

# Prevention Notes

## From the Director's Desk

### The Role of Guidelines

**K**nowing what constitutes appropriate care is a major challenge for clinicians because the information on which decisions are made is constantly changing. David Sackett and his associates have established a paradigm that clarifies our obligations.<sup>1</sup> Whereas traditional medical practice has been based on emulating experts, decisions now are based on a rigorous analysis of available evidence. Although new evidence is published daily, clinicians often fail to receive it. Thus, the gap between what is known and what we do widens with time. Research has proven that traditional Continuing Medical Education programs often do not improve clinical performance. By contrast, clinicians that rely upon evidence-based medical summaries are found to deliver superior care. In many cases, the best summaries are found in protocols and guidelines generated by persons with the time and talent to analyze the complex and voluminous medical literature.

Although guidelines have been used by VHA clinicians since the 1980's, few of the early efforts were done on a national level. Beginning in 1995 with the pioneering VAREhabilitation Service Guidelines for Managing Stroke and Amputation, many have worked to adapt this approach to improve quality in patient care. The ensuing proliferation of guidelines created a new set of challenges, including the need to coordinate the work of many individuals and groups (at times with competing values or perspectives) so the bedside provider was not confronted with differing guidelines for the same condition.

VHA addressed this problem in 1998 by forming an Advisory Council for the Adoption, Development and Implementation of Clinical Practice Guidelines. Because many published resources do not meet the criteria proposed by Sackett, the Council set to work developing standards for Clinical Practice Guidelines suitable for use by VHA clinicians. As the name implies, adopting material from reliable sources is acceptable provided satisfactory research has gone into the effort, and adaptation is done to align the guideline with VAREalities. Reliable resources utilized for guideline templates include publications by the Agency for Health Care Policy and Research, (AHCPR), the Centers for Disease Control and Prevention (CDC), the Institute of Medicine (IOM), the National Academy of Sciences, the United States Preventive Services Task Force (USPSTF) and others. The Council embarked on a process to support and improve resources expressly designed "for the VA, and by the VA." The sophistication and complexity of the VHA's efforts in this regard are remarkable.

Once evidence-based guidelines are adopted by the Council, and mandated for use throughout the system, VHA clinician compliance with recommended procedures can be measured by the Office of Performance and Quality. The presence of a measurement process raises clinician interest and increases guideline utilization. Long experience has shown "What gets measured, gets done!"

Thanks to guideline publication and the associated audit, there are now several examples where variability in VHA clinical care is reduced and quality improved.

The National Center for Health Promotion (NCHP) has long been active in this movement through endorsement of guidelines for health promotion and disease prevention. Evidence-based screening tests, counseling, immunization and chemoprophylactic regimens are described in the new *VHA Health Promotion and Disease Prevention Handbook 1120.2*. The NCHP champions guidelines that target asymptomatic individuals of all risk categories who are cared for in the primary care setting. The pioneering work of the USPSTF is the foundation for the majority of NCHP recommendations. The *Handbook* was endorsed by the Guideline's Council as part of the VA headquarters concurrence process prior to release.

To assure compliance with recommendations for optimal practice, VHA clinicians need to know which activities come under guideline surveillance. To answer that question, in collaboration with the Council, the NCHP now includes a table in the *Handbook 1120.2* indicating strategies that are monitored by the Office of Performance and Quality. Citations direct the reader to the appropriate sources where evidence for each recommendation is presented. As envisioned by Sackett, VHA Guidelines summarized in the *Handbook* provide excellent reviews of the latest information while the monitor process permits clinician feedback on performance.

Although evidence-based guideline recommendations are an invaluable resource for clinical practice, clinicians must use them to support excellent patient care and not rely on them to dictate a solution to all problems. Situations always arise that require deviation from established protocols. Explaining why a path other than standard procedure is pursued will satisfy clinical audits. The goal is to deliver the right care at the appropriate time in a cost-effective manner. Top quality clinical guidelines, such as those adopted by the VHA Guidelines Council and published in the *VHA Health Promotion and Disease Prevention Program Handbook 1120.2* can help reach that goal.

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## Editor's Notes

### PMPC Conference Call March 2, 1999 Summary

114 (73%) PMPCs (Preventive Medicine Program Coordinators) and health care staff were on line for the first FY1999 semi-annual conference call. For those unable to call in, the following synopsis is offered. Contact the NCHP if you have questions or concerns.

### Network Liaisons in Prevention

Dr. Lois Katz, Chair of the Preventive Medicine Field Advisory Group, moderator for the call, described a Network 3 liaison program in preventive medicine. (see related article p. 6)

### NCHP Handbook Update

The revised *Handbook* emphasizes evidence-based recommendations from the United States Preventive Services Task Force (USPSTF). The Handbook will be available in 6-8 weeks and carries the new number 1120.2.

### Smoking Cessation Program for Employees

Dr. Anne Joseph, PMFAG member, reported on an employee smoking cessation program at the Minneapolis VAMC. The program evolved from their patient program. Groups are run on a periodic basis with strong support from hospital administration allowing employees time to attend sessions. Size of the groups range between 8 – 12 people and meet monthly or bi-monthly. The Minneapolis VAMC has supplied free of charge Nicorette gum and the patch for the past ten years. Since the smoking cessation directive extends to all federal employees for protection from exposure to environmental tobacco smoke and encourages them to quit, it seems that methodologies consistent with AHCPR Guidelines should include the authority to purchase Nicotine Replacement Therapy (NRT) for employees. A proposal is before the Secretary at this time to authorize payment in the VHA for this purpose. In the absence of this motion however, payment would have to be negotiated on a local basis from medical facility directors.

Facilities are encouraged to develop smoking cessation programs for their employees similar to the one in Minneapolis. Dr. Joseph will be happy to answer questions related to this program.

### Education Programs In Prevention

Rose Mary Pries, PMFAG member, discussed current education plans in prevention. A needs assessment is being conducted with network clinical managers to determine how best to meet their educational needs. This effort represents a continued collaboration between the Office of Primary/Ambulatory Care, the National Center for Health Promotion, and the Preventive Medicine Field Advisory Group. One of the ideas proposed is a national conference that will showcase "best practices" in preventive medicine in both the private and public sectors. As these ideas for educational programs unfold, periodic updates will be provided to the Patient Health Education Contact persons and the Preventive Medicine Program Coordinators through the St. Louis Education Center and our office. If a national program is planned, participant travel will once again be the responsibility of the individual VISNs or the medical facilities.

### Summary of Survey Conducted at the 1998 National Prevention Meeting

Dorothy Gagnier provided a synopsis of responses to a questionnaire distributed to attendees at the latest meeting on prevention in New Orleans last fall. (See related article p. 7)

### "Future Is Now" Plan

Dr. Rob Sullivan spoke about the NCHP strategic plan to 2005 which has gone forward to Dr. Kizer. The document emphasizes that behavior change

is the real mechanism by which illness is prevented. This is a challenging area for clinicians to deal with, especially since each behavior requires a different strategy, e.g., smoking cessation, diet, exercise and personal safety. These approaches in prevention will involve the use of teams and specially trained clinical assistants. The proposal was submitted to the Undersecretary's office in December.

The NCHP is also considering various marketing strategies in health promotion and disease prevention. There is a need for some kind of logo or motto that will bring health promotion before VHA staff. Ways of reaching out to enrollees who are healthy, prior to the onset of any clinical illness, is likewise being pursued.

### New Prevention Code Proposal

The proposal submitted to the Information Technology Clearinghouse last Fall, a plan to create a uniform system of capturing health promotion and disease prevention information in our computer system, will also allow the generation of reminders. Investigative data indicates a positive response on the part of clinicians and patients to the use of reminders. The proposal, complements work underway in the Information and Technology Office on Guidelines and Work Load analysis. A major concern is the downloading of the information to Austin so that appropriate tabulations can be made and sites compared. Work continues on this project although a final date for completion has not been set.

### Tobacco Cessation Guideline

Rob Sullivan has been working on the Guideline that addresses tobacco use cessation. The Guideline will summarize the best of evidence-based information on the subject. The Guideline includes a simplification in the counseling requirement (done only when advisable) requested by field staff. Healthy People 2000 Goals for the general population include reducing the number of tobacco users to a level of 15% by the year 2000 and 12% by the year 2005. It is well documented that the veteran population uses tobacco products at a higher rate than the general population. Last year's Veterans Health Survey data indicated that 30% of male and 27% of female veterans currently smoke. This is a challenging goal to accomplish with veterans but one that we feel can be accomplished.

### Veterans Health Survey

The NCHP sponsored the Veterans Health Survey in 1997 and 1998 with each VISN and medical facility receiving summaries of these reports. Mailings were sent to 60,000 veterans during the first week in December for the 1999 Survey. The sample population is selected from veterans who have received primary care from VHA clinicians within the last year.

A response rate in the 67% range, as achieved in the past two years, allows confidence in the generalizability of findings (response rate for 1999 already has reached 65%). Dr. Branch stated that we hope to forward copies of the 1999 summaries to the VISNs and medical facilities by July 1. Copies will be sent to the Preventive Medicine Program Coordinators, the Patient Health Education Contact person, the hospital Director, the Associate Chief of Staff for Ambulatory Care, the JCAHO Coordinator at each site and the Preventive Medicine Network Coordinators. Copies of the reports are also mailed to appropriate staff at Headquarters and the VISNs.

VHS reports can be very helpful for JCAHO accreditation site visits. Some of the medical facilities have been able to use survey findings to their advantage in these reviews. Let us know if your facility has been successful in doing this so we can share this information with the rest of the field. A Veterans Health Survey for next year is currently under discussion. If you think this would be valuable, Dr. Branch and his staff would like to hear from you.

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### Discussion/Questions from the Field

Dr. Katz reminded people newly appointed as PMPCs to forward personal information (address, phone, fax, and e-mail address) to the National Center. Call Mary Burdick 919.416.5880 ext. 227.

A question was asked concerning changes within EPR requirements that may not match the new Smoking Cessation Guideline. Dr. Sullivan responded that EPR staff are involved in the development of Guidelines, so future audits should follow Guideline recommendations.

A question was asked concerning clinical reminders. The current computer system (CPRS) does not seem to track the EPR data collection requirements for preventive medicine activities. This is an issue that requires a national solution. Rob Sullivan mentioned that there is an intense effort underway to correct the situation. In the meantime, Rolland Jenkins at the Long Beach VA is working on measures using education topics and health factors to solve some of the problems.

AHCPR (Agency for Health Care Policy Research) has a web page with helpful information including patient education materials such as posters and a template for patient reminder post cards. The web address is <www.ahcpr.gov/ppip>.

Staff at the Cincinatti VAMC reported on an employee smoking cessation program using the American Lung Association's seven week program.

Employees pay for the materials used and are later reimbursed if they complete the entire program. A question was raised concerning the possibility of using employees' health insurance to cover these costs. If any medical center has had success with this approach, the people in Cincinatti would be interested in learning about it. Programs can become costly so it is necessary to search out other means of supporting them.

### PMPC Conference Call

The next PMPC conference call will be held October 5, 1999 at 1:00 pm EST; 12:00 pm CST; 11:00 am MST; 10:00 am PST and 9:00 am AST. Call 1.800.767.1750 and tell the operator you are calling for the Preventive Medicine Program Coordinator's call. Anyone interested in or working in prevention is welcome to join us. If you have agenda items you would like discussed, send them to Dr. Lois Katz at the New York VAMC 212.686.7500, ext 7134; Fax: 212.951.3382.

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## Cochrane Collaboration Update

The Cochrane Collaboration held its Sixth International Colloquium in Baltimore, MD on October 22-26, 1998. The Cochrane Health Promotion Field, a new subgroup of the Collaboration dealing with prevention issues, held a meeting during which the following goals for the "field" were discussed.

### Overall Goal

To promote the conduct, dissemination, and utilization of systematic reviews of all health promotion and public health topics.

### Specific Goals

1. To create and maintain a database of all systematic reviews and meta analyses on topics related to health promotion and public health.

The Cochrane Library includes registered completed and proposed systematic reviews of all health related topics. The proposed health promotion database will be a specialized central database which will include all reviews completed and underway internationally on topics related to health promotion and public health. This will enable tracking of topics for which reviews have been completed and topics which yet require reviews or updating. In addition, there are numerous systematic reviews related to public health and health promotion that are not "Cochrane" reviews. These reviews will be identified, the authors contacted and invited to revise and update their reviews for inclusion in the Cochrane Library.

2. To disseminate the findings and clinical and policy implications of the completed reviews to health promotion and public health practitioners internationally, to health policy makers, to governments,

to funding agencies and to consumers, and to evaluate dissemination strategies.

The health promotion field will work with stakeholders to identify and evaluate methods for regular and frequent dissemination of review findings including newsletters, best practice information sheets, mailings to public health departments and centers for health promotion.

3. To identify those health promotion and public health topics which have not yet been summarized in systematic reviews and to identify researchers who are willing to undertake them.

Persons or groups who are willing to undertake systematic reviews in health promotion will be identified and connected with existing systematic review groups. The field will provide support in the identification of studies for reviews, and help reviewers to obtain the required training if necessary, through the Cochrane Collaboration. To assist with the identification of studies, members of the health promotion and public health field will hand-search all issues of relevant journals and submit the study citations to a central Health Promotion Field database that currently includes over 7200 references.

4. To contribute to the advancement of methodologic issues related to the conduct of high-quality systematic reviews.

Key methods issues include techniques to conduct comprehensive international searches for public health and health promotion study reports and reviews, adoption of standardized tools to assess the quality of these reports and reviews, development of criteria for evaluating

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Preparing, maintaining and disseminating  
systematic reviews about health care

## Cochrane Update

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and meta-analyzing observational studies, and approaches to summarizing results across two or more studies.

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### Recent Health Promotion reviews which have been added to the Cochrane Library (1998, Issue 3)

#### *Smoking cessation programs implemented during pregnancy*

The objective of this review was to assess the effectiveness of smoking cessation programs implemented during pregnancy and to assess the impact of these programs on the health of the fetus and infant, the mother and the family. The review concluded that "smoking cessation programs implemented in pregnancy increased smoking cessation, led to a small increase in mean birthweight and a small reduction in low birthweight and pre term birth. No trials have yet reported an assessment of the impact of the intervention on operative delivery, breast feeding, maternal psychological well-being or the well-being of other family members."

#### *Impact of mass media on health services utilization*

The objective of the review was to assess the effect of mass media on health services utilization. The review concluded that "despite the limited information about key aspects of mass media interventions and the poor quality of the available primary research, the study found evidence supporting the view that these channels of communication may have an important role in influencing the use of health care interventions. Those engaged in promoting better uptake of research information in clinical practice should consider mass media as one of the tools that may encourage the use of effective services and discourage those that are unproven."



*Verona Hegarty*

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## The Third US Preventive Services Task Force

Following the model established by the Canadian Task Force on the Periodic Health Examination in 1976, the U.S. Preventive Services Task Force (USPSTF) began work in 1984 to prepare recommendations for clinicians on the appropriate use of preventive interventions based on a systematic review of evidence of clinical effectiveness. The first USPSTF report published in 1989 carried the title *Guide to Clinical Preventive Services*. It was an immediate success and signaled the beginning of a new phase in the battle against premature death and disability. Reviews published in the *Guide* covered over 100 interventions to prevent 60 different illnesses and conditions. The report addressed the uncertainty experienced among clinicians about recommendations from multiple sources and skepticism about effectiveness. It emphasized the importance of the clinician's role in counseling patients to change unhealthy behaviors related to diet, smoking, exercise, injuries, and sexually transmitted diseases.

Reconstituted in 1990, a second USPSTF continued the assessments and published an updated and expanded second edition of the *Guide* in 1996. The new book immediately assumed the position of premiere reference source on the effectiveness of clinical preventive services. It has been the foundation for selecting strategies promoted throughout VHA.

Following a three-year hiatus, a third USPSTF convened on November 2, 1998 in Arlington, Virginia to begin another four-year cycle of review. Alfred O. Berg, M.D., chairs the new group which is composed of fourteen members representing behavioral medicine, family medicine, geriatrics, internal medicine, nursing, obstetrics and gynecology, pediatrics and preventive medicine. The scientific staff at the U.S. Department of Health and Human Services, Agency for Health Care Policy and Research (AHCPR) provides support. The group plans to produce updates of individual 1996 USPSTF recommendations, along

with assessments of new preventive services not previously considered. The publication date for the third edition of the *Guide to Clinical Preventive Services* is late 2002. Meanwhile, anticipate release of individual reports and recommendations as they are completed.

The AHCPR has contracts with the Oregon Health Sciences University and the Research Triangle Institute/University of North Carolina to provide scientific support to the USPSTF over the next four years. Designated as Clinical Prevention Centers, they are among the 12 Evidence-based Practice Centers selected by AHCPR in 1997 to develop systematic reviews of medical topics for AHCPR. This marks the first time the USPSTF has enjoyed this level of support. In the past, individual task force members carried much of the burden for review and technical report preparation.

The USPSTF encourages a close working relationship with the major primary care societies and Public Health Service Agencies. Liaisons from these organizations attend the quarterly meetings. Liaisons now include non-Public Health Service Federal partners such as the Veterans Health Administration, the Health Care Financing Administration and individual branches of the Armed Forces. The liaisons coordinate peer reviews although they do not participate in drafting recommendations or USPSTF votes. Dr. Sullivan, Director of the VANational Center for Health Promotion is currently the VA liaison.

*Robert J. Sullivan*

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# Shared Decision-Making

**J**ourney of Change II emphasizes VHA's continuing transformation. One of the four quality parameters to be adopted to achieve the 10 for 2002 targets is the patient as partner. A critical component in the partnership between patients and their healthcare providers is sharing healthcare decision-making.

VHA Policy Directive 98-023, *Guidelines for Implementation of Primary Care, April 17, 1998*, defines primary care as "the provision of integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal healthcare needs, developing a sustained partnership with patients, and practicing in the context of family and community." Partnership between patients and healthcare providers recognizes the contributions and value that each brings to this dynamic relationship.

More specific statement of partnership is found in the following definition of shared decision-making, "the case for letting patients decide which choice is best... a process by which patients are educated about likely treatment outcomes, with supporting evidence, and engaging with them in deciding which choice is best for them, taking into account their preferences, values and lifestyles."<sup>1</sup>

The VHA commitment to promoting shared decision-making underscored the need to develop educational strategies to assist field-based personnel in their understanding and implementation of the practice. In December, 1998, the Employee Education System (EES) convened a group of content experts in shared decision-making and education, clinical providers, and a representative from the Office of Primary/Ambulatory Care in Headquarters. Three target audiences were selected as priorities for education in the current calendar year: clinical providers, clinical administrative support personnel, and patients. Strategies for addressing each of these audiences are described as follows.

## Clinical Providers

- A video/print product is being created, targeted for clinical providers, and designed to raise consciousness about the meaning and value of true shared decision-making. This product will contain a "position paper" on shared decision-making, offering extensive content on the evidence basis for shared decision-making, orienting staff to issues related to shared decision-making, and offering ideas and success stories for effective implementation. The product also will include a discussion guide, frequently asked questions, and a reference list. This product is expected to be available in late Spring and will be generally distributed to libraries and an education contact at every medical center.
- Notification of this video/print package will occur through a variety of newsletter articles, conference calls, and electronic announcements. In addition, we are hoping to recruit the patient education contact persons to help in championing this project at their local medical centers. To that end, we will be conducting a special discussion of this video/print package on the April 5 PHE Hotline and April 23 PHE Conference Call.

## Clinical Administrative Support Staff

The clinical administrative support staff are critical to the efficiency and satisfaction of the patient-provider interaction. They have opportunities to talk with patients before and after the clinician's visit, and can play an important role in encouraging patients to ask questions of their providers. Support staff can also direct patients to resources needed as follow-up to discussions with clinicians.

To assist this audience, we will be developing a brief video/print package to be used by clinical managers with administrative staff. The package will be designed to raise consciousness about shared

decision-making, and provide ideas to the staff about how they can help patients make the best use of their time with the clinical provider. Some "scripted" text will be provided for staff-patient conversations; the product also will include frequently asked questions, and a list of resources the clinical staff might use to answer or refer patients' questions. This package is expected to be released in late Summer, 1999.

## Patients

Our patients constitute a third critical audience for the successful implementation of shared decision-making. In considering educational strategies to pursue, we decided to begin our work with an evaluation study of a product developed by the Bayer Institute for Health Care Communication, *Prepare to be Partners in Health Care*. This product includes an audio tape and patient booklet, which leads the patient through a series of considerations about planning for a doctor's appointment, reporting concerns, asking questions, discussing choices, agreeing on a plan for care, etc. We expect to pilot test this product at three to four VAMedical centers before Summer, 1999. Our intent in this evaluation is not to duplicate the extensive evaluation that currently is underway by the Bayer Institute, but rather focus on the value and usefulness of the product to our patient population. We can also determine if our system of care can support use of this product by our patients.

If you would like additional information about these educational initiatives, contact Carol Craft at 314.894.5736, or by using MS Outlook, or Forum e-mail programs.

<sup>1</sup> Woolf, S. Shared decision-making: The case for letting patients decide which choice is best. *The Journal of Family Practice*. 45(3)1997:205-208.



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## National Smoke-Free Advisory Group

The National Smoke-Free Advisory Group was formed in 1992 in the VA Office of Public Health and Environmental Hazards.

The current chair is Michael Geboy, Ph.D., and members include Peter Amenoff, M.D., Linda Ferry, M.D., M.P.H., Anne Joseph, M.D., M.P.H., Oliver Parr, Robert J. Sullivan, Jr., M.D., M.P.H. and Eric Westman, M.D., M.P.H. The committee is multidisciplinary and includes expertise in the areas of public health, epidemiology, prevention, clinical intervention, education, and administration. The group convenes several times every year to address issues regarding the prevention of tobacco-related disease in the VHA.

Currently the Advisory Group is working on two major projects. The first is a collaborative effort with the Department of Defense to develop a comprehensive clinical guideline to address tobacco use. This guideline will be a current adaptation of the AHCPR Smoking Cessation Practice Guideline, designed to address the needs of the clinical populations served by the Departments of Defense and Veterans Affairs. It includes an algorithm that spans issues ranging from prevention of initiation of tobacco use to treatment of smokers with co-morbid conditions, such as psychiatric disease and post-traumatic stress disorder. The guideline also proposes performance mea-

asures such as identification of tobacco users in the medical record. It is currently under review by the authors of the original AHCPR Practice Guideline (published in 1996), as it includes updated information from clinical trials on new treatments (such as bupropion) that was not previously available.

The Advisory Group has also initiated work on an employee survey regarding smoking behavior and interest in a variety of potential employee smoking cessation services. This baseline survey will initially be conducted in Headquarters, as a pilot for national administration. Information from the survey will be used to develop protocols for employee services that are maximally responsive to employees' specific needs and interests. It will provide data that will help in consideration of a current proposal to support nicotine replacement therapy for all VHA employees. The survey instrument is currently under review at Headquarters.

Please feel free to contact members of the Smoke-Free Advisory Group with your suggestions.

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## VISN 3 Preventive Medicine Council

In January 1998, Network 3 formed a Preventive Medicine Council charged with the responsibility for assuring facility compliance with the Preventive Medicine Index and implementation of the VHA Smoking Cessation Guideline. The Preventive Medicine Program Coordinators at each facility were invited to attend an organizational meeting and participate on the Council. For medical centers whose PMPC's were not primary care physicians, it was requested that a primary care physician be part of the group. The Council meets monthly. During the initial meetings, prevention activities at each facility were discussed and innovative ideas shared. The group also reviewed EPRP results for the Prevention Index and discussed ways to improve performance.

The initial emphasis was on Smoking Cessation and implementation of the clinical guidelines. Individuals who were coordinating smoking cessation activities were invited to join the Council. Various types of programs available to veterans, both internal and external to the VA, were discussed and a resource list was created. Together with the VISN Formulary Committee, a network-wide plan for Nicotine Replacement Therapy that made the prescribing of nicotine-replacement products less restrictive, was developed. It was noted that most facilities had excellent intensive smoking cessation programs but that they reached only a small number of patients. The decision was made to make smoking cessation interventions more widely available, preferably through the Primary Care Clinics. Realizing that nicotine replacement without counseling was

unlikely to be effective, the Council decided to offer an educational program on smoking cessation for primary care practitioners. Since the New York State Medical Society had a grant to offer such programs throughout the state, the Medical Society was asked to do a demonstration program at one of the hospitals. Subsequently, other facilities within the VISN arranged for similar programs to train primary care providers.



The Council believes that through collaborative effort they are able to accomplish things which medical centers alone might never be able to. The goal for this year is to work on improving Network 3's performance on the Prevention Index. Members of the Council have been asked to develop a strategy to improve performance for "Putting Prevention into Practice" in facilities. Representation from the VISN Patient Health Education Council on the Preventive Medicine Council has been informative and helpful. Plans are to continue coordinating Council activities with them. The Preventive Medicine Council reports to the Network Chiefs of Staff Council in VISN 3.

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## 1998 NCHP Survey on Participant Satisfaction

Conference attendees at the last national program on prevention were provided a questionnaire as to how the NCHP might meet their needs better. Respondents answered that coordination of NCHP data collecting measures with those of EPRP would be helpful. Promoting education through the quarterly newsletter, expanding the web page to include an interactive forum ("chat room") and serving as a clearinghouse for educational materials on prevention were also mentioned as ways the Center might assist the field.

Commenting upon the role that the NCHP should have regarding the VISNs, it was recommended that the Center should continue to disseminate guidelines on prevention, communicate the importance of prevention to the networks, have a preventive medicine liaison at each facility and network, and provide information about prevention activities. The NCHP should partner with the VISNs in promoting a prevention agenda, push for a network-wide approach for implementing prevention activities, and provide standards for evaluating outcomes.

Concerning the selection of educational formats, the following suggestions were made: quarterly conference calls, national conferences on prevention and education (the meetings are considered invaluable for providing updated information and the opportunity for professional networking), an interactive educational web site, and providing computer-assisted instruction on various prevention topics.

Participants in the survey were asked if the NCHP should have a role

in assisting with organizational change at the local level. Respondents answered that the Center should advocate the hiring of patient education coordinators at facilities, communicate the role of the preventive medicine coordinator to the VISNs, demonstrate effective educational and clinical programs, and try to influence the development of an infrastructure in the VISNs that would drive successful implementation of the 36 Prevention Guidelines as outlined in the new *Handbook 1120.2*.

Topics considered crucial in the development of preventive medicine educational materials and policy were as follows: listing of a set of core competencies in communicating with patients; colorectal cancer and PSA screening; successful clinical and educational strategies in health promotion and disease prevention; alternative/complementary medicine modalities; informatics; computer reminders for patients; behavior change in patients and clinicians; counseling techniques; encounter forms; self-care; hormone replacement therapy; advanced directives and prioritizing prevention practices.

The NCHP will try to implement as many of these suggestions as possible. We appreciate the input provided by participants in the survey. If any facility feels that they have a stellar program in any of the areas mentioned above, we would like to feature it in the newsletter. Send your suggestions to **Dorothy R. Gagnier, Ph.D.**, by Fax **919.416.5879** or by e-mail using either MS Outlook or Forum.

## WellVet Clinic

The WellVet Clinic is for new patients to our ambulatory care center. It is an interdisciplinary approach to health-risk appraisal, preventive medicine and orientation to our facility. All new patients are scheduled for the WellVet Clinic. We have been connecting our outreach program with this clinic to give the new patients a positive first encounter, encourage prevention, and promote healthy lifestyles.

Prior to the WellVet Clinic, patients would be lost or overwhelmed at this large and spread-out facility. This did not foster a good first impression. At the time of the patient's initial sign-up they are given a health questionnaire to fill out and bring to the clinic on their scheduled day. The questionnaire covers lifestyle and health habits, cancer risks and screening, mental health, functional status, and trauma/domestic violence/sexual abuse, using predominantly externally validated measures. They are given an appointment to the lab for a non-fasting total and HDL cholesterol blood draw.

The WellVet Clinic is held in the Patient Education Resource Center and education is one of the primary and essential parts of the clinic. Patients are first given an introduction and presentation about PERC. They hear a short talk from a representative of their assigned team. They receive basic information about services, eligibility, and location of their doctors, nurses, and clerks. The patient then has a screening pulmonary function test and meets with a physician, a dietitian, and a social worker. These health care professionals use the patient questionnaire and lab results to assess and advise the patient. The patients are scheduled for follow-up, and classes for health education as needed. These classes could be on cholesterol reduction, weight reduction, smoking cessation, diabetes control, or fitness. The WellVet Clinic promotes patient-provider communication.

### Benefits

The patient benefits by learning that we are concerned with keeping them healthy and encouraging their input in their care. They receive a favorable first impression of the ambulatory care center and meet their health care providers. Medicine, nutrition, social work, and public health trainees learn more about preventive medicine counseling. The combination of outreach and WellVet Clinic has resulted in an increase of new patients to our facility.



The comments of the patients have been overwhelmingly positive. We feel that this will lead to a beneficial association between staff and patients at the Sepulveda V.A.

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# WellNet Clinic:

## A Dual Opportunity Orientation and Health Risk Appraisal

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### Background

- Started in 1993
- Intended primarily for new patients
- Goals
  - Orient new patients to system
  - Provide interdisciplinary health risk appraisal
  - Increase patient involvement in care
  - Teach trainees to provide behavioral modification counseling

### Scheduling

- New patients encouraged to attend
- Given 69-item questionnaire to complete
- Sent for WellNet blood panel (currently a non-fasting total and HDL cholesterol)

### Structure

- Telephone reminder before appointment
- Held in the Patient Education Resource Center
- 5 patient slots/half-hour
- 20 patients maximum
- Show rate is 70-85%

### Questionnaire

- Prior cancer screening and family cancer history
- Health habits-smoking, alcohol use, exercise
- Nutrition screening
- Cardiac risk factors
- Domestic violence/abuse
- Mental health
- Functional status
- Self-perceived health

### Patient Characteristics \*

- New to Sepulveda
- 44% current smokers
- 30-40% history of alcohol abuse
- 50% exercise inadequately

\* based on a random sample of 100 questionnaires



### Process

- Each patient sees: Administrator, PERC manager, Pulmonary function technologist, Physician, Dietitian, Social worker
- Goal is for each provider to spend 5-10 minutes with the patient
- Focus is on brief behavior modification counseling
- Patient assigned to Primary Care Provider
- Patient referred to limited range of health service classes

### Patient Satisfaction \*

- Patients felt it was helpful to see:
  - Physician (76%)
  - Dietitian (76%)
  - Social worker (60%)
- 88% expressed satisfaction with Sepulveda
- 40% reported having changed health habits (primarily diet and exercise) as a result of the clinic

\* based on a random sample of 43 patients called 1-3 months after their appointment

### Costs

- Non-billed clinic (in keeping with community norms)
- Staff costs: approximately \$200/hour
- Cost/patient: approximately \$50/patient
- Typical session 12-20 patients in 2-3 hours

### Benefits of Clinic

- It is interdisciplinary
- Patients oriented to system
- Health risk appraisal done
- Trainees are supervised providing behavior modification counseling
- Patients are scheduled appropriately for follow-up

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