



# Health **POWER!**

## PREVENTION NEWS

Veterans Health Administration

May 2003

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## From the Director's Desk...

### The **MOVE!** is ON!

Anyone unaware of the weight epidemic in the U.S.? Research has clearly shown the links between excess weight and physical activity and numerous disease processes, including psychiatric pathologies. This also adversely affects Quality of Life. The health care costs resultant from excess weight and physical inactivity are considerable (over \$100B annually). There is no similar single health risk that is so prevalent and is connected with so many diseases and decreased quality of life (even surpassing the adverse effects of smoking) — and which is preventable.

Maybe you don't know that veterans, as a whole, are heavier than the comparable non-veteran population (69% versus 54%; BRFSS data, NCHPDP unpublished results). This veteran population includes those enrolled in the VHA, as well as those who have *not yet* come into our healthcare system. Overweight veterans are at increased risk for developing weight-related chronic disease — and there is the likelihood that un-enrolled vets will seek out the VHA when their healthcare costs escalate.

This means that the VHA should expect more weight-related health problems as the veterans age. Should we stock up on more medications and services in anticipation of treating the increase in diabetes, hypertension, heart problems, strokes, several cancers, hyperlipidemia, gall bladder disease, arthritis — to name a few? Or should we stop the disease? By way of analogy, do you send unprotected soldiers into a known ambush, when you have the options to use armored vehicles and Kevlar, or even go around the ambush or use air strikes to eliminate the enemy? If there is an option, it makes best sense to prevent it/avoid it in the first place. In the same way, while we must be prepared to treat disease, we also must seriously begin to protect our vets by weight management and increased physical activity, before they get weight/sedentary-related diseases.

So, in DEC 01, the NCHPDP decided to proactively commit to overweight prevention, beginning the development of a weight management/physical activity (WM/PA) program to ensure a standardized and nationwide (but minimal) VHA approach to attack excess weight and sedentariness in veterans.

There have been several issues to our advantage in getting this initiative started. Since the US Surgeon's General *Call to Action* in JAN 02, the recognition of epidemic proportions of obesity and inactivity in the U.S. has stirred intense governmental (including Presidential) and academic interest in research and programmatic derivation. Scientific findings, correlations, new treatments, advice and policy have flooded the news. But, only VA is uniquely positioned to pioneer and field a nationwide WM/PA program. No other government or civilian health care organization has the magnitude of responsibility, the number of medical centers, the inter- and intra-connectivity, the high standards of quality, or the central hierarchical organizational structure, as VA, giving it the best chance for success. No other organization or patient population holds the interest of Congress in the same way as the VA and the veterans.

After a fitful start, with typical birthing pains found in any endeavor of this magnitude, the **MOVE!** (Managing Overweight/Obesity for Veterans Everywhere) program was born at NCHPDP, especially due to the Herculean efforts of Dr. Rich Harvey, Virginia Zele, and Asha Sultzer. It is based on the following key guidelines.

- No grandiose strategies. Keep it simple and straightforward.
  - Minimal cost for development (outside-VA grant).
  - Utilize existing resources; adaptable to ongoing VHA clinical operations.
- Not an "experiment"; conforms to NIH guidelines/evidence-based methods.
- No product/diet/methodology endorsements.
- Intent is to lose weight/increase activity for the sake of health, not looks.

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### **NCHPDP Mission Statement**

The VA National Center for Health Promotion/Disease Prevention (NCHPDP) is the central resource for All Things Prevention, to include: prevention information, prevention education and training, prevention research, and prevention recommendations for the VHA. The Center facilitates the improvement and availability of prevention services in order to reduce illness, death, disability, and cost to society resulting from preventable diseases.

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- Not just a weight loss program, but also a *do-able* permanent lifestyle change.
- Weight problems are treated as a chronic disease, so enrollment is lifetime.
- Multi-disciplinary approach: Nutrition, Exercise, Behavior, Medical.
- Zero to minimal burden on the provider (aimed to decrease related workload).
- "Same day" enrollment;
  - Patient's initial intake questionnaire automatically generates a nutritional, exercise, behavioral plan that is tailored to the individual.
- Increasing graded steps/levels of intensity of intervention, as needed.
  - Incorporates same options for weight management as generally available to the US public.
- Applies to VA employees (to extent allowed); VA providers as Role Models.
- Multi-VHA section involvement in development of initiative, but speedy design and implementation.
  - However, constantly monitor and evaluate program, with flexibility to make improvements.
  - Use of web for distribution of materials and updates to providers and patients.
- Development of CPGs, Performance Measures, toolkit and Provider manual, and Directive to legitimize the initiative.

Where are we now?

- Initial design of the initiative has been completed.
- Development, validation, and automation of the enrollment assessment questionnaire are finished.
- Patient and provider educational materials have been developed.
- The initiative has received field input. (See article in this issue on the 10 APR 03 *MOVE!* course.)
- Fourteen VA medical facilities have offered to serve as pilot sites.
- The IRB approval process has been started.
- An extensive evaluation piece is being developed to monitor facilities, *MOVE!* personnel, patient outcomes/satisfaction, materials, implementation process.
- A *MOVE!* training module has been incorporated into the VA Prevention Coordinators training course, approved for 11-14 AUG 03 in Albuquerque, NM. (\*\*Contact NCHPDP for further details.)
- A WM/PA Executive Advisory Council made of VA, other government, and academic national experts has been established as a steering group.

You bet, the *MOVE!* is ON! VA can take the lead to define the blueprint for Weight Management for the nation, while having a positive impact on reducing disease and associated costs, and increasing Quality of Life for its veterans.

Wanna join?

**yevich, out!**

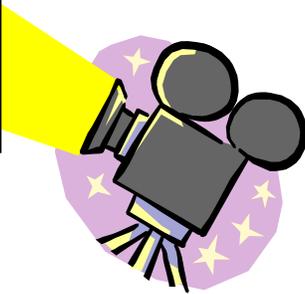


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## From the Chief of Staff -

### SPOTLIGHT ON NCHPDP STAFF



Mary Burdick, PhD, RN

In this edition, NCHPDP will spotlight Mike Harrelson, who for the last 10 months has been our IT Specialist. Mike comes to NCHPDP with nearly a decade of experience with software development and computer system consulting. He has designed and developed computing solutions to facilitate every facet of business from sales and marketing to engineering and manufacturing to finance and accounting. His background includes software, hardware and firmware design.

At NCHPDP, Mike has enhanced our interoffice collaboration by building and continuing to maintain our local area network and network resources. He has standardized and updated our workstation configurations and information systems.

With input from NCHPDP clinical staff regarding content, Mike designed the NCHPDP Internet and Intranet sites, including custom graphics, content styles and intuitive content navigation. Through use of Active Server Pages and other automation tools, Mike has created scalable, organized and extensible Internet and Intranet websites for NCHPDP. Some examples of Interactive content include a Patient Health Assessment tool (currently being tested), Prevention Champion Nomination page, PMPC search functionality and other miscellaneous web-based surveys that are schedule to be published in the near future.

In addition to network management, Webmaster duties and workstation maintenance, Mike is working to develop applications that help automate research.

Mike has managed to do all the above and tend to all the every day computer problems experienced in the office with patience and a great sense of humor. He assesses and fixes problems quickly. His other talents include the ability to assimilate any software program and make it work for us very quickly. His skills with PhotoShop have enhanced the quality of pictures for the newsletter and other deliverables, such as the monthly Prevention topic materials distributed to the field. He keeps us in touch with how technology can enhance the implementation of prevention services in the VHA, and has been involved in virtually every project the Center has undertaken during his tenure.

The entire staff of the NCHPDP offers thanks to Mike for his dedication to the Center's projects, and creative solutions to the many problems encountered along the way.

## MOVEing FORWARD!!

It was 42 degrees outside on April 10 and 11 and pouring rain. But that did not dampen the spirits of the 80+ individuals who had convened at the Millennium Hotel in Durham, NC for the introduction of the NCHPDP Weight Management/Physical Activity program – *MOVE!* – Managing Obesity/Overweight in Veterans Everywhere. This workshop was partially funded by an unrestricted educational grant provided by Roche Laboratories.

Attendees were presented with a huge notebook of program materials, including the clinical algorithm, program description,

patient handouts, scripted interventions with patients, appendices, etc. Each participant also received a bag filled with useful items, such as a "Weight to Health" Wheel, and sample menus for different calorie ranges of American or Southern fare. Available throughout the conference were teaching posters illustrating the health effects of extra weight, Hispanic menus, and information about NCHPDP and CORE (Centers for Obesity Research and Education). Each participant was also given a pedometer.

The conference began with a welcome by the Center's Director, Steve Yevich, MD, MPH, and the first of several opportunities for some brief physical activity led by Asha Sultzer, NCHPDP fitness expert. All sessions were moderated by our NCHPDP Chief of Staff, Mary Burdick, PhD, RN.

Initial presenters were from the CORE (Center for Obesity Research and Education) based at the Minneapolis VAMC. Charles Billington, MD, discussed some of the scientific findings regarding obesity, as well as assessment and treatment. Information on Motivational Interviewing was presented by John Billig, PhD. Heidi Hoover, MS, RD, LD, discussed the obesity treatment programs at the Minneapolis VAMC. "Exercise: An Essential Component" was presented by James Rettler, KT. The CORE presentations were capped by Mr. Larry Peterson's personal story of his journey with obesity. (See his article, "A Personal Journey", on page 5 in this newsletter.)

The *MOVE!* program was then presented by the NCHPDP staff who developed the materials: Richard Harvey, PhD; Virginia Zele, MS, RD, LDN; and Asha Sultzer,



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BS. The history and development of the materials and an overview of content in the manual were reviewed. The NCHPDP website-based *MOVE!* assessment instrument, programmed for the computer by NCHPDP IT Specialist, Mikeal Harrelson, was "tested" by attendees as they answered questions and checked off options to create a "sample patient". Upon completion of the questions, the computer immediately generated an individualized summary profile to be given to the patient, a list of tailored patient education handouts based on the patient's responses, and a written summary of findings for the provider, suitable for copying and pasting into CPRS. Participants offered feedback on the assessment process, which will then be used to refine the assessment instrument.

On Friday, participants were split into smaller workgroups by VISNs to discuss facility barriers to implementation of the *MOVE!* program, and to suggest solutions to those barriers. Many potential and real barriers were identified. However, the list of solutions to most barriers was long and creative.

The workgroups then tested some of the sample scripts and handouts as they role-played scenarios of several different typical veteran patient profiles. Throughout the morning, feedback and suggestions for improving the materials were contributed by the participants.

The final session of the conference started with a summary review of the barriers and identified solutions. Administrative (leadership) support was clearly identified by most as an issue. NCHPDP has already obtained support from some of the key VACO officials for this program and takes responsibility for securing that support. Other issues identified will be addressed as the program evolves.



Dr. Yevich brought the workshop to a close by thanking participants for their energy, enthusiasm, and thoughtful suggestions for improvement. He challenged them to carry the information back to their facilities for implementation, and requested that facilities consider being a pilot site for implementation of the program. All participants were invited to submit further suggestions for improvement, offers to pilot, etc.

What's next? NCHPDP staff will revise the procedures and materials based on feedback from the conference participants. Field trials at selected sites will follow, with additional detailed feedback gathered from staff and patients at each site. Further refinement of the program will result from these trials. The *MOVE!* program will then be distributed throughout



the VHA, accompanied by multiple modalities for training staff who will conduct the program.



**NCHPDP Staff**



The NCHPDP/Dietitian Field Team was formed in March 2002. The team assists NCHPDP by reviewing *MOVE!* materials and giving feedback; pilot testing assessments, program components; and the sharing of knowledge and expertise. The team also assisted with development of the following prevention monthly topics - hypertension, cholesterol, diabetes and healthy weight week. Other team members include: Melinda Saxon, Sonya Corum, Millicent Lasslo-Meeks, Maryann Shavink, Kimberly Gustafson, Alicia Swanson, Sonia Fulambarker, Richard Harvey and Virginia Zele.

These members pictured attended the *MOVE!* Conference:

First row - left to right: Pat Collins; Terry Hoos

Last row - left to right: Lynn Novorska; Debbie Tirpak; Heidi Hoover; Susi Lewis

## A Personal Journey: 600+ Pounds And In Trouble

In 1999, Larry L. Peterson lay in a hospital bed in Spirit Lake, Iowa. He was suffering from pneumonia complicated by the many blood clots lodged in his lungs. After his family/friend doctor pulled him through, he exclaimed "Peterson, the only time I've seen so many blood clots in a person's lungs is in a cadaver." Then Larry was sent to a larger medical center to fully recover; Larry remembers this as one of the most important medical crises that would precede the low point of his life-long fight against obesity.

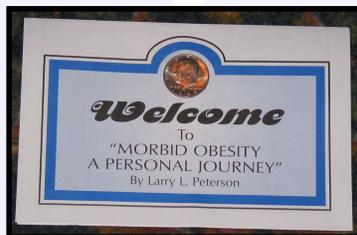
Larry, a purple heart recipient and Vietnam veteran, turned to the Veterans Administration for additional insurance after incurring steep medical bills during his recovery from pneumonia. This decision eventually led him to the professionals who would help him turn his life and health around.

Larry has struggled with obesity his entire life. Now in his 25-year career as a real estate broker, he found his obesity limiting his work in many ways. By now he found it difficult to get into his car, he was afraid to sit down for fear he would break a chair, his business was suffering and he felt so much guilt for letting his real estate agents and employees down. Larry would eventually end up selling his business in 2001.

As weight was added and his activity level understandably decreased, Larry experienced another complication. The skin of his lower leg broke open twice. Healing was slow and infection a constant concern.

Throughout his life, Larry had enjoyed various forms of competition. Now he was limited to darts as a hobby and enjoyed competing in dart tournaments. In November of 2000, Larry was in Minneapolis, MN participating in such a tournament. Though he was indoors, he was wearing a parka while his fellow competitors were in shirtsleeves. Larry landed in the VA hospital in Minneapolis with another medical crisis. His kidneys were shutting down and he faced the possibility of having a part of his leg amputated.

Normally a cheerful person, the recent events were now affecting his outlook on life. Larry had lost most of his reason to go on except for Pam, his wife of four years, who was and is his shining light. Even so, he felt he was letting her down by turning her into a care taker and he rationalized that his life insurance policy was worth much more to her than he was. At this point, he thought the easiest way out was to continue his destructive eating patterns which would eventually lead to an "acceptable suicide."



But a team of people with the Minneapolis VA Weight Management Program and a few key people in his life would step in to head off that scenario.

After Larry turned down an offer of stomach stapling, Heidi Hoover, a registered dietitian with the Intensive Weight Management Program of the Minneapolis VA Hospital in Minneapolis, came into Larry's hospital room to discuss the programs available for weight management at the VA. She explained the evaluation and the inpatient program for severely obese individuals.

Heidi added that the first available opening in this popular program was in six months.

Larry was not interested. He had been on so many diets. He might lose a little weight initially, but he always gained the pounds back. Just to get Heidi out of his room, he promised her he would come to the clinic in six months. He thought to himself that he wouldn't even be around by that time anyway.

When an opening at the inpatient program occurred in three months and Larry turned it down, Larry's wife Pam got hold of his brother, Glenn, and a friend, Duane Williams, and they talked to Larry about his intentions. Larry realized that he could not divulge his personal agenda, which was to die, and would have to go through the motions by attending the weight loss program.

At 603 pounds and unable to get around by walking, Larry entered Ward 4E in the Special Diagnostic Treatment Unit at the Minneapolis VA Medical Center in a wheel chair. The Intensive Weight Management Program uses a team approach. His team included Dr. Charles Billington, physician; Dr. John Billig, psychologist; Heidi Hoover, registered dietitian; Jim Rettler, kinesiologist; and Jack Pfieler, vocational recreational therapist.

Larry learned quickly that the emphasis of the program would be on making lifestyle changes under supervised conditions. One of the conditions was that everyone, regardless of incoming weight, would be on an 800-calorie diet. In addition, everyone would participate in some kind of exercise two times a day.

He remembered clearly that when he was wheeled into the exercise room that Jim, the kinesiologist, treated him with kindness and respect. He asked him to walk as far as he could, then rest and walk a bit again. Larry did just that. He also followed the 800-calorie diet and began feeling better within two days.

Dr. Billig helped Larry realize that he had handled difficult situations in the past and could use his strengths to work toward a new attitude that would help him in the future. Instead of excuse-making and negative messages to himself, Larry formulated the following conviction. "It is my mind that has been holding me back and it is my mind that will make me better." The support that each of the clinic participants gave to each other as they reshaped their behavior was another key to Larry's success.

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The daily classes taught participants how to eat mindfully, plan menus, prepare low fat foods and eat out healthfully. Larry also determined to incorporate exercise into his life - but exercise that fit his own lifestyle. Nevertheless, when the program drew to an end, Larry was troubled with doubts about making it on his own. This is where Larry took a look at his own lifestyle and what he enjoyed doing and used the information that he learned in the weight management program and also all the good information he has learned throughout his life and incorporated that into what became his own personal weight management program. Larry also realized that a support group is a very necessary part of his program. For that reason, Larry has been a dedicated attendee at the weight loss clinic and support group, a weekly follow-up meeting which reinforced what has already been learned about altering food and activity choices. Most importantly, this clinic is a problem solving session where the struggles of individuals can be discussed and plans agreed upon for approaching those struggles. After losing 300 pounds, Larry has become a role model for success at the weight loss support group meetings.



Dr. Charles Billington, Larry, Heidi Hoover

Other veterans ask if he will be coming. When the answer is in the affirmative, the attendance is always up.

Dr. Charles Billington, director of the obesity program, has helped Larry through the inpatient weight loss program and through the follow-up clinic. Last fall, Dr. Billington and Larry were both featured speakers at an obesity seminar for doctors. The seminar was sponsored by the Center for Obesity Research and Education (C.O.R.E.) and the Minnesota Obesity Center. Larry also spoke at a Minneapolis gathering of health care professionals.

Other seminars that Larry has presented in the states of Iowa and Minnesota include TOPS (Take Off Pounds Sensibly) groups, hospital staffs lectures and community education classes. At each seminar,

he openly tells of his personal journey from the depths of obesity to the commitment of helping others. He is also conducting one-on-one counseling, by appointment or doctor referral. His Power Point presentation includes "before and after" pictures of his weight loss success. He displays the clothing that he wore before he lost 300 pounds, as well as a variety of items which were helping him exist - items which he no longer needs, but which fill the back of his van as he travels the roads of the upper Midwest.

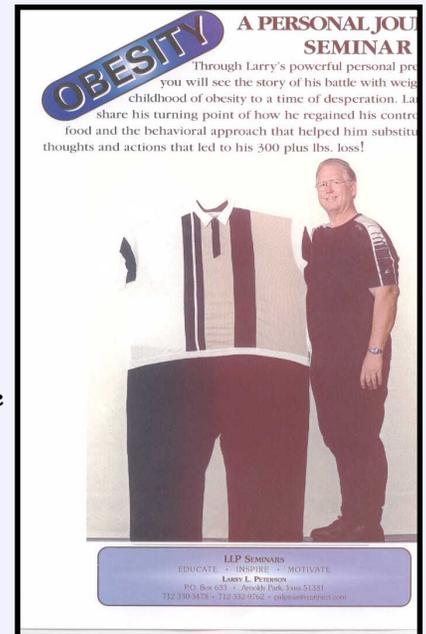
His wife, Pam, is an active and enthusiastic assistant in the seminars. She runs the Power Point, organizes handouts and readily answers questions after Larry's seminar.

His message is clear. Every person, despite physical or emotional problems, can make the lifestyle changes that fit his or her own personality.

Larry is so grateful to all the professionals at the Minneapolis VA Medical Center who did not give up on him even when he was ready to give up on himself. He is grateful to the relatives and friends who stood by him. And he is gratified to hear from so many about how his personal journey of change has given them the impetus to start their own lifestyle changes. One man who felt like Larry's struggle was so like his said, "Larry did not tell me I should. He only made me see I could. He talked from the heart. He has changed my life and the life of my wife and family."

Now Larry can not wait to get up each morning to greet the challenges of telling others about how he has put the lessons of attitude and behavior change into practice. The promise this man of integrity made to Heidi Hoover is now a promise he keeps to hundreds of others. "I will honestly tell my story; I will truly care about helping you just as others have helped me."

If you would like to contact Larry you can email him at [palpinia@rconnect.com](mailto:palpinia@rconnect.com) or send a letter to Larry L. Peterson, PO Box 633, Arnolds Park, Iowa, 51331.



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***SERVICE AND DEVELOPMENT ARE  
HABITS FOR DAYTON  
PHYSICIAN ASSISTANT***



Maritha Trass, PA-C, is a go-getter at the Dayton Veterans Affairs Medical Center. Since her arrival in 1995, things have changed largely in part due to her innovation, organization and compassion. She was hired into the Ambulatory Care Service to bolster the compensation and pension section. While working under the "system" she began to notice ways to improve services. Her psychology degree from Marquette University and her Physician Assistant studies at Alderson – Broadus College, and her HMO and Federal Prison employment had all served her well. She began to see women veterans in the compensation setting and listened to their comments that there seemed to be no further or only limited care resources for women veterans. Her investigation enlightened her that no "organized" women's services were available for an increasing number of women veterans. She positioned herself to be "on call" for emergency department women's issues, and took note of the lack of follow-up services available. She aligned herself with the existing limited services for women and advocated for more health care.

Eventually she was named Women's Health Care Coordinator for the Dayton VAMC, reporting directly to the hospital director and representing Dayton on the VISN10 clinical council, which was dealing with care for women. She developed a clinical practice providing screening and preventive care services, prenatal care arrangements, surgical biopsy, and specialty gynecological exams arrangements as the individual case dictated. She stimulated a sharing agreement with Wright Patterson Air Force Base radiologists for mammography and for surgical evaluations. She also made necessary contract referrals to the community. She began to be an organizational advisor for women's veterans groups and helped them meet, organize and prosper. Eventually, as electronic medical records came into practice, she reviewed and suggested changes to the national women's health care screening. She was also involved in instituting an awareness process for a women veterans' sexual assault program.

In her concurrent position in the compensation and pension section, she saw numerous deficiencies and began to organize this program as well. Her initial assessment was bolstered by a patient satisfaction questionnaire she developed to determine how

the section was performing. After reviewing those results, she urged redesign of the clinical flow of patients and redesigned the internal structure for ordering supportive laboratory and x-rays and a method for retrieval in a timelier manner. Those actions alone improved patient satisfaction and resulted in a great, unexpected benefit of better clinical staff satisfaction and performance improvement. Further observation of local processes brought to her attention the duplication of services to recently discharged or retiring veterans. She advocated for changes in the evaluation process of out-processing active duty personnel with regard to disability examinations. A sharing agreement between the United States Air Force and the Dayton VAMC resulted in a "one time" pre-discharge exam that served to identify disabling illness or injury at the time of discharge. This exam serves both the needs of the Air Force and the Bureau of Veterans Benefits disability process. This has saved countless hours of duplicated services from both the Department of Defense and the Department of Veterans Affairs. Through these changes, she has shown her knack for innovation.

Although she notes the wheels of government change too slowly, she persists in achieving her goal: to provide outstanding patient care with reasonable and sensible approaches to organizational issues. Maritha would be doing enough with all this, but there is more. She also precepts Physician Assistant students, is mother of an active 9-year old, is an involved member of her church and is a homemaker for herself and husband of 15 years. She is indeed an innovator and a valuable asset to the veterans of VISN 10 and the Dayton Veterans Affairs Medical Center.

(Original article submitted by Craig Ankeney, PA-C)

(This article was reviewed by Joseph O. Streff, PA Advisor)



**Women's Health 2003 at the VA Southern Nevada Healthcare System in Las Vegas, NV on 5/14/03**

## A JEWISH VIEW ON HEALTH MAINTENANCE AND ILLNESS PREVENTION

Contemporary western medicine has, for the most part, focused on the treatment of diseases, rather than on their prevention. Until rather recently, medical schools primarily have taught that prescription drugs are the most powerful tools doctors have for treating disease; diet and other lifestyle changes are increasingly presented as therapeutic tools, but not as emphatically as medications. Once a doctor enters medical practice, the drug message is reinforced: drug companies give out free samples; virtually all the advertisements in medical journals are for prescription drugs; the bulk of medical literature relates to the use of drugs and drug comparisons. Hence, while this appears to be changing slowly, the generally accepted response to many diseases today is to prescribe medications first and perhaps recommend lifestyle changes as an afterthought.<sup>1</sup>

Judaism's historic approach is fundamentally different from that of modern medicine. While treating sick people is certainly a religious obligation, Judaism puts a priority on the *prevention* of disease. The foundation for the Jewish emphasis on preventive medicine can be found by considering the verse in the Bible where God is described as the *rofeh*—healer—of the Israelites:

And He said: "If you will diligently hearken to the voice of the Lord, your God, and will do that which is right in His sight, and will give ear to His commandments, and keep all His statutes, I will put none of these diseases upon you which I put on the Egyptians; for I am the Lord, your healer".<sup>2</sup>

*Rashī*<sup>3</sup>, a famous Jewish biblical commentator, interpreted this verse to mean:

I am the Lord, your healer, and I teach you the Torah<sup>4</sup> and the commandments in order that you may be saved from these diseases—like a physician who says to a man: "Do not eat this thing lest it will bring you into danger from this illness."<sup>5</sup>

What are the implications for modern medicine? Just as God's healing role in the above Torah verse is to prevent illness, so too a physician must emulate the Divine role by emphasizing the prevention of illness. For we are obligated to "follow in God's ways."<sup>6</sup>

In Judaism, health is a religious, not just a personal, concern. Rabbi Moses Maimonides, who was one of the greatest physicians of his time (1135-1204), was also one of the most important Jewish philosophers and codifiers of Jewish law in the Middle Ages. In his authoritative legal code called *Yad ha-Hazakah* (the "Strong Hand"), Maimonides noted that "Since maintaining a healthy and sound body is among the ways of God—for one cannot understand or have any knowledge of the Creator if he is ill—therefore he must avoid that which harms the body and accustom himself to that which is helpful and helps the body become stronger."<sup>7</sup>

For this reason it is a religious obligation to take care of one's health. There are many *halakhic*<sup>8</sup> regulations enacted for health purposes. In general, health regulations are treated with greater stringency than any other section of *halakha*. In the section dealing with "Murder and the Guarding of Life," Maimonides wrote:

It is a positive commandment to remove any stumbling block that constitutes a danger and to be on guard against it. The sages have prohibited many things because they endanger one's life. If one disregards any of them and says "I am only jeopardizing myself, what business do others have with me"; or "I don't care [if they are dangerous] I use them (that is, harmful things)," he can be subjected to disciplinary flogging.<sup>9</sup>

Rather than regarding personal autonomy in lifestyle choices as the highest principle of human ethics and society, Judaism sees life as not being the exclusive possession of the individual. A person must avoid harm to self and must also avoid being a source of harm to others.<sup>10</sup>

The following anecdote about Maimonides is instructive about preventive health care. During the period when he served as the royal physician of the Sultan of Egypt, the Sultan never became ill. One day the Sultan asked Maimonides:

"How do I know that you are an expert physician, since during the period that you have been here, I have never been ill, and you have not had the opportunity to test your skills?" Maimonides replied, "In truth, the great and faithful physician is the Holy One, Blessed Be He, as it is written, 'I am the Lord, your healer.' And this Great and Faithful Physician was able to promise his people that because He is their Physician, He will be able to protect them from all the illnesses that were put on Egypt." Maimonides concluded, "Therefore, we learn that the ability of a physician to prevent illness is a greater proof of his skill, than his ability to cure someone who is already ill". (*Yalkut Lekach Tov, Shmot, B'Shalach*)<sup>11</sup>

The Torah indicates another moral obligation that might demand physicians take a greater interest in preventive medicine: "Do not stand idly by the blood of thy neighbor".<sup>12</sup> One is not supposed to remain passive if he or she sees another person in danger. For example, if one sees a person drowning or being attacked by robbers, he or she should do everything possible to rescue the person<sup>13</sup>. Based on this verse, the *Chafetz Chaim*,<sup>14</sup> in his classical work *Shemirat HaLashon*,<sup>15</sup> taught that one must not withhold information which can save another from death or any type of damage. The following Talmudic teaching reinforces this principle: "Those who have the capacity to eliminate a wrong and do not do so bear the responsibility for its consequences."<sup>16</sup>

According to the above, Judaism strongly posits that physicians should put far greater emphasis on preventive

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medicine, advising their patients about dangers related to smoking, high-fat diets, and other lifestyle choices.

It should not be assumed, of course, that the Torah places the entire responsibility of maintaining good health on physicians. In fact, our Sages have stated that the major responsibility falls on the individual. To take care of one's health is a *mitzvah*,<sup>17</sup> and the Sages find this mandate implied in the words, "Take heed to thyself and take care of your lives."<sup>18</sup> and, again, "Be extremely protective of your lives."<sup>19</sup>

Rabbi Samson Raphael Hirsch<sup>20</sup> writes powerfully in his classic book, *Horeb*,<sup>21</sup> about the *mitzvah* of guarding our health:

Limiting our presumption against our own body, God's word calls to us: "Do not commit suicide!" "Do not injure yourself!" "Do not ruin yourself!" "Do not weaken yourself!" "Preserve yourself!" (p. 298). You may not, in any way, weaken your health or shorten your life. Only if the body is healthy is it an efficient instrument for the spirit's activity....Therefore you should avoid everything which might possibly injure your health. . . . And the law asks you to be even more circumspect in avoiding danger to life and limb than in the avoidance of other transgressions. (p.300)

Thus, a core principle of Judaism lies in the Biblical verse: "Take good care of your lives."<sup>22</sup> As Rabbi Seymour Siegel wrote: "This reflects the understanding basic to all biblical faiths, that life is a gift, a privilege given to us by the Creator. This means that we are bidden to guard, preserve and enhance our lives and the lives of others. To neglect our health, to willfully do something which can harm us, is not only to court disaster for ourselves but is also an affront to the One who gave us life."<sup>23</sup>



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#### Footnotes:

<sup>1</sup>Yosef Ben Shlomo Hakohen and Richard H. Schwartz, Ph. D. "Prevention: Torah Perspectives on Preserving Health." See <http://schwartz.enviroweb.org/health.html>.

<sup>2</sup>Exodus 15:26

<sup>3</sup>Rabbi Solomon ben Isaac of Troyes (1040-1105 C.E.)

<sup>4</sup>Jewish biblical law.

<sup>5</sup>Rashi's commentary on Exodus 15:26.

<sup>6</sup>Deuteronomy 11:22.

<sup>7</sup>Maimonides, *Yad ha-Hazakah*, "Laws on Correct Attitudes" (4:1).

<sup>8</sup>Pertaining to *halakha*, Jewish law.

<sup>9</sup>Maimonides, *Ibid.* "Laws on Murder and the Guarding of Life" (11:4-5.).

<sup>10</sup>Seymour Siegel, *Smoking: A Jewish Perspective*. See <http://www.koach.org/Smoking.pdf>.

<sup>11</sup>This work is an anthology of Jewish lore based on the Bible.

<sup>12</sup>Leviticus 19:16.

<sup>13</sup>Babylonian Talmud *Sanhedrin* 73a.

<sup>14</sup>Rabbi Israel Meir Hacoen Kagan (1838-1933).

<sup>15</sup>Kagan, *Laws Related to Correct Speech*. (1868).

<sup>16</sup>Babylonian Talmud *Shabbat* 54b

<sup>17</sup>Hebrew word for commandment or good deed.

<sup>18</sup>Deuteronomy 4:9.

<sup>19</sup>Deuteronomy 4:15.

<sup>20</sup>German Jewish theologian, 1808-1888.

<sup>21</sup>*Horeb: Essays on Israel's Duties in the Diaspora* (1838). This was Hirsch's legal-philosophical presentation of the basic laws of Judaism.

<sup>22</sup>Deuteronomy 4:15

<sup>23</sup>Siegel, *Ibid.*

## \*National Health Observances July - September 2003

### July

Eye Injury Prevention Month [www.aao.org](http://www.aao.org)

### August

National Immunization Awareness Month (NIAM)  
[www.partnersforimmunization.org](http://www.partnersforimmunization.org)

### September

Cold and Flu Campaign [www.lungusa.org](http://www.lungusa.org)

Gynecologic Cancer Awareness Month [www.wcn.org](http://www.wcn.org)

Healthy Aging Month [www.healthyaging.net](http://www.healthyaging.net)

National Alcohol and Drug Addiction Recovery Month  
[www.recoverymonth.gov](http://www.recoverymonth.gov)

Family Health and Fitness Days USA  
[www.fitnessday.com/family](http://www.fitnessday.com/family)

National Cholesterol Education Month  
[www.nhlbi.nih.gov](http://www.nhlbi.nih.gov)

Ovarian Cancer Awareness Month [www.ovarian.org](http://www.ovarian.org)

Prostate Cancer Awareness Month  
[www.pcacoalition.org/home.htm](http://www.pcacoalition.org/home.htm)

National 5 A Day Week (21-27) [www.5aday.gov](http://www.5aday.gov)

## PRIMARY CARE SOCIAL WORKERS – A VITAL CONNECTION

Social workers in the Primary Care setting can have a vital role in the health and well-being of our veterans. Despite the increased use of various tools to detect depression in our patients, depression is still very much underreported and undertreated. There are various reasons for this:

- Many of our veterans have lost connections with social support systems. Their family members may have died, live in another state, or be unavailable for other reasons. Sometimes veterans with a long history of maladaptive behavior have burned bridges to families and friends. Thus, there may be no one close enough to the veteran to notice depression and encourage treatment.
- Veterans may not feel comfortable discussing their feelings with families or friends. “People born early in the century were taught to keep their feelings to themselves. For example, WWII veterans didn’t come home and talk about the war. They were shell-shocked and didn’t necessarily understand their own psychological states.”<sup>1</sup> (Pipher, 1999)
- Older people don’t generally acknowledge depression and are often unwilling to engage in or see the value of psychotherapy. “The older generation grew up in a time when mental illness was much feared and hated. Most decided that they would rather suffer than face the shame, the labels and the admission of defeat that therapy implies.”<sup>2</sup> (Pipher, 1999)
- The presence of other medical conditions can mask the symptoms of depression or depression can be considered a normal response to dealing with the pressures of life.
- Culture can further cloud the symptom picture. Approximately 63% of African Americans believe that depression is a personal weakness, and only 31% believe depression is a health problem. Only 1 in 4 African Americans recognize that a change in eating habits and sleeping patterns are a sign of depression; only 16% recognize that irritability is a sign of depression. These attitudes reduce the chance that symptoms would be seen as something to report to a health professional. (NMHA, 2003)

The effects of untreated depression can be devastating to the life of the individual and the family, as well as being life-threatening.

- Depression occurs in about half of all people who have had a heart attack, and in about 1 of 5 people who have coronary heart disease, but who have NOT had a heart attack. (NMHA, 2003)
- After a heart attack, people with clinical depression have a three to four times greater chance of dying in the next 6 months. (NMHA, 2003)
- One in four people with cancer also suffer from clinical depression. (NMHA, 2003)
- One in four people with adult onset diabetes have depression; depression affects as many as 70% of patients with diabetic complications. (NMHA, 2003)
- People with depression experience greater distress, an increase in impaired functioning and less ability to follow medical regimens, thus hindering the treatment of any other medical conditions.
- The highest suicide rates in the US are found in white men over age 85 – six times the national rate. (NIMH, 2003)
- Tragically, 70% of the elderly who commit suicide visit their family doctor within a month before their death, nearly 40% have a medical encounter within a week of killing themselves, and 20% have visited a primary care physician on the same day as committing suicide. (NIMH, 2003) The fact that up to half of depressed persons are neither diagnosed nor treated by their primary care providers is not the fault of the providers – rather, it is an indication of the confusing diagnostic picture depression presents and the limited time providers have in which to assess the patient’s entire medical condition.

As social workers in the primary care setting, we are in a position to assist patients and providers to improve the diagnosis and treatment of depression. One of the most positive interventions we have in our arsenal against depression is to establish a real connection with the people who come to us for services. Whether that initial contact is related to concrete services such as information about finances, home health or advance directives, to general questions about how the VA system functions, or to a concern a veteran has about health or family problems, we have a unique opportunity in that initial meeting to establish a genuine connection with that veteran.

Even in a brief meeting, if we take a few extra minutes to listen, really listen, to learn something about the fascinatingly unique individual we have in front of us, the veteran will sense our interest and concern and we will have made an important connection. Many times this is all that is necessary for the veteran to pour out a flood of information. Once the real issues are known, we can do the things social workers do best – make referrals, engage the veteran in treatment and/or collaborate with other health care professionals. Because we are connected with the primary care clinic, we are oftentimes in a position to “introduce” therapy to a veteran in a non-threatening way that may help them to overcome reluctance to be referred to a mental health professional.

The value of establishing a connection with each and every veteran we see cannot be overemphasized. In a recent *Social Work* article, the authors report that a very powerfully important factor from the client’s point of view was the “unique connections [that] had been woven between them and their social workers.”<sup>3</sup> Dr. Dean Ornish whose primary focus is coronary heart disease has stated, “Study after study are showing that people who feel lonely and depressed are more likely to get sick and die prematurely than those who have a strong connection, caring and community.”<sup>4</sup> Risk factors for suicide speak to a lack of connection in the person’s life – ie, unmarried, living alone, lack of social support, unemployment, rejected by spouse or lover, freedom from responsibility for children under age 18.

While we certainly cannot replace the connections of a veteran’s family or close friends, for some of our veterans we can at least provide some kind of meaningful relationship in a sea of otherwise relative strangers. That relationship may turn out to be the means by which a life is saved.

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 Director, Social Work Service, Department of Veterans Affairs Central Office)

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3. Ribner DS, Knei-Paz C. Client's View of A Successful Helping Relationship. Social Work 2002 Oct; 47(4): 382.
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**Guest Speaker at NYHHC during Women's Health Week**  
**5/15/03**

## High-Value Preventive Services

The top ten high-value preventive services for adults, based on evidence that they protect health and are cost-effective, include: \*

1. Tobacco cessation counseling
2. Vision screening for those 65 and older
3. Cervical cancer screening
4. Colorectal cancer screening
5. Hypertension (high blood pressure) screening
6. Influenza vaccination
7. Chlamydia screening
8. Cholesterol screening
9. Problem drinking screening and counseling
10. Pneumococcal vaccination for those 65 and older

To guide employees in preventive service decision-making, Partnership for Prevention developed a report about high-value services and steps to boost delivery rates. The report can be found online at <http://www.prevent.org/clinicalpreventativescvs.htm>.

\*Coffield AB, et al. Priorities among recommended clinical preventive services. *American Journal of Preventive Medicine*. 2001;21(1): 1-9.

## Individual Preventive Medicine Counseling/Risk Factor Reduction Codes 99401-99404

Preventive health counseling services are provided at a visit separate from a visit for diagnostic purposes or follow-up and are for the purpose of promoting health and preventing illness or injury. These codes vary by age and the length of time counseling/risk reduction is provided. Time-based codes are measured in 15 minute increments:

- 99401 – approximately 15 minutes
- 99402 – approximately 30 minutes
- 99403 – approximately 45 minutes
- 99404 – approximately 60 minutes

These codes cannot be used to report counseling and risk factor reduction interventions provided to patients with symptoms and/or established illness. For counseling of patients with symptoms and/or established illness, the appropriate office, hospital, consultation or other E & M codes should be used.

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## Women's Health – Nutrition

In many ways, and for women in particular, nutrition is often synonymous with diets and weight loss instead of achieving or maintaining good health. Weight gain is commonplace as women age, in part because of changes in hormones, metabolism, and amounts of physical activity, but also because of eating habits. In our society we have become dependent on fast foods, convenience foods and eating on the run, because of hectic schedules and high stress. Many of the foods we eat tend to be low quality foods – providing calories, but lacking in nutrients, like refined flours and sugars in processed foods and fast foods. Women may be jeopardizing their health by the exclusion of foods that can help us optimize our well-being. Some nutrients that fall into this category are calcium, omega-3 fatty acids, soy and fiber. These may help reduce the risk of developing chronic diseases, or managing chronic diseases like hypertension, obesity, heart disease and osteoporosis as we continue to age.

**Calcium:** Did you know that calcium is one of the nutrients most likely to be lacking in the American diet and that three out of four women do not currently get adequate calcium in their diets? One reason women may not get adequate calcium is they often drink soda or juice instead of a high calcium drink like milk. Many women also avoid certain calcium-rich foods because they are concerned about too much fat or calories. But it is possible to get the calcium you need without too much fat or too many calories.

It is important to get enough calcium to prevent osteoporosis later in life. With adequate calcium intake, bones increase in density from birth through age 30; after that our bones begin to lose calcium. In addition to strong bones and teeth, we need calcium in a steady supply in our body to regulate muscle contraction and relaxation (including the heart muscle), blood clotting, and to make new cells and tissues. New studies are also beginning to show other protective effects of adequate dietary calcium including protection from colon cancer, a reduction in PMS symptoms, improvement in blood pressure and a reduction in the incidence of kidney stones. When we don't get enough calcium in our diet, our body will steal it from our bones to have enough for all our body processes. Most women do not achieve peak bone mass by age 30 to protect them later in life from osteoporosis; additionally, women also go through rapid bone loss in the first five years after menopause.

With osteoporosis, bones fracture easily because they lose too much of their mass and become brittle and porous. Factors that ensure reaching and maintaining bone mass include adequate dietary calcium, vitamin D and weight-bearing activities. Other dietary factors to consider for bone health include limiting caffeine and alcoholic beverages, stopping smoking, and limiting protein intake to 6-9 ounces per day. The amount of calcium you need daily depends on your age. Ages 9-18 require 1300 milligrams per day; ages 19-50 require 1000 milligrams per day; over age 50 require 1200 milligrams per day; pregnant or breastfeeding women require 1000 milligrams per day.

The best sources of calcium are low fat and nonfat dairy products like milk and yogurt or reduced fat cheese. One cup of milk provides 300-350 milligrams of calcium. Some easy ideas for including low fat dairy products throughout your day include having yogurt as a snack or using it as a dip for vegetables; add a slice of low fat cheese to a sandwich; add milk to soups, sauces and hot cocoa mix instead of water; order a nonfat latte instead of plain coffee.

Some people are lactose intolerant or have intestinal discomfort after eating dairy products. Here are some tips that may help you consume adequate calcium even if you are lactose intolerant:

- Drink milk with foods, not on an empty stomach.
- Try small portions of milk - as many people can tolerate small amounts of milk at a time.
- Purchase an over the counter enzyme supplement like Dairy Ease that can be added to milk or consumed with milk or try lactose reduced milk.

Even if you are lactose intolerant, you can still ensure adequate calcium intake by choosing nondairy calcium sources. Nondairy calcium sources include dark green leafy vegetables like kale, broccoli, collard greens, turnip greens, also, dried figs, almonds, canned fish with bones, and tofu processed with calcium. Other nondairy sources of calcium are foods fortified with calcium like calcium-fortified juice, bread, snack bars and cereals.

When reading labels, look for foods that contain 10% or more of the Daily Value for calcium. Foods high in calcium or fortified with calcium may be labeled as "calcium rich" or "excellent source of calcium".

Calcium from pills appears to be absorbed adequately by the body. However, calcium-rich foods not only provide calcium in a natural form, they also contain many other nutrients, such as vitamin D, to help your body absorb the calcium and use it more efficiently. If you find it difficult to get all the calcium you need from food, a calcium supplement may be useful. Talk to your physician or a registered dietitian.

**Omega 3 Fatty Acids:** Fats are a tricky area for women. Many women try to avoid or limit fat to help with weight control. This is a good idea since fat is more calorically dense than either carbohydrates or protein, containing 9 calories per gram as compared to 4 calories per gram. However, all fat is not created equal. The kind of fat you eat makes a difference in your health. While it is important not to overconsume fat of any kind since it can lead to obesity, striving to achieve sources of omega 3 fatty acids in our diet can be beneficial to our health. Studies are showing that diets high in omega 3 fatty acids may help prevent or arrest the growth of breast and colon cancer as well as reduce the risk of cardiovascular events. The best sources of omega 3 fatty acids are flaxseeds and fish.

The American Heart Association recommends eating a variety of fish 2-3 times a week because most seafood contains the heart-healthy fish oils. One serving of fish is about 3 ounces (about the size of a deck of cards). Good choices are fresh or frozen cold-water fish like salmon, mackerel, albacore tuna, sardines and lake trout. Remember to grill, broil, poach or bake fish as a heart healthy method of preparation.

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Flaxseeds are another abundant source of omega 3 fatty acids. They also contain lignins, which have anticancer and estrogenic effects and are an excellent source of antioxidants and fiber. You may be less familiar with how to incorporate flaxseeds into your diet. You can purchase flaxseeds as whole seeds, ground flaxseeds, flaxseed flour and flaxseed oil at health food stores. Ground or whole flaxseeds have a nutty flavor and you can add 1-2 tablespoons to yogurt, salads, soups, casseroles, or on cereal. You can also try replacing ¼ of the flour called for in a recipe with flaxseed flour in your favorite breads, cookies or muffins. Flaxseed oil works best in cold foods so try it in salad dressings.

Like many other plant foods, flaxseed is rich in phytochemicals, one of which is a plant estrogen. While this compound may lower risk of breast cancer, women who already have breast cancer may need to be careful about consuming excess amounts. Check with your physician if you have a history of breast cancer before adding flaxseed to foods.

**Soy:** Reputable research is currently showing that soy protein, in a low fat meal plan, can help reduce the risk of heart disease by lowering bad cholesterol and possibly increasing good cholesterol. It is less clear if soy can help prevent some forms of cancer, reduce the symptoms of menopause, or help prevent osteoporosis. Since soy protein contains many chemicals, including isoflavones that may play a role in health, the recommendation is to rely on food as a source of soy protein instead of supplements. A supplement may not contain all the important phytochemicals, and some chemical activity of soy may be lost in the processing. Also, soy foods are typically used to replace meats, so they increase dietary fiber while lowering saturated fat and cholesterol intake.

As far as how much soy is needed to gain health benefits, most studies suggest 17-25 grams of soy protein per day in place of animal protein and 30-50 mg of isoflavones. There are many ways to incorporate soy into your diet since soy is found in flour, tofu, tempeh, soymilk, soy yogurt, soy cheese, textured vegetable protein, soy nuts, and soy nut butter.

Some research claims that soy protein may stimulate breast cancer development, and further research shows contradictory information on hot flashes as well. You should talk to your physician if you have a history of breast cancer before adding soy to your diet. The best solution is to incorporate soy foods into your eating plan, while avoiding soy supplements or heavily fortified foods.

**Fiber:** Fiber is often forgotten as a nutrient important to our health because it does not contain calories, vitamins, or minerals; however, it is important for maintaining good health. There are 2 types of fiber:

soluble and insoluble. Soluble fiber helps the body get rid of cholesterol and slows the digestion and absorption of carbohydrates and release of glucose into the blood. Soluble fiber is found in citrus fruit, apples, potatoes, dried peas, beans, oatmeal, and oat bran. Insoluble fiber speeds the passage of waste through the intestines and helps reduce the risk of colon cancer. Insoluble fiber is found in wheat bran, whole wheat, whole grain breakfast cereals, and vegetables. Additional benefits of high fiber foods are that they are low in fat, take longer to eat, increase fullness sooner, and may suppress appetite by regulating insulin. Therefore diets high in fiber can help you to lose weight, lower blood pressure, lower cholesterol and control blood sugar. It is important to remember to start gradually when adding high fiber foods to your diet and drink at least 6-8 glasses of water per day. The recommendation is to include 25-39 grams of total fiber in your diet daily with 6-11 grams soluble fiber per day and 15-28 grams insoluble fiber per day. A food is considered a good source of fiber if it contains at least 5 grams of fiber per serving. An example of how to incorporate adequate fiber throughout the day would be:

High fiber breakfast cereal	=	5 grams
3 servings fresh fruit	=	9 grams
3-4 servings vegetables/salad	=	6 grams
2 slices whole wheat bread	=	6 grams
1 cup beans, corn, peas, lentils	=	10 grams
Total	=	36 grams

**Conclusion:** Many people, especially women, when thinking about how to make their diets healthier, lower in calories or fat, often think about what foods they need to exclude. We suffer from “overconsumption malnutrition” - too much of the wrong foods. A better and less restrictive approach would be to shift the focus to what foods need to be included to optimize health. If we work to include a minimum of 2 servings of fruit, 3 servings of vegetables, 2 servings of low fat dairy products daily, and replace several typical dinners with fish 2 times a week and try a meatless meal made with soy – there is much less room for empty calorie foods. It will improve the overall

Nutritional Value of Common Soy foods\*

Soy food Item	Amount	Isoflavones (mg)	Calories	Protein (g)	Fat (g)	Fiber (g)
Soy nuts	¼ c	60	193	17	10	3
Tempeh	½ c	40	165	16	6	6
Soybeans, cooked	½ c	38	150	14	7	5
Soy Flour	1/3 c	38	130	11	6	5
Soy Butter	2 Tbsp.	38	170	6	11	1
Soy Milk	1 cup	33-40	80-130	6-7	4	0-3
Textured Soy Protein, dry	¼ c	35	80	12	0	4
Tofu, raw, firm	3 oz.	32	90	10	6	1
Green Soybeans	2/3 c	30	73	7	2	4
Mori-Nu Silken Tofu, firm	3 oz.	26	50	6	2.5	0
Mori-Nu Silken Tofu, Lite, firm	3 oz	18	31	5	1	0

\*Values in this table may vary slightly due to differences between brands

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quality of your diet and you will see the results of the health benefits as an easier way to maintain or achieve a healthy body weight, a reduction in cholesterol and blood pressure, and increased bone density.



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(This article was reviewed by the Clinical Nutrition Manager's Advisory Council.)

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**Prevention Champions - Making a Difference in the Year 2003**

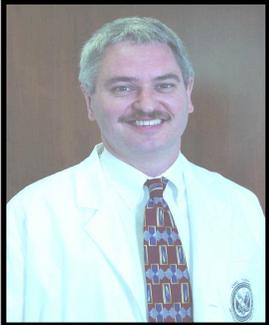
The National Center for Health Promotion and Disease Prevention is pleased to announce that a total of 38 names were submitted for the 1st, 2nd and 3rd quarter National Prevention Champion Awards (see list below). This award was originally to be presented to one VA employee per quarter in recognition of meritorious and distinguished accomplishments in the field of Prevention and Health Promotion in the Veterans Health Administration. However, upon review of the nominations, it was clear there were numerous outstanding field contributions which resulted in the recognition of two (2) winners per quarter, whose names and pictures are on the next two pages.

The Prevention Champion Award is designed to recognize:

- \* Someone who has made significant contributions in the field of health promotion and disease prevention (clinical, education, research)
- \* Someone who has done an excellent job in a function or on a project related to prevention/health promotion
- \* Someone who has taken initiative, shown innovativeness, persistence, impact and/or made a difference in prevention/health promotion to veterans served
- \* Someone worthy of such an award, maybe a leader, a helper, a shaker and a mover who makes the impossible happen

VISN	Name	Facility	VISN	Name	Facility
1	Michael Mayo-Smith Sue Kancir	Manchester, NH West Haven, CT	12	Jeanette Diels Marian Frosch Douglas Lanska Tarynne Bolden Theresa Berg James Otto Patsy Green	Madison, WI Madison, WI Tomah, WI Detroit, MI Saginaw, MI Chicago (LS), IL Danville, IL
2	Geoffrey McCarthy John Sanderson Wayne Beach	Albany, NY Buffalo, NY Syracuse, NY	15	Suzanne Opperman	Columbia, MO
4	Valerie Boytin Karen Harrison	Wilkes-Barre, PA Pittsburgh, PA	16	Vicky Ramsey Jennifer Purdy Johnny Henley Mona Benson	Little Rock, AR Little Rock, AR Fayetteville, AR Fayetteville, AR
6	K.V. Tummala Nancy Smith Nahid Nikfar Mary K. Voss Tracy Yoda	Beckley, WV Beckley, WV Beckley, WV Hampton, VA Hampton, VA	17	Esmeralda Martinez Maria Santos Diana Ramos Teresa Cannon	San Antonio, TX San Antonio, TX San Antonio, TX Temple, TX
8	Mark Daniels Leslie Clark	Bay Pines, FL Tampa, FL	18	Robert White Michael Geboy	Albuquerque, NM Prescott, AZ
10	Kim Eskridge Elizabeth Noelker Bettye Morgan Christina Gomer	Cleveland, OH Cleveland, OH Cincinnati, OH Dayton, OH	20	Barbara Hetrick Linda Vollrath	Walla Walla, WA White City, OR

## Prevention Champions Making a Difference in the Year 2003 *Clinical - "Hands On"*



### 1st Quarter

**Douglas J. Lanska, MD (Tomah, Wisconsin - VISN 12)** Was nominated by his supervisor for serving as an "outstanding prevention champion at the facility, throughout VISN 12, and nationally." He has been an invited speaker at national meetings with various topics, including primary prevention. He publishes regularly on a number of prevention related topics. He recruits colleagues to contribute articles. He seeks out best practices to adopt at his facility and develops model processes to improve practice. He has established processes to improve coordination and accountability for preventive care and has included a wide range of staff in these efforts. The result: "his efforts have dramatically improved both the provision of preventive care to veterans and the efficiency of clinic, hospital and nursing home care unit operations at the facility."



### 2nd Quarter

**Bettye W. Morgan, RN (Cincinnati, Ohio - VISN 10)** Was nominated by her supervisor for carving "a very strong structure for the beginning of a wellness program for the organization." She linked her efforts to Personal Mastery in the HPDM Model to develop a high performing work force. To achieve this goal, she conducted employee surveys, initiated a walking program, established fitness teams, started support groups, and hosted Lunch and Learn sessions and other educational events to teach staff about healthier behaviors. She submitted a proposal for an onsite fitness facility at two divisions in the medical center. Construction of a fitness room is in process. She strives to assist employees to achieve personal mastery and therefore increase work productivity for the workforce of 1200 employees at her facility.



### 3rd Quarter

**Robert E. White, MD (Albuquerque, NM - VISN 18)** Was nominated by a group of colleagues for his "unfailing dedication to improving the care of our veteran population." He worked with providers to update problem lists and to trigger Clinical Reminders. He stresses Clinical Reminders as useful tools for documentation and has helped redesign several. Off work time, he developed processes to ensure completion of important clinical reminder information regarding flu and pneumovax. He has created databases for patients by provider panels to identify patients needing colorectal cancer screening. He ensures patients receive screening cards and educational materials. For patients with Hep C, he created a letter which can serve as a lab order slip without a provider visit if the patient needs further testing.

## Prevention Champions Making a Difference in the Year 2003 Administrative – “Behind the Scenes”



### 1<sup>st</sup> Quarter

**John Sanderson, MD (Buffalo, New York - VISN 2)** Was nominated for being a “Change Agent who is passionate in his leadership of primary care practices that ensure the finest disease preventive medicine.” He has led his system in development of a primary care team best practice model which has a mechanism to evaluate patterns of performance, quality and efficiency. Teams are compared for access, preventive medicine reliability, cost and veteran satisfaction. The comparisons have helped elevate and standardize the VISN’s primary care achievements and led to high ratings by NCQA, compliance with Performance Measures, and patient satisfaction surveys. And “this VISN has no Primary Care waiting lists, never did.” He has the VISN to achieve prevention guideline adherence, veteran access and satisfaction, and cost-effectiveness.



### 2nd Quarter

**Mary Voss, MD (Hampton, Virginia - VISN 6)** Was nominated by her supervisor for her “vigorous refusal to accept status quo and to JUST DO IT.” She advocates three key premises: grade all physicians’ electronic progress notes to assess thorough preventive care; answer the phone quickly and politely and assess which patients need to speak to a provider; use nurses in an expanded clinical support role to impact patient flow and scheduling, communicate normal findings to patients, thus ensuring more efficient use of provider time. She has another plan to help improve compliance with Clinical reminders and impact positively on patient satisfaction with their health care team. She makes every team member feel valued and that they are part of the “best team.”



### 3rd Quarter

**Mona Benson, RN (Fayetteville, Arkansas - VISN 16; also the Preventive Medicine Program Coordinator at the medical center)** was nominated by a colleague for her dedication “to a high standard of excellence that has been evident throughout the years.” In the past year she increased her leadership role by coordinating a telecare program and providing education and oversight of performance measures for Primary Care. She has implemented a number of different strategies to improve performance: created wallet size VS cards for veterans; initiated a nurse managed Flu Vaccine clinic; suggested nurse-generated consults in the Women’s program to improve compliance with PAP smears and mammograms; helped develop a clinical reminder to improve foot care in diabetics; and monitors charts to ensure compliance with EPRP standards and good patient care.

**National Public Health Week**  
**April 6-12, 2003**

Did you know that April 6-12, 2003 was National Public Health Week?

To highlight the week, NCHPDP worked with several CO offices, spearheaded by Dr. Fran Murphy, Deputy USH for Health Policy Coordination, EES, Public Affairs, and others in VACO. At Central Office, a special kickoff event was held on April 7, 2003 with a presentation by Virginia Inglese, MA, RD, LCSW on "Power Up and Be Healthy", which was taped and shared with the field. Other topics presented during the week included: Stress Management, Smoking and Tobacco Use Cessation, Seat Belt Use, and Getting in Shape for the Future: Healthy Eating.

NCHPDP contributed in several major ways to this national initiative:

- Created and promoted "Great Veterans Weigh-In", a campaign to have veterans weigh in at their local facility and determine their BMI (Body Mass Index)
- Created and sent to all facilities a 24-page weight management resource booklet with ideas about how facilities could involve veterans and staff in health promotion activities (can be accessed via [health4vets.com](http://health4vets.com) or [vaprevention.com](http://vaprevention.com))
- Taped a Public Health segment for VATV that aired during Public Health Week
- Authored daily prevention messages regarding weight and physical activity which were communicated via *Hey VA* and on paystubs
- Encouraged facilities to plan activities for Public Health Week
- Provided a summary report of activities for Dr. Robert Roswell.

Examples of health related activities held at different facilities which participated during Public Health Week include:

- At Northampton, MA VAMC (VISN 1), the local Patient & Family Health Education Committee (employees and patients) hosted a booth in their Canteen on April 8. A steady stream of veterans and their families visited the display and were offered handouts with practical information about weight loss, education about BMI and various healthy lifestyle books. Also provided were directions about how to get a referral for local exercise programs and appointments with a dietitian for individual assistance with weight issues. POC: Anne Murray
- Clinical dietitians at Asheville, NC VAMC (VISN 6) organized a booth, weighed and measured veterans and relatives, determined their BMIs, discussed risks of being overweight, and gave handouts from the resource booklet developed by NCHPDP each morning of Public Health Week. POC: Doris Walker
- Nashville, TN VAMC (VISN 9) used Medical Media to develop "Great Veterans Weigh-In" bulletin boards and handouts taken from the NCHPDP resource booklet. POC: Mary Hofwolt
- Tomah, WI VAMC (VISN 12) developed the "Weight-to-Go" clinic for outpatients. The program provides monthly education and group support focusing on healthy eating, appropriate physical activity, and lifestyle modification, while promoting veterans' active participation in their health care and health care decisions. More than 160 veterans have participated in the program. POC: Deborah Thiel
- On April 8<sup>th</sup>, Columbia, MO VAMC (VISN 15) implemented a new multidisciplinary group clinic specifically designed for weight loss and fitness, called "Shape Up, Shape Down". POC: Rebecca Rahmoeller, Nurse Manager

These are just a few of the many activities provided throughout the nation to support National Public Health Week and to emphasize "Great Veterans Weigh In". **NCHPDP STAFF**



**National Women's Health Week  
May 11-17, 2003**

The National Center for Health Promotion and Disease Prevention and the Center for Women Veterans participated with the Office of Women's Health in the U.S. Department of Health and Human Services to celebrate National Women's Health Week at events across the country May 11-17, 2003. The first event was the Women's Annual Check-up Day held on May 12, 2003.

**SOME FACTS:** National Women's Health Week is a national effort by an alliance of organizations to raise awareness about manageable steps women can take to improve their health. The focus is on the importance of incorporating simple preventive and positive health behaviors into everyday life.

**WHERE:** Across America - in communities, neighborhoods, towns, cities, counties, the Internet, job sites, places of worship, recreation centers, VA Medical Centers, Community-Based Outpatient Clinics (CBOCs), Vet Centers, and wherever people choose to celebrate the role of good health practices in the lives of women.

**ADDITIONAL INFORMATION:** [www.4women.gov/whw](http://www.4women.gov/whw)

We have highlighted just a few of the reported activities from across the nation:

**Facility:** Cheyenne VA Medical/Regional Office Center - VISN 19

**Contact Person:** Margo Burrows – Cheyenne, WY, (307) 778-7550 x7051

**Special Events:** Dinner/Lecture: A free dinner/evening lecture on bladder dysfunction for the female veterans. All women from our CBOCs and local medical center were invited and, in some cases, transported by bus. The first female Urologist in WY was our guest speaker and provided the lecture at no cost. The American Legion provided the space, and the Texas Road House catered the dinner at a reduced charge.

**Facility:** VA Salt Lake City Health Care System – VISN 19

**Contact Person:** Kathi Kuntz – Salt Lake City, UT, (801) 582-1565 x1869

**Special Events:** Brown bag lunchtime discussions; topics included: Self defense for Women; Discussion on Integrative Health; Time Management Skills; 10 Quick, Easy, Healthy and Cheap Snacks for Better Nutrition; News on Hormone Replacement Therapy

**Facility:** Rochester Outpatient Clinic – VISN 2

**Contact Person:** Geraldine Wiess – Rochester, NY, (585) 242-0160 x2344

**Special Events:** Prevention screenings/exams. The following topics were discussed: Physical therapy exercise demonstration for osteoporosis and cardiac health; Education on Breast Self Examination; Laboratory cholesterol screening; Dietitian presentation on Healthy Eating; and Physical Therapy exercise demonstration for osteoporosis and cardiac health.

**Facility:** Philadelphia VAMC – VISN 4

**Contact Person:** Maria Villot – Philadelphia, PA, (215) 823-2016

**Special Events:** Brown bag inservices. The following topics were discussed: Osteoporosis; GYN vaginal cancer; arthritis and rheumatologic diseases; Hormone replacement therapy; Breast cancer. Also a group of female veterans traveled to Arlington VA to visit the Women's memorial on 5/9/03.

**Facility:** Asheville VAMC – VISN 6

**Contact Person:** Peggy Patterson – Asheville, NC, (828) 299-2525

**Special Events:** Health Fair. A comprehensive health fair for women veterans was held to celebrate National Women's Health Week. Booths included information on: History of Women's Health, Stop smoking; Safety and preparedness; Hearing; Women's Health Issues; Educational Resources; and Information on Women's Clinics.

NCHPDP will be compiling a report to be submitted to Mr. Principi's office detailing all field activities. NCHPDP, Primary Care, Women's Health, Dr. Robert Roswell and Mr. Principi express much gratitude to the medical centers and community based outpatient clinics who participated in this great event.

*(Pictures and write-ups included here were the first to arrive in the office. By the time the newsletter went to the printer, many more pictures and testimonials had arrived. Look for more pictures in this newsletter and see more about this event in the next edition.)*



**NCHPDP Staff**

**Honolulu,  
Hawaii**



**Shreveport,  
Louisiana**



**NCHPDP, EES and the DOD announce:  
Building the VA Prevention Workforce -  
*Preventive Medicine Training Conference***

**For:** primary care physicians, nurse practitioners, nurses, dietitians, psychologists, physician assistants and social workers, who are Preventive Medicine Program Coordinators and VISN Preventive Medicine Leaders, and others who are interested in prevention.

**Topics:** program development and implementation, evidence-based recommendations, behavioral change counseling techniques, delivery models for preventive services, and other practical information on health promotion and education.

**Albuquerque, New Mexico**

**August 11-14, 2003**

Registration at URL: <http://chppm-www.apgea.army.mil/FHP>

**You can now access the NCHPDP web site via:  
Health4 vets.com or vaprevention.com**

VA National Center for Health Promotion  
and Disease Prevention  
3000 Croasdaile Drive  
Durham, NC 27705

Putting Prevention Into Practice in the VA