

Prevention Notes

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From the Director's Desk

Two recent events have stimulated discussion in Preventive Medicine circles this past month. The first was the report of the *National Institutes of Health*

(NIH) *Consensus Development Statement about Breast Cancer Screening for Women age 40-49* published on January 24, 1997. Consensus reports are prepared by a non-advocate, non-Federal panel of experts based on presentations by investigators working in areas relevant to the consensus question. Newly available data from both observational studies and randomized trials were evaluated in light of existing evidence. The panel concluded that there was no difference in breast cancer death within 7 years between women assigned to receive, or not receive, screening. Mathematical models of available data confirm these conclusions. However, trends were noted suggesting that women in their late forties might benefit from screening. Problems of false negative mammograms in younger women (up to 25%) as compared to older women (10%) along with false positive mammograms being relatively more common in younger women raise questions about the value of this screening modality in the younger age group. Ductal carcinoma in situ, frequently diagnosed in mammographically screened women ages 40-49, may never progress to invasive cancer thus creating a risk of over-treatment. Additional radiation exposure due to examinations of women from ages 40 to 50 can cause breast cancer. After weighing the benefits against the risks, the panel offered the following conclusion: "At the present time, the available data do not warrant a single recommendation for mammography for all women in their forties. Each woman should decide for herself

whether to undergo mammography." The panel recommended counseling regarding benefits and risks to help with the decision, and stated the costs of the mammograms should be reimbursed by third-party payers or covered by health maintenance organizations.

The Consensus Statement was greeted with displeasure by Congress where the Senate passed a non-binding resolution on February 4, 1997, calling for the National Cancer Institute (NCI) to reconsider its stance on mammograms for this age group. Dr. Richard Klausner, NCI Director, will convene an advisory panel this spring to offer greater clarity on this subject. The American Cancer Society will also convene an expert panel to review their guidelines for breast cancer screening for women of all ages. Thus, we are likely to see continuing pressure to impose clarity where current scientific evidence suggests there is ambiguity. It seems certain that there will be revisions to guidelines promulgated by various organizations within the near future. To date, the VHA Preventive Medicine Guideline for Mammography published in Handbook 1101.8 continues to offer a recommendation of mammography every two years for women ages 50-69. Mammograms are offered to women of any age whenever a VHA clinician feels sufficient indication exists and the patient concurs in that assessment.

The second Preventive Medicine event was the journal *Gastroenterology* publication (February issue) describing the deliberations of an interdisciplinary panel of experts that reviewed colorectal cancer screening procedures. Individuals of average risk were advised to choose from five screening methods which include: 1) annual fecal occult blood testing (FOBT), 2) screening sigmoidoscopy every five years, 3) both sigmoidoscopy and FOBT, 4) double contrast barium enema every five to ten years, and 5) colonoscopy every 10 years. The article includes an excellent review of the available literature and details

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of examination Procedures. Little controversy is expected in regard to these recommendations that serve to clarify existing practices in the medical community. The recommendations are also in agreement with those published in the *VHA Preventive Medicine Program Handbook 1101.8*.

Scientific evidence often emerges in a patchwork fashion creating uncertainty in the minds of public and professional interest groups regarding the optimum path to pursue. With the passage of time, continuing research yields

further clarity and medical practice patterns eventually conform to a new standard. The events of the past month offer further assurance that this process continues.



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Editor's Note

In the last edition of the newsletter in the article on smoking cessation, a statement indicating that Bupropion had been approved by the FDA as an aid for smoking cessation is incorrect ...”on December 12, 1996 the FDA approved

Bupropion as an aid for smoking cessation” (*Prevention Notes*, Vol.2 no.2, p. 8). An FDA drug abuse advisory panel study section recommended that the FDA approve Bupropion as a first-line drug for treatment of nicotine dependence. The FDA is expected to make their final decision for approval soon. We apologize for the error.

We hope that you noticed Secretary Brown's Daily Message on February 10. It addressed the issue of health promotion and disease prevention, the role of the NCHP and a brief description of the Veterans Health Survey. The Secretary's message reiterated the fact that the veterans health-care system is committed to leadership and excellence in preventive health care, and that the Veterans Health Survey will guide the VA in fulfilling this commitment.

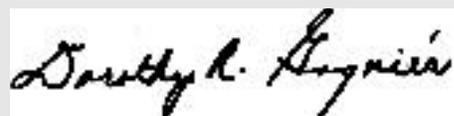
By now the medical center director and librarian at your facility should have received a copy of our latest publication entitled *Preventive Medicine Program Information Bulletin IB 11-89*. The document was created as a resource primarily for Preventive Medicine Program Coordinators (PMPCs) at VHA facilities. Included in the Bulletin are copies of two important documents, *The VA Health Promotion and Disease Prevention Handbook* and the related *Health Promotion and Disease Prevention Program Guide*.

The former document describes expectations and reporting requirements; the latter lists functions and skills appropriate for facility PMPCs. An announcement will be made on Forum when your personal copies are distributed. The NCHP wishes to thank the National Center for Cost Containment in Milwaukee for their assistance in the production of the Bulletin.



One hundred and fifteen VHA staff were on-line for the March 4 PMPC conference call. The topics presented were informative as was the discussion which ensued. Please join us on **October 7, 1997** for the next call which will be held from **1:00 - 1:50 PM EDT**. The phone number is **1-800-767-1750**. Inform the VANTS operator that you are joining the PMPC conference.

The NCHP is very interested in having this newsletter meet your program needs. Your input is very important to us. You can assist us by submitting articles that are helpful to the field. Articles for future issues can be provided at any time and should deal with topics related to preventive medicine.



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Prevention Research News



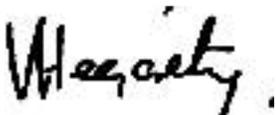
The NCHP Congressional mandate includes a requirement for dissemination of information on research in preventive medicine to VHA personnel.

Accordingly, the NCHP research group maintains surveillance of the current national and international literature.

We have also identified

Internet sites which deal with preventive medicine issues and which publish consensus statements/guidelines and current requests for funding for research projects.

Having considered how best to disseminate this information in a timely fashion to those with an interest in receiving it, we plan to publish a summary entitled *Prevention Research News*. This publication will be mailed exclusively to those requesting it and will also appear on FORUM. A subscription invitation has been sent on FORUM to the PMPC user group. Announcements will also appear in this newsletter inviting interested people to sign up. Recipients will be asked annually if they wish to remain on the mailing list. The goal of this publication is to inform VHA personnel working in prevention about "what's new" in research. This is a new endeavor on our part and we therefore welcome feedback so that we can ensure that *Prevention Research News* is useful to VHA staff. We can be contacted by phone: FTS (700) 671-5880, ext. 229 for Verona Hegarty, ext. 235 for Jane Kolimaga, by FAX: (700) 671-5879 FTS or on FORUM, Hegarty.Verona @forum.va.gov and Kolimaga.Jane @forum.va.gov.



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Committee Recommends VA Research Agenda

The Research Realignment Advisory Committee (VARRAC) was appointed by VA Secretary Jesse Brown in October 1995 to review the scope and structure of research programs within the VHA and to make recommendations regarding possible realignments in the program to VHA Under Secretary Kenneth W. Kizer, M.D., M.P.H.

In its Final Report, dated October 1996, VARRAC enumerates 12 major findings from which 10 recommendations were developed. VARRAC's first recommendation is an endorsement of the concept of Designated Research Areas (DRA) as an organizing principle for VA research. VARRAC recommends that initially there be 13 DRAs spanning the entire research and development program including basic, clinical and epidemiological research, cooperative studies, health services research, rehabilitation research, and career development.

Prevention is one of the 4 candidate DRAs categorized as a "challenge in health care delivery to veteran patients." This category also includes DRAs focused on organization and financing of health care, special population groups, and service-related chronic disease and exposures. Among the candidate DRAs categorized by "burden of disease in the veteran population" are several of the NCHP's focal areas: hyperlipidemia, hypertension, and breast cancer. Other proposed DRAs in this category include other risk factors for atherosclerosis and its sequelae, namely, coronary artery disease, peripheral vascular disease, and stroke; gastrointestinal, prostate, respiratory and skin cancer; aging; CNS injuries and associated diseases; degenerative diseases of bones and joints; dementias; diabetes mellitus and its complications; major psychoses; and substance abuse. A third category is identified as a "part of the VA's mission to provide support to the Department of Defense" and consists of one candidate DRA on combat casualties.

VARRAC proposes that the candidate DRAs be reviewed by the Research and Development Advisory Council which would make a final recommendation to the Under Secretary and Chief Research and Development Officer. VARRAC also recommends that the Council periodically review and update the list of DRAs.

A complete copy of the VARRAC report can be obtained through VAMC research offices.

Health Survey Findings ●



Did you ever wonder if our VAMCs were better at providing health promotion and disease prevention services than our non-VA counterparts? We did, and decided to look at the beta test results from the *1996 Veterans Health Survey* to clarify the issue. First of all, over half of the responding veterans reported that they received almost

all (90% or more) of their care from the VA. However, about one in ten reported that they received very little (less than 10%) of their care from the VA. So we compared those who reported getting 90% of their care from the VA with those who reported getting 90% of their care outside the VA. The findings are interesting.

As most of us have known, the veterans receiving care in the VA are significantly more likely to be current smokers than those receiving care elsewhere (28% versus 20%), and are significantly less likely to report almost always using a seatbelt (84% versus 94%). Hopefully, over time, these figures will improve particularly since the 1997 special health initiative is on tobacco cessation.

Of the 13 core health promotion and disease prevention services, there were six statistically significant differences between the veterans receiving 90% of their care within the VA compared to those receiving 90% of their care outside. One of these differences was in primary prevention and favors the non-VA system: 71% of veterans get-

ting care from the outside reported getting their tetanus booster within the last decade compared to 58% of those getting care within the VA. The other five significant differences (one in secondary prevention and four in assessment and counseling) each favors our VAMCs. The female veterans aged 50 through 69 getting at least 90% of their care from the VA were significantly more likely to have a mammogram in the past two years (94% versus 67%), while both male and female veterans of all ages were more likely to get alcohol counseling (15% versus 3%), more likely to get seatbelt counseling (6% versus 1%), more likely to get nutrition counseling (37% versus 19%), and more likely to get exercise counseling (50% versus 28%) than their counterparts getting 90% or more of their care outside the VA.

Given these findings, on average veterans receiving 90% or more of their care from the VA are receiving significantly more health promotion and disease prevention services than the veterans receiving 90% or more of their care from non-VA facilities. Keep up the good work.

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Associate Director
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Prevention



Joseph Appointed to PMFAG

Anne M. Joseph, MD, MPH, Staff Physician at the Minneapolis, MN VAMC and Associate Professor of Medicine, University of Minnesota has been appointed to the Preventive Medicine Field Advisory Group. Dr. Joseph graduated from the University of Michigan Medical School and completed her training in Internal Medicine at the University of Minnesota. She received an M.P.H. in

Anne M. Joseph

epidemiology from the University of Minnesota School of Public Health in 1985.

Her preventive medicine interests include colorectal cancer screening and smoking cessation strategies. She chaired the VA Smoke-Free Field Advisory Group from 1992 - 1995, and remains a member. She was also active in the develop-

Table 1

Health Promotion/Disease Prevention Service	Penetration Rates		P-value
	Veterans reporting 90%+ care in the VA (n=909)	Veterans reporting 90%+ care outside the VA (n=185)	
PRIMARY PREVENTION			
1 Received Blood Pressure Check within the last 2 years	96.0%	94.0%	0.225
2a Received Cholesterol Check in the past five years (Males aged 35-65)	81.0%	84.8%	0.503
2b Received Cholesterol Check in the past five years (Females aged 46-65)	85.6%	71.4%	0.317
3 Received Influenza Vaccine this year (Aged 65+)	75.2%	68.8%	0.286
4 Received Pneumococcal Vaccine at least once (Aged 65+)	49.5%	42.6%	0.315
5 Received Tetanus Booster at least once in the past decade	58.0%	70.6%	0.002
SECONDARY PREVENTION			
6 Females Receiving Pap Smear Test in the past 3 years (Under age 65)	93.4%	95.8%	0.519
7 Females Receiving Mammograms in the past 2 years (Aged 50-69)	93.7%	66.7%	0.020
8 Received Fecal Occult Blood Test this year (Aged 50+)	30.2%	36.3%	0.239
ASSESSMENT AND COUNSELING			
9a Current Smokers	27.9%	20.5%	0.038
9b Tobacco Users Offered Counseling	84.6%	81.6%	0.628
10 Received Alcohol Counseling this year	15.3%	3.2%	0.001
11 Received Nutrition Counseling this year	37.3%	18.9%	0.001
12 Received Exercise Counseling this year	50.1%	28.6%	0.001
13a Almost Always Using Seatbelts	83.7%	93.5%	0.001
13b Received Seatbelt Counseling this year	6.0%	0.5%	0.002

ment and implementation of the national Department of Veterans Affairs smoke-free policy. Her research has included work on the feasibility of smoke-free institutional policies and their effect on special populations, such as substance dependence disorder and psychiatric patients. Recent interests include conduct of randomized trials of interventions for smoking cessation in medically ill popula-

tions. She is the principal investigator in the TRANSCAP (Transdermal Nicotine Replacement Therapy in Cardiac Patients) study, a randomized double blind, placebo-controlled trial of transdermal nicotine for smoking cessation in high risk cardiac patients that was conducted in 10 VA medical centers.

New PMFAG Chair

Lois Anne Katz, M.D., is the new Chair of the Preventive Medicine Field

Advisory Group, (PMFAG). She assumed responsibilities on January 1, 1997. Dr. Katz is Professor of Clinical Medicine at the New York University School of Medicine and Associate Chief for Ambulatory Care and Associate Chief of Nephrology at the New York Veterans Affairs Medical Center. She graduated from Wellesley College in 1962 and the NYU School of Medicine in 1966. She completed an internship and one year residency in Medicine on the NYU Divisions at Bellevue Hospital and was Chief Resident in Medicine at the New York Veterans Affairs Medical Center (VAMC) where she also completed a Fellowship in Nephrology. Dr. Katz is a board certified internist and nephrologist and Fellow of the American College of Physicians.



Dr. Katz is employed at the New York VAMC in clinical practice in nephrology, hypertension, and general internal medicine. She has supervised the Home Dialysis Training Program there since its inception in 1971. Other administrative responsibilities in ambulatory care include all of the outpatient clinics, the Hospital Based Home Care Program, Employee Health and the Visually Impaired Services Team. Her clinical research interests focus on drug treatment of hypertension and participation in several VACooperative Studies as well as investigations into clinical nephrology and dialysis and health services research.

In addition to her clinical duties, Dr. Katz is an attending physician in Medicine and in Nephrology at Bellevue and the New York VAMC. She teaches NYU medical students, serves as the NYU Women's Liaison Officer (WLO) to the Association of American Medical Colleges and chairs the Committee for Women in Medicine at the NYU medical school. She is a member of the NYU Joint Task Force on Women's Issues, a member of the Admissions Committee, and co-director of one of the Faculty Advisory Colleges. She is also the WLO for the New York VAMC. Her outside activities involve being a board member of the Women's Medical Association of New York City and serving as Alumna Admissions Representative for Wellesley-in-Westchester.

Help Wanted!

Your assistance is requested for a project being conducted at the Loma Linda VAMC Preventive Medicine Section by Dr. Linda Ferry, PMFAG member. A smoking cessation resource guide is planned to document successful strategies carried out at VHA facilities during FY 1997 under the Special Health Initiative on Smoking Cessation. The publication will include background information and resources for all Preventive Medicine Program Coordinators and Patient Health Education Contact persons at VAMCs who would like to improve delivery of smoking cessation services to veterans. Target date for the completion of the guide is late summer.

The edition will also include cutting edge information regarding nicotine treatment. If you have collected data on nicotine dependent veterans, ongoing smoking cessation research projects, or creative solutions that improved smoking cessation services, call the Loma Linda VA to provide a description of the program. The best "how to" information will be incorporated into the program guide.

Contact **Ms. Rani Williams, 909/825-7084, Ext. 2996; FAX 909/422-3106; DHCP or Forum address is: Williams,Rani@Loma-Linda VAMC.VA.gov.** Program descriptions can also be mailed to: **Jerry L. Pettis Memorial VAMC (11C/605), 11201 Benton St., Loma Linda, CA 92357.**

A proposed outline of the guide follows.

VHA Program Guide for Nicotine Dependence Treatment

1. Epidemiology of tobacco-related diseases in US veterans
2. Smoking characteristics of veterans
 - a. Gender differences
 - b. Psychiatric co-morbidity
 - c. Chemical dependency
 - d. Post -Traumatic Stress Disorder
3. Cost effectiveness of smoking cessation programs in VHA
4. AHCPR Guidelines in the VHA system
5. Special FY 1997 Smoking Cessation Initiative results
6. Research in VHA facilities regarding smoking cessation
7. Model program descriptions (overcoming local barriers to implementation)
8. Behavioral and pharmacological interventions
9. VHA year 2000 goal for nicotine dependence (*VHA Handbook 1101.8*)
10. Patient and Provider education resources

In the summer issue of Prevention Notes look for "Tips for Improving Your Smoking Cessation Program" from recently published research studies and abstracts accomplished at VAMCs.

Preventive Medicine Field Advisory Group Mission and Goals

Last August 1996 the Preventive Medicine Field Advisory Group (PMFAG) developed a mission and goals statement which has been approved by the Chief Consultant, Primary/Ambulatory Office (112).

Mission

The mission of the PMFAG is to improve the health of veterans receiving care at VHA facilities by providing evidence-based guidelines for health promotion and preventive medical care. This is accomplished by bringing together experienced clinicians working in VHA facilities, program leadership at headquarters and staff of the VA National Center for Health Promotion and Disease Prevention to discuss strategies. The PMFAG also provides advice and counsel regarding guideline implementation and monitors the success of preventive medicine initiatives.

Goals

1. *Recommend evidence-based guidelines for preventive medical services suitable for application in VHA facilities.* The guidelines should include risk reduction recommendations for healthy veterans as well as those with known disease. The PMFAG will periodically review the guidelines in light of medical advances.

2. *Promote the establishment of simple and efficient methods to assess compliance with guideline recommendations.* Pursue documentation of health promotion and disease prevention services provided in VHA facilities through PCE software and encourages development of appropriate encounter-form technology to accomplish this goal. By means of a mail survey seek documentation of services received by veterans. Where alternative sources exist, such as the VA External Peer Review Program, seek to compare information to obtain the most accurate understanding possible regarding services being provided.

3. *Encourage the use of report formats soliciting data from field staff which can accurately reflect events of concern to the success of health promotion and disease prevention initiatives in VA facilities.* Provide review and advice regarding the annual facility report which is submitted by facility staff to the NCHP, the annual initiative report which is sponsored by the NCHP, and the ad-hoc report requests which are a regular part of the political process.

4. *Advise the Chief Consultant for Primary/Ambulatory Care regarding the annual Congressional report on Health Promotion and Disease Prevention activities conducted by VHA staff.*

5. *Advise the Chief Consultant regarding a standardized risk assessment method suitable for use by VHA staff in counseling veterans.*

6. *Promulgate innovative approaches to the provision of preventive medical services and education as a means to help VHA staff provide optimal services.*

7. *Promote interest in, and commitment to, VHA health promotion and preventive medical initiatives among veterans and VHA staff by actively marketing the program.* Among the methods to be used are meetings, telephone conferences, satellite television conferences, newsletters for veterans and staff, and electronic networks such as the World Wide Web.

8. *Educate patients and VHA staff about preventive medicine strategies.* Develop standardized education material and strategies.

9. *Encourage research regarding the delivery of effective health promotion and preventive medicine services.* Establish a research agenda focused upon health promotion and disease prevention strategies to be forwarded to the VA Health Services Research and Development Office. Encourage VHA leadership at the facility and network level to support research relating to this field.

New Smoking Cessation Resource

A stop smoking resource used at 35 VA medical centers has just been revised and updated. The QuitSmart Stop Smoking Kit (1997) includes a 96-page paperback, a relaxing hypnosis audio tape, and a patented realistic cigarette substitute. VAMCs receive a 40% discount from the publisher (call 1-888-73-SMART). The QuitSmart Kit was developed by Dr. Robert H. Shipley, who directs both the Durham VAMC Stop Smoking Program and the Duke University Medical Center Stop Smoking Clinic. An article by Dr. Shipley entitled "A Model Quit-Smoking Clinic", was published in the December 1996 supplement to the Federal Practitioner. Dr. Shipley can be reached at (919) 286-6934.



As an information resource, the NCHP is pleased to respond to questions from preventive medicine coordinators and others. Address your questions to any member of our staff and look for responses in the next edition.

Q: Will the guidelines for preventive medicine contained in the VHA Handbook 1108.1 be modified as new ones are published by other organizations?

A: Yes, they will. The guidelines contained in the VHA Handbook 1108.1 are evidence-based. As new evidence-based guidelines are published, the VHA will review them and determine whether or not a modification of current practices is required. Currently, the VHA is surveying recently published specifications on screening for colorectal cancer (*Gastroenterology*, 1997, 112: 594-642) and is closely monitoring the NIH debate on mammography screening for women 40 - 49 YOA (<http://odp.od.nih.gov/consensus>).

Q: What is the status of the veterans response to the Veterans Health Survey? Who should questions about the survey be addressed to?

A: At present after one mailing, the survey has a response rate of 46% which is right on target for such efforts. A second mailing will likely bring the response to over 60%. Veterans have been told to contact staff at the NCHP or the PMPC or PHEC at their local medical facility if they have questions about the survey.

Q: What are the special health initiatives established by the PMFAG for 1998 and 1999.

A: Reduction of alcohol abuse and problem drinking is scheduled for 1998 which was also the health initiative in 1992. Weight/nutrition and activity/fitness are scheduled initiatives for 1999. The current special initiative is smoking cessation and the reporting date is September 30 of this year.

Q: What is the median U.S. smoking rate for people over age 17?

A: The median U.S. smoking rate for people over age 17 is 22.4%. Utah has the lowest rate (13.2%) among the states reporting rates for 1995 and Kentucky the highest (27.8%). Among all the states, Utah alone has achieved the year 2000 goal of an adult smoking rate of 15% or less.

Q: How effective are nicotine patches with highly addictive smokers?

A: A person who smokes on the first day of using a nicotine patch is 10 times more likely to resume smoking. A study at the Durham VAMC and Duke University shows many smokers may need to include counseling and other therapies as part of their cessation attempt. See: Westman EC, Behn FM, Simel DL, Rose JE. Smoking behavior on the first day of a quit attempt predicts long-term abstinence. *Arch Intern Med* 1997;157:335-40.

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Address Correction Requested

Putting Prevention Into Practice in the VA