

Health *POWER!*

Prevention News • SPRING 2010



TRANSFORMING VA HEALTHCARE

- 2 From the Chief Consultant
- 3 The Patient Centered Medical Home Model
- 5 Developing a Facility Health Promotion and Disease Prevention Program
- 7 Integration of the VHA Preventive Care Program into the Patient-Centered Medical Home
- 8 Training for Preventive Care: An Ambitious Plan
- 10 Health Risk Assessment: A New Tool for VA
- 11 The Veterans Health Library
- 12 NCP News

Linda Kinsinger, MD, MPH
 Chief Consultant for
 Preventive Medicine

The VHA Preventive Care Program

Change is coming to the Veterans Health Administration! As noted in the Winter 2009 issue of HealthPOWER! Prevention News, VHA is launching a major new effort to transform the way we provide health care to our nation's Veterans. The largest component of this change process is the initiative called "Patient Centered Medical Home," led by the Office of Primary Care in the Office of Patient Care Services. Our feature article by Dr. Richard Stark describes what this initiative is all about – patient-driven, team-based, coordinated, comprehensive, whole-person healthcare.

Closely aligned with the Patient Centered Medical Home approach is another new initiative – the VHA Preventive Care Program. Led by the VHA National Center for Health Promotion and Disease Prevention, this initiative is designed to provide Veterans with comprehensive health education, clinical services, and self-management

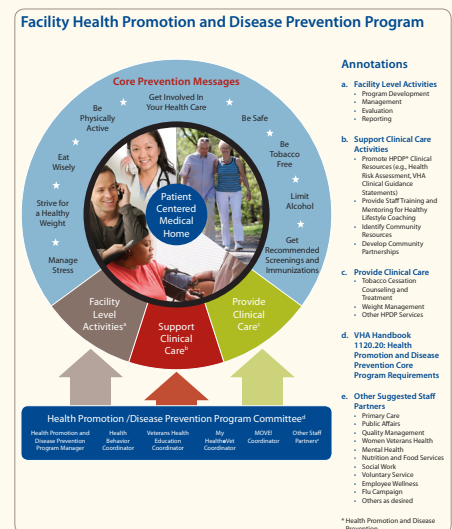
support for health promotion and disease prevention needs. The initiative will focus on key prevention areas, including nutrition, physical activity, weight management, smoking, alcohol use, stress management, clinical preventive services, safety, and healthcare communication. The Preventive Care Program has three main components: 1) building a facility-level infrastructure for health promotion/disease prevention by funding two new full-time positions in each facility: a Health Promotion/Disease Prevention Program Manager and a Health Behavior Coordinator, who will jointly lead the Health Promotion/Disease Prevention Program Committee; 2) supporting the delivery of health promotion and disease prevention services in the Patient Centered Medical Home, including training for PCMH staff; and 3) developing new tools for Veterans to provide health education, both general information in the Veterans Health Library and individually tailored information in the Health Risk Assessment. All these components are more fully described in articles on the following pages. In addition, other tools being developed for future deployment include a nation-wide smoking cessation quitline and national telephone lifestyle coaching call center,

as well as a program for mental health promotion, based on problem-solving techniques.

The graphic below illustrates how these components fit together. Because of space limitations, the picture is fairly small. For a larger size and more details, please go to our VHA Preventive Care Program intranet web page: http://vaww.prevention.va.gov/VHA_Preventive_Care_Program.asp.

Change is usually not easy but it often leads to a better place for everyone involved. VHA's exciting new direction for patient-centered healthcare, with an increased emphasis on health promotion and disease prevention, is no exception.

Linda Kinsinger



The Patient Centered Medical Home Model

Contributed by
Richard C. Stark, MD
 Director of Primary Care Clinic
 Operations

Jane, a 47 year old diabetic on insulin, demobilized a few months ago and attended a new patient orientation at her local Community Based Outpatient Clinic (CBOC). The clinic, pharmacy, and her benefits were explained, clinic contact information was conveyed, and Jane completed a Health Risk Assessment. After the orientation, Jane had her first visit with her Primary Care provider and was introduced to some of the other members of her Medical Home Team: her nurse care manager, clinical associate (LPN), and administrative associate. She also works with a Clinical Pharmacist and a dietitian who help her control her glucose and her weight. Jane tracks her fingerstick glucose regularly, and can use My HealtheVet (MHV) to track her values. To handle most of her health needs, she can contact her Team via secure messaging right from the MHV site or she can speak to someone on the phone.

“With my busy schedule, it is difficult for me to come in for a visit, so I appreciate having access to my Primary Care Team when it’s convenient for me,” Jane says. “It’s nice to know they are looking out for my health even when I’m not there in the clinic.”

More than fifteen years ago VA began a dramatic transformation from a bed-based, hospital inpatient system to one rooted in primary care. While the incorporation of Primary Care within VHA has been associated with improvements in patient satisfaction and important quality measures, our healthcare system still remains largely focused around the provider and healthcare team, rather than the patient. We are now taking our transformation to the next level by transforming all VHA Primary Care practices into Patient-Centered Medical Homes. The Patient Centered Medical Home (PCMH) Model builds upon the success of the last 15 years. It is a patient-driven, team-based approach that delivers efficient, comprehensive and continuous care through active communication and coordination

of healthcare services. Implementation of a PCMH Model in all VA healthcare facilities takes our care to the next level and helps us deliver care in a patient centered manner, so that we can provide care that truly meets patient needs.

Patient-centered care focuses on overall health rather than the patient’s current condition or disease. A partnership among the Primary Care team, patients, their families and caregivers ensures that the patient’s wants, needs, and preferences are respected and at the hub of decision-making. Responsibility for the overall care of the patient lies with an interdisciplinary team that includes the patient and the clinical and administrative staff necessary to meet the health goals and needs of the Veteran.

The PCMH Model is a patient-driven, team-based approach that delivers efficient, comprehensive and continuous care through active communication and coordination of healthcare services.

Continuity is a key component of primary care, and development of a continuous, longitudinal relationship between the patient and provider is of utmost importance. The Primary Care provider directs the team in its responsibility to deliver all of the patient's healthcare needs, appropriately arranging care with other qualified professionals when necessary. Communication between the patient and team members is honest, respectful, reliable and culturally sensitive. Information sharing among the team maintains a focus on the patient.

The Primary Care team uses screening, education, preventive care, lifestyle coaching, and appropriate consultation to deliver comprehensive whole-person care. The medical home team considers the community as a resource, understanding the importance of where and how people live, their exposures, experiences, and special risks that contribute to overall health. The PCMH team in partnership with the

patient develops an evolving plan for care that is coordinated across all elements of the healthcare system. Coordination is achieved through active interdisciplinary collaboration and facilitated by registries and other information technology.

Technology is also utilized to support patient care, performance measurement, systems redesign, patient education, and enhanced communication. This allows patients to receive appropriate care when they need it, and for all team members to work at the top of their competency.

VHA began the journey to implement the medical home model in June 2009 with a summit that gathered Primary Care and other clinical experts from VHA and the private sector to discuss how VA could move forward in implementing the model. In October 2009 a PCMH readiness assessment using the American College of Physicians Medical Home Builder, an assessment and resource tool for PCMH, was administered to 850 VHA Primary

Care sites. The survey indicated that VHA already has many strong PCMH practices in place. VHA is currently rolling out PCMH according to a plan which includes augmenting Primary Care Team staffing, demonstration labs that provide an opportunity to test innovations, comprehensive education for primary care teams, tactical guidance, and implementation tools.

Over the past fifteen years, VHA created arguably the best primary care system in the world. It is built on many of the key components of PCMH. However, we recognize the need to evolve and improve to better serve our patients. Redesigning our Primary Care practices as part of a process of continuous improvement aligns VA with national healthcare reform initiatives, enabling VA to continue to provide leadership in healthcare delivery while assuring that our patients' health is managed with the utmost quality, safety and effectiveness. ■



Developing a Facility Health Promotion and Disease Prevention Program

Contributed by
Sue Diamond RN, MSN
Program Manager for Health
Promotion and Disease Prevention
Programs
and
Kenneth Jones, PhD
National Program Director for
Weight Management

According to VHA Handbook 1120.02, Health Promotion and Disease Prevention Core Program Requirements, a Health Promotion and Disease Prevention (HPDP) program is required in each facility. Compliance with this requirement varies across VHA. The recent FY2009 Prevention Program report revealed that only 59.3% of facilities had a team or committee overseeing prevention activities and clinical preventive services. Additionally, the report showed that facility prevention coordinators spent a median of only 6 hours per month performing prevention coordinator duties.

The VHA Preventive Care Program aims to establish an infrastructure within VHA facilities to provide the required focus and support for HPDP activities and services for Veterans. The Initiative provides financial resources to Veteran Integrated Service Networks (VISNs) to distribute to parent medical facilities to fund one full-time (1.0 FTEE) HPDP Program Manager and a 1.0 FTEE Health Behavior Coordinator at each facility. The establishment of these two new positions represents critical infrastructure enhancement as a way to ensure programmatic leadership to establish a robust, multidisciplinary HPDP program at each facility. The vision for the facility HPDP program and the major duties of the HPDP Program Manager and the Health Behavior Coordinator are described below.

Facility HPDP Program

There is a growing recognition that unhealthy lifestyles contribute to many diseases. Many problems facing Veterans, such as unhealthy eating, maintaining a sedentary lifestyle, smoking, and failing to maintain a healthy weight are affected by lifestyle choices. The overarching goal of the facility HPDP Program is to oversee the integration of

preventive services into clinical care, to develop programming, and to integrate the delivery of services to Veterans that address the following core prevention themes: Be Tobacco Free, Be Physically Active, Eat Wisely, Strive for a Healthy Weight, Be Safe, Manage Stress, Limit Alcohol, Get Recommended Screenings and Immunizations, and Get Involved in Your Health Care. Critical to this goal will be developing healthcare team members who are competent in motivational interviewing and health coaching, to foster patient interest in making lifestyle changes and in helping patients establish goals, make lifestyle change plans, self monitor, and solve problems with their self-management plans. As discussed in the article in this newsletter, "Integration of the Preventive Care Program into the Patient-Centered Medical Home," primary care nursing staff will play a critical role in helping patients make these changes by serving as effective health coaches. The facility HPDP program will support this integration by assisting with training and the development of competency in these communication approaches. The backbone of the HPDP program will be a multidisciplinary HPDP Committee. The new

HPDP Program Manager and the Health Behavior Coordinator will co-chair the committee. Core membership of the HPDP committee will include the facility MOVE! Coordinator, Veterans Health Education Coordinator, My HealtheVet Coordinator, and representatives from the Patient-Centered Medical Home. Other suggested committee members include Primary Care, Public Affairs, Quality Management, Women Veterans Health, Mental Health, Nutrition and Food Services, Social Work, Voluntary Service, Employee Wellness, and Flu Campaign.

Health Promotion and Disease Prevention Program Manager

The newly funded full-time facility Health Promotion and Disease Prevention Program Manager (HPDP-PM) will replace former facility Prevention Coordinators and HealthierUS Veterans Points of Contact. In addition to establishing and co-chairing the facility HPDP committee, the HPDP-PM will be responsible for strategic planning, HPDP program development, implementation, monitoring, and evaluation for the facility and affiliated Community Based Outpatient Clinics (CBOCs). The HPDP-PM will work closely with staff in

The recent FY2009 Prevention Program report revealed that only 59.3% of facilities had a team or committee overseeing prevention activities and clinical preventive services.

the Patient-Centered Medical Home to enhance involvement in and delivery of local health promotion and disease prevention programs, services, and activities. The HPDP-PM will serve as a content expert for health promotion and disease prevention and will ensure the integration of HPDP training into the Patient-Centered Medical Home and into new employee orientation. The HPDP-PM will serve as the primary facility point of contact for the National Center for Health Promotion and Disease Prevention (NCP) for national health promotion campaigns and events, ensuring local implementation and Veteran participation. The HPDP-PM will also provide leadership in the implementation of the planned national Health Risk Assessment for Veterans described in the article in this newsletter, "Health Risk Assessment: A New Tool for VA," and the dissemination, implementation, and evaluation of Clinical Preventive Services.

Health Behavior Coordinator

Also newly funded is the position of Health Behavior Coordinator (HBC). This is anticipated to be a clinical health psychologist with training and experience in behavioral medicine, who will work closely with the HPDP Program Manager (HPDP-PM). The HBC will serve several roles. First, the HBC will train, mentor, and guide primary care and other staff members to support patient self-management of health-related behaviors via effective health behavior coaching and the use of motivational interviewing and other empirically based communication

and health behavior management approaches. Thus, the HBC will have a significant role as a consultant for clinical staff members who promote patient self-management of health behavior. Second, the HBC will work closely with the HPDP-PM to develop new or adapt existing VHA programs, guide implementation, and coordinate evaluation strategies to determine the efficacy of health promotion and disease prevention programs at each medical center. In this role, the HBC will serve as co-chair of the facility HPDP Program Committee. Third, the HBC will have clinical responsibilities related to health promotion interventions such as group and individual smoking cessation and weight management counseling. Fourth, the HBC will carry out discipline-specific health psychology assessments (e.g., pre-bariatric surgery psychological assessments).

HPDP Program Evaluation

NCP will develop metrics to evaluate facility health promotion and disease prevention programs and communicate them to facility leadership and program leaders once available. Metrics for FY2010 will likely focus on acquiring baseline data and progress toward implementation of the proposed infrastructure. NCP will also set up a system of regularly scheduled national conference calls and live meetings as well as email groups to establish a system of ongoing communication between NCP and this new national field of facility HPDP program leaders. ■

Integration of the VHA Preventive Care Program into the Patient-Centered Medical Home

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

The VHA Preventive Care Program is designed to work closely with the Patient-Centered Medical Home (PCMH) Initiative to provide financial resources, training, and support for Health Promotion and Disease Prevention activities within the PCMH. The goal of VHA Primary Care is to provide healthcare in a manner that is continuous, coordinated, comprehensive, and accessible. A carefully structured, efficient, and high functioning primary care team can provide a “medical home” for the Veteran, where he or she receives guidance and nurturing as health-care needs change with time. Integrating preventive care services into the primary care of Veterans through a Patient-Centered Medical Home is a key feature of the VHA Preventive Care Program. In addition to providing care to patients in ways that are coordinated and comprehensive, the PCMH also strives to meet the Veteran’s needs, values, and preferences.

Each of the members of the PCMH plays an important role in ensuring that Veterans have the knowledge they need

to make informed decisions to improve or maintain their health. The VHA Preventive Care Program provided funds to support the goal of integrating preventive care services into primary care. Nurses will take a population management approach to their team’s panel of patients for process improvements. For example, data can be used to identify preventive services that the panel as a whole has not received. The nurses will look for patterns and work with their teams to develop plans to ensure that Veterans are being offered and understand the services needed to make informed decisions about their healthcare. Nurses will take the lead role in working with individual Veterans to develop a health promotion plan of care and evaluate the progress toward meeting each Veteran’s health goals. All staff will use principles of health coaching and patient self-management to assist Veterans in identifying individual health risks and setting goals to minimize those risks. Training curricula are being developed to help improve health coaching skills and

ensure that all Veterans receive the same messages concerning preventive services and healthy lifestyle behaviors. As some of the principles of health coaching may be unfamiliar to staff, Health Behavior Coordinators will be available to assist staff in improving their skills in health coaching.

In the future, the Health Risk Assessment (see article in this newsletter on HRAs - page 10) will be a valuable tool for Veterans and will make it easier for staff and Veterans to track progress toward health goals. Clinical guidance statements are being developed to assist clinical staff in determining what preventive services should be offered to Veterans and promote discussion between staff and Veterans. Additional system-level performance and outcome measures will be developed for health promotion and disease prevention in the PCMH to help us monitor our progress and continue to deliver the “best care anywhere” to our Veterans. ■



Contributed by
Richard Harvey, PhD
Program Manager for
Health Promotion

Training for Preventive Care: An Ambitious Plan

Changing one's health behavior is difficult. For example, smokers who are trying to quit often make numerous attempts before succeeding. People seeking to lose weight try different diets, programs, and perhaps pills during their repeated attempts. Once some weight is lost, studies indicate that most people regain a certain portion, if not all, of that weight. Maintaining weight loss is clearly a bigger challenge than losing it in the first place. That people begin an exercise program and then fail to continue is also a well known fact.

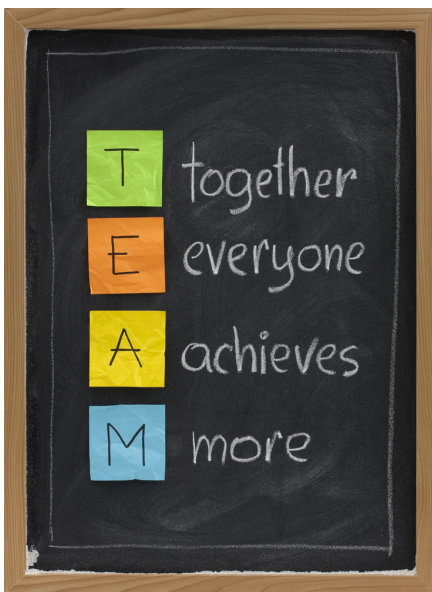
From the point of view of medical providers and their associated healthcare teams, it is indeed challenging to get patients to change their health behaviors. However, many health behavior change strategies have been shown to be effective. These include motivational interviewing¹ and health coaching, using the "5A's"^{2,3}, as well as behavioral techniques like setting very specific ("SMART")⁴ goals, self monitoring using behavior records, making stimulus control changes, changing thinking patterns, and arranging for support from others. Unfortunately, medical providers and their team members often lack skills and knowledge in these areas. This need has been recognized in medical education in recent years. Nearly all (124 out of 126) medical schools offer courses in communication skills. An equal number of medical schools offer courses in prevention and health maintenance, which include

some of these topics.⁵ The lack of training in behavior change among healthcare staff has been repeatedly mentioned in the professional literature, and many books have been written and other efforts made to fill that gap.^{6,7,8} Training does change practice patterns, although the extent to which that is true may depend not only on trainee characteristics and institutional support for change, but also on course content.^{8,9}

The "whole person" orientation of the Patient-Centered Medical Home (PCMH) provides renewed impetus to help patients improve their health behaviors. Certain clinical members of each PCMH "teamlet" (medical provider, RN Care Manager, Clinical Associate, and clerk) are expected to provide health and wellness consultation and coaching to Veterans working on health behavior changes, and the entire teamlet is to emphasize healthy living in addition to routine medical care. To be most effective, training in motivational communication, health coaching, health literacy, prevention, and related skills will be necessary for staff to provide these services.

The National Center for Health Promotion and Disease Prevention (NCP) has drafted a plan to provide that training both at the PCMH Learning Centers and locally at each medical center. The NCP VHA Preventive Care Program training plan includes substantive training for many of the PCMH and other interested staff, as well as for Preventive Care Program staff members including the Health Promotion and Disease Prevention Program Manager and the Health Behavior Coordinator.

A curriculum on motivational communication is being developed collaboratively



with several VHA program offices including the Employee Education System (EES), Office of Mental Health Services, Public Health and Environmental Hazards, Office of Nursing Services, Spinal Cord Injury Service, and others. Other new curricula are being developed within NCP.

The plan calls for each Health Behavior Coordinator to receive training to become a facilitator for the "Patient Education: TEACH for Success" program (TEACH). The well-established 14-hour TEACH program includes components on communication and establishing rapport, health behavior change, coaching and partnering, and assessment of patient needs. Health Behavior Coordinators are also expected to receive training in motivational interviewing, prevention, and health literacy. In addition to many other activities, they will use their expertise to provide guidance to PCMH coaching staff members who are working with Veterans on health behavior change. The Health Promotion and Disease Prevention Program Managers will receive training in prevention science and practice and health literacy, as well as the staff-level version of TEACH. Their training will enable them to be content experts in prevention and related areas and to lead the Preventive Care Program effectively. They also will provide guidance to PCMH and other staff who are implementing and practicing preventive care.

Veterans Health Education Coordinators who are not already certified TEACH Facilitators will have an opportunity to receive TEACH Facilitator training. Once that process is complete, each medical center will have both the Veterans Health Education Coordinator and the Health Behavior Coordinator available to present the TEACH curriculum.

PCMH teamlets throughout VHA are to receive training at one of five regional Learning Centers to maximize their functioning in the PCMH model. As part

of the planned training on team design and performance and care management and care coordination, the Preventive Care Program plan recommends that teams be offered courses on motivational interviewing, prevention, and, for some members, the "Clinician-Patient Communication to Enhance Health Outcomes" course from the Institute for Healthcare Communication.⁸

Back at each medical center, TEACH Facilitators will present the 14-hour course for as many PCMH and other staff members as time and scheduling permit. Skills learned through TEACH will be helpful in coaching patients on health behavior change and for facilitating other preventive care activities. Further, the Health Promotion and Disease Prevention Program Managers will be able to present a course on health promotion and disease prevention of variable length (1-8 hours), as time permits. In addition, three online health literacy courses are available. Those courses cover health literacy communication skills; creation of, and working with, health education print materials; and conducting a health literacy assessment of the facility environment. Additional training and coaching on motivational interviewing is also anticipated.

Although providing training of this magnitude is an ambitious undertaking, it is clearly necessary if the PCMH is to facilitate positive health behavior changes effectively among patients. VHA is devoting substantial resources to the New Models of Care Transformation and the Patient-Centered Medical Home component. Training staff to facilitate patients' health behavior change will be a major part of that effort.

REFERENCES

1. Motivational interviewing literature. www.motivationalinterview.org.
2. Glasgow RE, Emont S, Miller DC. Assessing delivery of the five "As" for patient-centered counseling. *Health Promotion International* 2006;21(3):245-255.
3. Institute for Healthcare Improvement. <http://www.ihl.org/IHI/Topics/Patient-CenteredCare/SelfManagementSupport/EmergingContent/5AsBibliography.htm>
4. Doran GT. "There's a S.M.A.R.T. way to write management's goals and objectives," and Miller AF, Cunningham, JA. "How to avoid costly job mismatches." *Management Review* Nov 1981;70(11).
5. American Association of Medical Colleges. <http://services.aamc.org/currdir/section2/2008hottopics.pdf>
6. Rollnick S, Mason P, Butler C. *Health Behavior Change: A Guide for Practitioners*. Churchill Livingstone, New York, 1999.
7. Rollnick S, Miller WR, Butler CC. *Motivational Interviewing in Health Care: Helping Patients Change Behavior*. The Guilford Press, New York, 2008.
8. Institute for Healthcare Communication continuing education courses. <http://www.health-carecomm.org/index.php?sec=courses>
9. Baer JS, Wells EA, Rosengren DB, Hartzler B, Beadnell B, Dunn CW. Agency context and tailored training in technology transfer: Evaluating motivational interviewing training for community counselors. *Journal of Substance Abuse Treatment* 2009;37:191-202. ■

Health Risk Assessment: A New Tool for VA

Health risk assessments (HRAs) are tools that 1) systematically collect information from patients through the use of a structured questionnaire, tailored to each user as it is completed, and 2) provide information back to patients about the status of their health, with recommended steps to improve health. HRAs usually include questions about demographics, family history, lifestyle and health behaviors (such as tobacco use or physical activity), clinical preventive service needs, management needs for a limited number of common chronic conditions (such as diabetes and heart disease), health issues relevant to special populations (such as the elderly), and patients' readiness to change selected health behaviors. As part of the VHA's Preventive Care Program, an online HRA will be developed and hosted on the My HealtheVet web portal and will be electronically linked to VISTA/CPRS (Veterans Health Information Systems and Technology Architecture/Computerized Patient Record System). The National Center for Health Promotion and Disease Prevention (NCP), in collaboration with other VHA Program Offices, will be coordinating HRA development efforts. Despite several years of development work ahead of us, we are excited about building an HRA tool to serve as the foundation for future VHA health promotion/disease prevention services for Veterans.

HRAs provide benefits to Veterans by:

- Serving as a non-threatening way to provide sensitive personal data (such as sexual behavior) and receive information about health and health services;
- Creating an awareness of personal risk factors for chronic disease and injury;
- Empowering individuals with information about "do-able" actions to improve or maintain health;
- Allowing them to collaborate with their providers to set health-related goals and monitor progress; and
- Enhancing communication with their healthcare team members.

HRAs may also be helpful at the healthcare system level, by enabling systems to identify risks within a population (through better documentation of personal and family medical histories and risk factors), deliver follow-up interventions for those at risk, and track and analyze population health trends over time.

NCP is working to ensure that the HRA we develop for use within VHA will have the following components:

- A carefully constructed, dynamic set of initial questions, with further questions to probe into specific topics, depending on responses to initial questions;
- Algorithms that define risk status for a variety of conditions, based on responses to questions;
- Feedback algorithms that provide patients with appropriate information, based on patients' risk and health status assessment;
- Bidirectional data flow with VISTA/CPRS, so that the assessment tool can be pre-populated with information already in VISTA/CPRS (e.g., birth date, last blood pressure, last cholesterol level, etc.) and information entered by the patient into the assessment tool can be sent to appropriate fields in CPRS (currently existing or to be added) and labeled as self-entered data;
- Patient reports that are simple, interesting, and provide health information written in an easily understandable way, and direct patients to recommended care; and
- Provider reports that summarize patient

findings and recommended care in a brief format.

HRA items, risk scoring, and decision algorithms will be developed carefully and based on existing literature and evidence whenever possible. A workgroup is being convened to oversee content development and will include representatives from the field, VHA Central Office Programs, and subject matter experts. We will also ensure that the tool is written and designed appropriately for Veterans with low literacy.

Once both the content and the IT processes have been developed into a prototype, we will design a pilot program in several facilities to test implementation of the HRA. When it is ready for national implementation, we will provide guidance for use by patients and staff. Training plans for staff, and communication/marketing plans for patients, will also be developed. We expect that the facility Health Promotion and Disease Prevention Program Managers will play a key role in helping facilitate local processes for HRA implementation in terms of workflow and processes within the Patient-Centered Medical Home. ■

Contributed by

Linda Kinsinger, MD, MPH
Chief Consultant for Preventive
Medicine

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

Terri Murphy, RN, MSN
Program Manager for Prevention
Policy

The Veterans Health Library

Contributed by
Rose Mary Pries, DrPH
Program Manager
Veterans Health Education and
Information

Through the VHA Preventive Care Program, the Office of Veterans Health Education and Information (VHEI) plans to develop a Veterans Health Library. The Library will support VHA's transformation to Veteran-centered care in several ways. It will provide a consistent, comprehensive source of health education and information to Veterans and family members. Library topics will span the continuum of VHA healthcare delivery and will be available to Veterans and family members in the community and in all VHA healthcare delivery settings, no matter where a Veteran receives care.

Because the Library will also be available to family members, this information will help them support the Veteran's active involvement in healthcare while reinforcing the actions needed to promote health or to manage chronic or acute conditions.

The Library's educational resources will be available in print, electronic, and audiovisual formats as well as VHA-approved social media (e.g., texting, blogging, twitter) and other emerging technologies. Development of the Library's content will take existing resources such as My HealtheVet and iMed Consent into account.

The Library will link to VHA's Computerized Patient Record System (CPRS) for two important purposes. First, it will make it easy for providers and

clinicians to integrate Library resources and information into the health education they provide in either face-to-face or virtual clinical encounters. This will be especially important in the Primary Care Patient-Centered Medical Home as use of telephone care or secure messaging increases. Second, the link with CPRS will also make it easier for clinicians to document all health education services they provide. This will permit clinicians to build on the health education provided in previous clinical encounters and to meet The Joint Commission standards regarding documentation of patient education.

The Library content will be developed and formatted to take into account Veterans' health literacy needs. It will also accommodate their physical and visual impairments.

The Library will provide Veterans and family members with health education and information to help them:

- Promote their health and well-being.
- Prepare for clinical encounters.
- Understand their conditions and treatment plans.
- Communicate effectively with their healthcare team members.
- Actively partner with their provider and healthcare team members.
- Share in healthcare decision making.
- Self-monitor their conditions and guide their self-management.
- Prepare for transitions in care.

The Veterans Health Library will be a tangible commitment to VHA's Principle 5 of Veteran-centered care, to "empower Veterans through education and information." ■

The Veterans Health Library will provide a consistent, comprehensive source of health education and information to Veterans and family members.

News



TeleMOVE!—Care Coordination Home TeleHealth MOVE! Program

The Office of Telehealth Services and the MOVE! Team at NCP has finalized the new Care Coordination Home Telehealth – Weight Management – Disease Management Protocol (CCHT-WM-DMP), also known as TeleMOVE!. TeleMOVE! was piloted first with patients at the James A. Haley VAMC in Tampa and then at additional facilities in VISNs 1, 8, and 16. TeleMOVE! provides individual weight self-management support as an alternative to telephone care.

Patients enrolled in TeleMOVE! will interact daily through the home-messaging devices, responding to questions and receiving tips and guidance. NCP has stocked a booklet of all of the MOVE! Handouts in VA Forms that is a companion guide for TeleMOVE!. TeleMOVE! contains 82 separate daily communications that should be completed in about 90 days, and most patients will need to complete two cycles of the DMP, which will provide the recommended six months of weight management support required for most patients to meet their weight-loss goals. Patients will weigh in once per week through an attached electronic scale and report on their progress with personal weight loss, dietary change, physical activity, and behavioral goals. The care coordinators (staff who monitor patient progress in the CCHT system) will assist patients in problem solving and resetting goals, as needed, while also providing encouragement and support.

OTS has secured funding through the New Models of Care portion of the Transformational Initiatives for the 21st

Century to support VISNs in launching TeleMOVE!. Nineteen of the twenty one VISNs have requested this funding.

2009 MOVE! Training

Eight of the talks featured in the 2009 MOVE! training are now available to view in a video format on LMS. Log on to LMS and search with the keyword “MOVE!”

Guidance on Clinical Preventive Services

NCP is pleased to announce a new resource for staff on Clinical Preventive Services! VHA-specific ‘Guidance Statements’ are being developed for a wide range of Clinical Preventive Services (screenings, immunizations, brief counseling and preventive medications.) **VHA Handbook 1120.05: Coordination and Development of Clinical Preventive Services** describes the procedures used to develop the guidance statements. The first statement that has been posted is ‘Screening for Abdominal Aortic Aneurysm’.

VA staff can access the home page for this new initiative by typing “http://vaww.prevention.va.gov/Guidance_on_Clinical_Preventive_Services.asp” into their Intranet browser.

VHA Preventive Care Program

The VHA Preventive Care Program is designed to work closely with the Patient-Centered Medical Home (PCMH) Initiative to provide financial resources, training, and support for Health Promotion and Disease Prevention activities within the PCMH. NCP has posted more details, including role descriptions for the new HPDP Program Manager and Health Behavior Coordinators, on

the Intranet. VA staff can access the home page for more information by typing “http://vaww.prevention.va.gov/VHA_Preventive_Care_Program.asp” into their Intranet browser.

Transition in Employee Wellness Program

The need for additional NCP staff time and attention to initiate the new VHA Preventive Care Program—a major part of the VHA’s “New Models of Care” Transformation initiatives—has resulted in NCP no longer working in the area of employee wellness. NCP will, however, continue to support MOVEmployee!

The lead for employee wellness has transitioned to the Occupational Health, Safety, and Prevention Strategic Health Care Group in the Office of Public Health and Environmental Hazards. The VISN 23 Employee Health Promotion and Disease Prevention Pilot project, directed by Dr. Ebi Awosika, is going well and will be the nexus for employee wellness activities in VHA. The VHA Preventive Employee Wellness email list is now managed by Sandra Schmunk in Minneapolis (sandra.schmunk@va.gov), Program Manager of the Employee Health Promotion/Disease Prevention Pilot project.

We sincerely thank each of you for your interest and hard work over the years in promoting employee wellness throughout VHA, and hope your work in that area will continue unabated.

Meet Becky Hartt Minor

In January 2010, Veterans Health Education and Information (VHEI) at the National Center for Health Promotion and Disease Prevention (NCP) welcomed Becky Hartt Minor as our new Health



Educator. Prior to joining VHEI, Becky served as Program Director for the Cancer Information Service (CIS) Southeast Region, serving North Carolina, South Carolina, and Georgia. The Cancer Information Service (1-800-4-CANCER), a program of the National Cancer Institute, is a national information and education network.

Becky joined the Southeast Region in August 2006, but had worked for the CIS since March 1998, serving as Partnership Program Manager for the CIS Mid-Atlantic Region. Becky provided education and awareness about early detection, screening, diagnosis, and treatment of cancer. Through the Southeast Partnership Program, Becky was responsible for reaching out to medically underserved audiences, including minority groups and people with limited access to health information and services.

Before working with the CIS, Becky was the director of the Virginia Breast and Cervical Cancer Early Detection Program (1994–1998), a CDC-funded program providing no- and/or low-cost mammograms and Pap tests to under- and uninsured women aged 50–64, within the Virginia Department of Health.

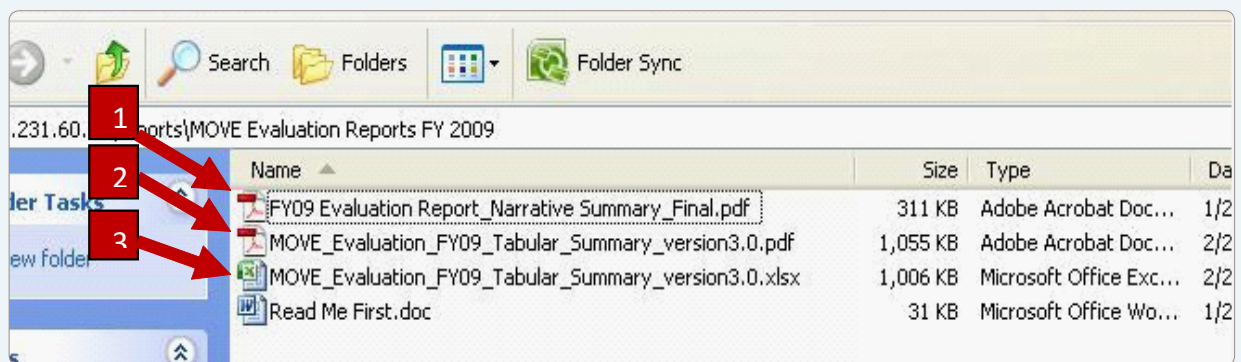
Becky received a Masters in Education with an emphasis in Community Health Education from West Virginia University and has worked as a Health Educator throughout her career.

Becky's community and medical care health education experience, plus her work with underserved populations, will contribute to VHEI's goal of promoting a comprehensive approach to Veteran-centered health education in Veterans Health Administration Central Office (VHACO) and the field. You can contact Becky at becky.minor@va.gov or (919) 383-7874 ext. 249. Please join us in welcoming Becky to VHEI and NCP.

2009 MOVE! Evaluation Report-Findings Now Available

The FY09 MOVE Evaluation Reports have been completed and have been mailed to all VISN coordinators and Facility coordinators who requested a hard copy. Electronic copies are available at the MOVE! Intranet website (<http://vaww.move.med.va.gov/Reports09.asp>). At this link you can select from among 3 documents:

1. A brief, eight page narrative summary
2. A detailed tabular summary in PDF format
3. The same detailed tabular summary, but in a Microsoft Excel format to facilitate cutting and pasting selected data elements



Major additions from prior year evaluation reports include the addition of key weight and Body Mass Index (BMI) change measures, some measures reported out at the CBOC level, and new measures in a variety of evaluation domains. Findings from this report can be used to guide future program policy and planning at all levels of the VHA organization.



For FY10, three areas for program improvement are suggested based on these findings:

- Increased use of motivational communication in primary care and other settings with patients who are ambivalent about seeking/receiving MOVE!-related care to promote increased engagement. Use of motivational communication to promote sustained engagement by patients who may stop participating in care after 1 or 2 visits.
- Ensuring the program is multidisciplinary in content and structure and is using behavioral strategies (as opposed to just educational strategies) for changing diet and physical activity behaviors that contribute to weight loss.
- Ensuring that height and weight for all visits (MOVE! and others) are documented within the Vital Signs Package of VISTA/CPRS, rather than as text entries in progress notes. A supplemental analysis of missing weight data by facility is available at the MOVE Sharepoint site: <http://vaww.national.cmop.va.gov/ncp/move/Shared%20Documents/Forms/AllItems.aspx>.

Recent Prevention-related research

- Yancy WS Jr, Westman EC, McDuffie JR, Grambow SC, Jeffreys AS, Bolton J, Chalecki A, Oddone EZ. A randomized trial of a low-carbohydrate diet vs orlistat plus a low-fat diet for weight loss. *Arch Intern Med*. 2010 Jan 25;170(2):136-45. [Link to PubMed abstract](#)

This randomized clinical trial led by Dr. Will Yancy, a VA obesity researcher, compared a low-carbohydrate diet to orlistat

combined with a low-fat diet in 146 primary care patients from the Durham VA Medical Center. After 48 weeks, weight loss and changes in lipids and glycemic measures were similar between the two groups; however, the group that received instruction on the low-carbohydrate diet had larger decreases in systolic and diastolic blood pressure.

- Noël PH, Copeland LA, Pugh MJ, Kahwati L, Tsevat J, Nelson K, Wang CP, Bollinger MJ, Hazuda HP. Obesity Diagnosis and Care Practices in the Veterans Health Administration. *J Gen Intern Med*. 2010 Feb 24. [Epub ahead of print] [Link to PubMed abstract](#)

This large retrospective cohort study used VHA administrative data from 6 VISNs over the years 2002 to 2006 for evaluating the extent to obesity diagnoses were made/coded and the various education, counseling, medical and/or surgical treatments for obesity that were delivered. Of 933,084 (88.6%) of 1,053,228 primary care patients who had recorded heights and weights allowing calculation of BMI, 330,802 (35.5%) met criteria for obesity. Among obese patients who survived and received active care (N = 264,667), 53.5% had a recorded obesity diagnosis, 34.1% received at least one outpatient visit for obesity-related education or counseling, 0.4% received weight-loss medications, and 0.2% had bariatric surgery between FY2002-FY2006. Receipt of obesity education varied by sociodemographic and clinical factors; providers may need to be cognizant of these when engaging patients in treatment.

- Enhancing Use and Quality of Colorectal Cancer Screening, Structured Abstract. February 2010.

Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/clinic/tp/crcprotp.htm>

This systematic review was conducted to assess the use and quality (including underuse, overuse, and misuse) of appropriate colorectal cancer (CRC) screening, including factors associated with screening, effective interventions to improve screening rates, current capacity, and monitoring and tracking the use and quality. Trends in the use and quality of CRC screening tests is also presented.

Sapna Kalsy MD, MPH - UNC Preventive Medicine Residency Program

NCP's affiliation with the University of North Carolina's Preventive Medicine Residency Program continues. Our newest resident, Dr. Sapna Kalsy, is a second-year Preventive Medicine resident with a background in Obstetrics and Gynecology. Dr. Kalsy is the current Chief Resident for the Preventive Medicine residency. She has completed her Masters of Public Health in the department of Health Policy and Management at the University of North Carolina School of Public Health. Sapna attended Drexel University School of Medicine in Philadelphia, Pennsylvania, where she earned her MD degree. She received her Bachelor's degree from Tufts University in Boston, Massachusetts, where her studies were focused on biology and the fine arts. She was born in Los Angeles, California and has been raised in numerous countries including Norway, Canada, and the northeast region of the United States. Her interests in health care include quality improvement, health-system policy and reform, as well as public health law.

CALENDAR *of* EVENTS

PATIENT CENTERED MEDICAL HOME SUMMIT

April 13-15, 2010, in Las Vegas, NV

This summit is for interdisciplinary front-line primary care staff and leaders at the facility and VISN level. The Summit will be a three day process in building upon what has already been done in order to make the most healthy, solid, effective Medical Home possible for Veterans

NCP Conference Call

2nd Tuesday of the month

1:00pm ET

1-800-767-1750, Access Code 18987

Apri. 13 (cancelled); May 11, June 8

VISN Preventive Medicine Leaders Call

1st Tuesday of the first month of each quarter

1:00pm ET

1-800-767-1750 Access Code 18987

• Next call—April 6, 2010

Preventive Medicine Field Advisory Committee Call

1st Monday of the month

3:00pm ET

1-800-767-1750, Access Code 18987

• Next call—April 5, 2010

Facility MOVE! Coordinators and Physician Champion's Call

2nd Tuesday of the first month of each quarter

3:00 pm ET

1-800-767-1750, Access Code 59445

• Next call—April 13, 2010

VISN MOVE! Coordinators Call

2nd Tuesday of the second and third month of each quarter

3:00 pm ET

1-800-767-1750, Access Code 59445

• Next call—May 11, 2010

Patient Health Education Hotline Call

1st Tuesday of the month

1:00pm ET

1-800-767-1750, Access Code 16261

• Next call—April 6, 2010

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

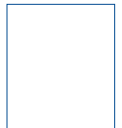
Nancy Granecki, Special Assistant
Connie Lewis, Program Analyst
Kate W. Harris, Editor (contract)

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

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



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



NCP MISSION

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