to the standard *MOVE!* Program at 10 VA facilities, using a group-randomized controlled trial. The enhancements include the use of tailored patient newsletters and the use of volunteer peer counselors. This

study also includes an organizational component involving staff interviews and surveys to better understand the barriers and facilitators of *MOVE!* and *MOVE*VETS* implementation. Finally, a peer counselor process evaluation will occur in the 5 intervention sites. Dr. Marci Campbell (Professor, UNC Chapel Hill) is the study's overall principal investigator and Dr. Linda Kinsinger (Chief Consultant for Preventive Medicine, NCP) is the overall VHA principal investigator. Dr. Leila Kahwati (Deputy Chief Consultant for Preventive Medicine, NCP) is serving as VHA Project Coordinator.

Recently Published

Almond N, Kahwati L, Kinsinger LS, Porterfield D. The Prevalence of Overweight and Obesity among U.S. Military Veterans. *Military Medicine* June 2008, Vol 173(6):544-49.

Overweight and obesity are increasingly contributing to disease burden among military populations. The purpose of this study was to calculate and examine the prevalence of overweight and obesity among the veteran population. Data were obtained from the 2004 Behavioral Risk Factor Surveillance System. Overweight (body mass index ≥ 25 kg/m²) prevalence in veterans was 73.3% (SE, 0.4%) for males and 53.6% (SE 1.7%) for females. Obesity (body mass index ≥ 30 kg/m²) prevalence in veterans was 25.3% (SE, 0.4%) for males and 21.2% (SE, 1.4%) for females. After adjusting for sociodemographics and health status, veterans were no more likely to be overweight (odds ratio, 1.05; 95% confidence interval, 0.99-1.11) or obese (odds ratio 0.99; confidence interval, 0.93-1.05) than nonveterans. Despite previous participation in a culture and environment that selects for and enforces body weight standards, veterans have a high prevalence of overweight and obesity that is similar to general population estimates.

MOVE!™ Weight Management Program for Veterans

FY2007 Evaluation

National Summary



VA National Center for Health Promotion and Disease Prevention
Office of Patient Care Services (VACO)
Veterans Health Administration
Department of Veterans Affairs

One of the best resources to help VA clinicians and patients manage chronic conditions is the recently released Patient Self-Management Toolkit, now available on the Office of Care Coordination Service's website at: <http://vaww.carecoordination.va.gov/topics/psm/>. It contains tools for both clinicians and patients.

Clinicians can use the tools to guide their assessments of how patients are managing:

- Medications—taking them appropriately (right amount at right time; difficulties with bottle caps, seeing syringe markings, or breaking pills in half; medication reconciliation)
- Coping behaviors—dealing with frustration, anxiety, stress, nervousness, insomnia, depression
- Activity—staying active, exercising, barriers or problems patients experience
- Meals—understanding and following special diets, getting groceries (including having enough money for food) and preparing meals
- Symptoms—monitoring signs and symptoms that indicate problems and taking appropriate actions if problems occur

Additional tools help clinicians promote patient confidence to self-manage their health problems:

- Find out the patient's most important concerns.
- Meld clinician and patient goals.
- Help the patient plan small steps that will lead to meeting his/her goals.
- Help the patient identify prior successes in managing issues, concerns, or challenges.
- Invite the patient to discuss how the two of you can work together to improve his/her health.
- Provide aids (e.g., reminders, mental rehearsals, routines) to help the patient succeed.
- Provide the patient with meaningful, non-judgmental feedback.
- Keep the door open—a positive

relationship is the most important tool you have to help the patient change behaviors. Patients who feel supported are more likely to be better self-managers.

- Use encouraging and affirming words to boost the patient's perception that he/she can achieve a goal.
- Celebrate successes and work together to understand and overcome any setbacks.

For patients, a brochure available on this same website outlines elements of self-management and explains how it differs from usual health care:

- Self-management is a way for you to be more involved in decisions about your health and treatments.
- Treatment decisions are made *with you*, based on goals that you feel are important.
- With self-management, you will learn more about topics specific to your healthcare needs and be more involved in setting your own goals.
- Follow-up will include a review both of your goals and of how well your treatment is working.

Although your healthcare provider can give you the information you need about your health and treatment options, the information you have about yourself and how your illness affects your life is just as important. The information you provide helps your healthcare provider consider treatment options that may fit better with your lifestyle.

The brochure also offers patients suggestions of ways to make the process work best for them:

- Ask questions—by answering your questions, your healthcare provider learns more about you and can consider treatment alternatives.



Veterans Health Education and Information (VHEI) (cont'd)

- Don't assume that your healthcare provider has all the answers—you are the most knowledgeable part of the team when it comes to how your health affects your life.
- Talk about what's working and what's not working in your treatment plan.
- Keep follow-up appointments.
- What if My Partner or Spouse Isn't Helpful?
- Coping with Flare-ups of Your Medical Problems
- What to Do When Your Health Plan Gets Off Track

The following resources for patients include brief, large-print handouts that offer specific, practical suggestions:

- When to Get Emergency Help
- Talking to My Provider about Making Changes
- Taking Charge of Your Care
- Deciding to Change
- Developing an Action Plan

Pamela Hebert, DrPH, Health Education Coordinator at VHEI, led a team of field-based patient education experts to create the patient education resources in the Patient Self-Management Toolkit. The toolkit's development was coordinated by Rita Kobb, MN, GNP-BC, Education Program Specialist, VHA Care Coordination Services. Remember, the Patient Self-management Toolkit is now available on the Office of Care Coordination Service's website at: <http://vaww.carecoordination.va.gov/topics/psm/>.

Contributed by Barbara Snyder, MPH



Upcoming Conference Calls

VHEI Patient Education Hotline (1-800-767-1750 Access Code 16261#)

First Tuesday of each month at 1 pm ET
July 7, August 5, September 2, October 7

VHEI Patient Education Conference Call (1-800-767-1750 Access Code 19630#)

Fourth Fridays of January, April, July and October, 1 pm ET
July 25, October 24



Veterans Health Education and Information (VHEI) News

VHEI Staff Update

Barbara Hebert Snyder, MPH, joined VHEI as Health Educator in March, 2008. Barbara obtained an MPH in Health Education from the University of Michigan School of Public Health. She had previously worked for nineteen years in VA as a Patient Health Education Coordinator. Barbara was one of the first coordinators to be employed in the VA's Patient Health Education Program. She was PHE Coordinator for Medical District #6 in Washington, DC and for the former Regional Medical Education Center (now Employee Education Resource Center) in Cleveland, OH. Barbara left VA in 1994 to form a health education consulting agency. She continued to work on a variety of health education projects with both government and private sector clients until coming to

VHEI. At NCP, she will be developing the VHA-wide new patient orientation program, working as master faculty for the Patient Education: TEACH for Success program, and serving as editor of the newsletter, *Patient Education in Primary Care*. Barbara can be reached at 919/383-7874, ext. 248 or at Barbara.Snyder2@va.gov.

New FDA Publication: Maturity Health Matters

FDA has a new, free on-line publication entitled, "Maturity Health Matters." Its purpose is to share important information of particular interest to older adults, a significant part of the VA health care patient population. View the newsletter online at: <http://www.fda.gov/cdrh/maturityhealthmatters>



Did you know that:

The HUSV website has two new features:

1. **Tip of the Week**—features a tip related to nutrition or physical activity. To see each Tip of the Week, visit the website at: <http://www.healthierusveterans.va.gov/>
2. **Fruit and Vegetable of the Month**—it is important to eat a healthy diet, but it can be difficult to sort through all of the information about nutrition and food choices. HealthierUS Veterans has compiled a variety of resources regarding healthier eating. One of those resources is a web tool prepared by the Centers for Disease Control and Prevention (CDC) entitled, *Eat a Variety of Fruits and Vegetables Every Day*. There is a calendar for *Fruits and Vegetables of the Month*. To view the fruit and vegetable of the month, visit the CDC's website at: <http://www.fruitsandveggiesmatter.gov/month/index.html>



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

Chief Consultant for Preventive Medicine—
Linda Kinsinger, MD, MPH

Executive Assistant—
Gregory Moore, SPHR

Administrative Officer—
Pamela Frazier, BS

Staff Assistant—
Vacant

Program Analyst—
Connie Lewis

Special Assistant—
Nancy S. Granecki, RN, MSN
Rosemary Strickland, APRN, BC

IRM/ISO—
Kraig Lawrence, BBA, CSP
Steve Cosby

Contract Editor
Kate W. Harris

Deputy Chief Consultant for Preventive Medicine—
Leila C. Kahwati, MD, MPH

Program Manager for Prevention Practice—
Vacant

Prevention Policy Coordinator—
Terri Murphy, RN, MSN

Program Manager, Community Health—
Sue Diamond, RN, MSN

Research and Evaluation Analyst—
Trang Lance, MPH

Program Manager for Health Promotion—
Richard Harvey, PhD

National Program Director for Weight Management—
Kenneth Jones, PhD

MOVE! Project Coordinator, Contractor—
Susi Lewis, MA, RN

MOVE! Dietitian Program Coordinator—
Lynn Novorska, RD, LDN

MOVE! Physical Activity Coordinator—
Sophia P. Hurley, MSPT

MOVE! Program Management Analyst —
Tony Rogers

Program Manager for VHEI—
Rose Mary Pries, DrPH

Health Education Coordinator—
Pamela Hebert, DrPH, CHES

Health Educator—
Barbara Hebert Snyder, MPH

Calendar of Events:

July

Information Technology Conference—Baltimore, MD
Connie Lewis, Tony Rogers
July 7-10

Evidence-Based Practice Workgroup—Washington, DC
Leila Kahwati
July 7-8

HUSV/MOVE Exhibit—Greenville, SC
Sue Diamond, Susi Lewis
July 14-17

US Preventive Services Taskforce Meeting—Gaithersburg,
MD
Linda Kinsinger
July 14-15

Promoting Behavioral Change Conference—New Orleans, LA
July 14-17
Linda Kinsinger, Richard Harvey, Ken Jones, Rose Mary
Pries, Terri Murphy, Lynn Novorska, Tony Rogers

Primary Care Field Advisory and Primary Care Conference—
Washington, DC
July 29-August 1
Rose Mary Pries

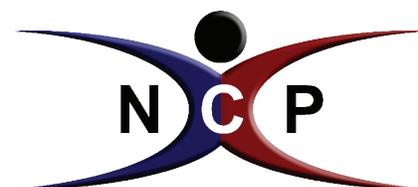
August

TEACH Conference
August 4-8
Rose Mary Pries, Pam Hebert

AMVETS Meeting—Orlando, FL
August 6-8
Sue Diamond, Lynn Novorska

VFW Meeting—Orlando, FL
August 14-17
Susi Lewis

Senior Management Conference—Washington, DC
August 26-27



Postage

VA National Center for Health Promotion
and Disease Prevention (NCP)
Office of Patient Care Services
Suite 200
3022 Croasdaile Drive
Durham, NC 27705

NCP Mission Statement

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

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