

National Center for Health Promotion and
Disease Prevention

Health **POWER!**

P R E V E N T I O N N E W S

Veterans Health Administration

Winter 2003

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From the Director

The Essential Roles of Leadership and Personal Responsibility in Prevention

Do you work in Primary Prevention? Let me tell you what you already know.

- 1) You can help MORE people and save MORE lives through Primary Prevention initiatives, compared with the “treatment approach” to disease.
- 2) Preventing a disease (Primary Prevention) costs less than treating the disease.
- 3) Disease lowers your Quality of Life; so it follows that prevention of the disease carries a better QOL (all things being equal, and disregarding pedantic philosophizing). Along these same lines, Primary Prevention of disease is less severe than treatment of the disease (one of the principles of Prevention).
- 4) The U.S. Military leads the world in Prevention initiatives, and most U.S. veterans KNOW when they are engaging in risky behaviors – this is very good for the VA . “Everyone” in the U.S. military knows about the threat and principles of protection from STDs; they know that tobacco is bad for one’s health; they know that using illicit drugs or excessive use of alcohol is outright illegal and can result in poor health, and/or can cloud judgment and result in poor decisions that affect one’s health. Ergo, they are ATTUNED, and they know when they are engaging in risky behaviors.

Now for some heartbreakers...

- 5) “Prevention” is the easiest medicine to prescribe, but the hardest to take.
- 6) Preventive behaviors are the easiest to “forget” and the easiest to ignore, even in the face of better judgment, past experience, and rational thinking (e.g. “I guess I just was being stupid”, “What was I thinking?!!”, “I knew better!”) When death or injury is not an imminently visible threat, human nature causes us to minimize, deny or ignore the threat. And, as in the case of long-term threats, like from tobacco, it is hard to perceive one’s death or harm when it is years away.
- 7) Prevention needs CONSTANT reinforcement and repetition. Even recent servicemen and retirees from the military “forget” the Preventive guidance that they followed during their service (e.g., they gain unnecessary weight, they become progressively more sedentary, they return to tobacco use, they drink more alcohol.)

Now for some uppers...

- 8) Leadership in the U.S. Government is recognizing the importance of “Prevention” and is demonstrating organizational commitment to keeping the nation healthy— showing recognition of the essential role that LEADERSHIP must play in Prevention. The President’s HealthierUS initia-

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NCHPDP Mission Statement

The VHA National Center for 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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tive is aimed at pulling together, recognizing, and coordinating the Prevention practices in all government agencies. The Director of the CDC is channeling research to respond to the growing burden of preventable diseases. The Institute of Medicine's "Quality Chasm" report identifies several specific preventive actions in their 20 Priority Areas for transformation of the nation's healthcare system – emphasizing the need to go beyond a disease-based approach and extend across the full spectrum of health care – keeping people well and maximizing overall health.

- 9) What's even better than the talk, is that they're walking the walk! The President, HHS Tommy Thompson, The Surgeon General (Commando Carmona, De Oppresso Liber!) – are all providing personal endorsement by being role models for healthy living.
- 10) And, repetition WORKS – a principle that advertising agencies have known and used for decades. Think about seat belt usage in the 1960s compared to now. Usage has become so automatic that most people fasten seat belts without thinking, and they feel unsecured without them. What about tobacco use? Ever think you'd see the day when social awareness of cigarette smoking would be to the extent that large cities could seriously propose establishment-wide no-smoking laws?! Repetition, repetition, repetition – it works.

SYNOPSIS OF WHAT I JUST SAID? Prevention is "Righteously Right"; most vets already know the basic tenets of Primary Prevention; the success of Prevention is burdened and side-tracked by Human Behavior; Leadership in Government (and, most importantly, non-Health-related Leadership) is taking an active role in promoting Prevention.

Leadership Endorsement/Command Emphasis – The "Real" Driving Force in Prevention.

This prompts me to remark on the often forgotten, but critically essential, role of leadership in successful Prevention. Traditionally, our biggest focus on Prevention tends to be at the Provider-Patient interface. Considerable emphasis is spent on improving educational, training, counseling and promotional aspects, in order to improve Provider communication and Patient understanding of Prevention issues. However, no matter how highly these aspects might be tuned, if the LEADERSHIP (both healthcare and non-healthcare leadership) does not provide the supportive environment, Prevention services are doomed to tiny one-on-one successes, restricted by the limited energy of the limited few who scrounge for other resources, or take it out of their own hide to support Prevention.

What constitutes Leadership Endorsement? Command Emphasis/Leadership Endorsement is not made of superficial platitudes and knee-jerk "politically-correct" acknowledgement of the need to prevent disease and keep healthy. It is the blatant commitment of resources, authority, and enforcement – as well as role-modeling behaviors of the leaders themselves.

Prevention in the Military. The U.S. military, from which the VA's entire population is derived, is THE organization that leads the nation in the practice of Prevention. It preaches, repeats, hones, promotes, and enforces Prevention throughout its ranks, from Basic Training until retirement or discharge. There are NO EXCUSES. No one comes close to the U.S. Military's commitment to Prevention, in leadership, role models, resources, repetition, and responsibility.

LEADERSHIP RESPONSIBILITY / PERSONAL RESPONSIBILITY. What happens if a service member fails to assume **personal responsibility** to protect his/her health by following prescribed preventive actions? There is punitive retribution for service members who knowingly ignore health risks and incur bad health outcomes ("destruction of 'Gov't property'" -- even sunburn!). What happens if a Commander ignores prescribed preventive measures and allows his/her troops to operate without risk minimization? Again, punitive retribution is defined for the Leadership who ignore, or who allow their subordinates to ignore, health risks. (In other words, the Commander is held personally responsible for his/her subordinates' compliance.) **Leadership responsibility!** There are NO EXCUSES.

What does this mean to the VA? Since the 1970s (if not before), every single one of our veterans has been a recipient of the military's excellent Preventive training, ideology, Leadership and organization. This means that veterans have a sense of **PERSONAL RESPONSIBILITY** for their health, and know the basic tenets of behaviorally-based disease prevention, even without expert medical guidance. This was instilled in them. **Veterans from the U.S. Military KNOW about**

Prevention – virtually none can claim ignorance of the ill effects of tobacco, weight, physical inactivity, drugs or alcohol, as well as other risky behavior “walking the wild side”.

So, let’s look around and ask ourselves: Are we serious about Prevention? Is Leadership at every level committed to disease prevention in our veterans? ...and when do we start asking how committed our patients are in improving their health? Is there a point where PERSONAL RESPONSIBILITY also must play a role in healthcare, balanced against human behavior to “forget”? ...after all, we are derived from a military culture, where there are NO EXCUSES.

KEYS TO PREVENTION? Leadership commitment; personal responsibility; resources; role models; repetition, and awareness of human behavior/human weakness.

Stay tuned to next issue for THE ANSWERS!!

In the meantime, Go Go Go! Push Push Push!!

yevich, out!




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Home of Our Heroes— Birthplace of a VHA Prevention Force

In the VHA, our heroes’ home is out on the VHA front lines, taking care of veterans. It is where veterans currently receive exemplary care – proven better in many respects than other American health care systems offer. It is also a place that is saturated with reality and ripe with opportunity for innovation in preventive HEALTH care. In spite of the fact that our VHA already sets high standards for the nation, our national VA healthcare system has the potential to blow the socks off the nation’s record in confronting the incidence of new-onset illnesses in our population. Many powerful supports are already in place, including the national CPRS, clinical reminders and performance measures. In order to keep pace with the steadily increasing workload, we need creativity in devising additional supportive systems that will allow us to continue to excel in this area. The challenges facing the nation, as played out in the VA trenches (I know you know first-hand what the problems are), provide opportunities for everyone of us to personally interact, and get involved in finding solutions.



Mary Burdick, PhD,
RN – Chief of Staff

Growing national attention is being given to increasing the provision of clinical preventive services, in order to reduce illness, death, disability, and cost to society from preventable diseases. Effective and proactive interventions are available that can help people avoid disease by promoting wiser personal choices. While the VA leads the nation in implementing preventive services, there are additional ways that the VA can continue to set the pace by further enhancing the provision of high quality evidence-based preventive care to veterans.

One such opportunity is protecting those veterans enrolled in the VA who haven’t gotten all the chronic diseases, YET! There is still time to head off a lot of diseases!!! Many seemingly well veterans are headed in the direction of getting sick if they don’t make some very important personal health decisions. These are the ticking time-bombs. How many veterans fall though the cracks that could benefit from focused attention on prevention? How are we going to deliver effective preventive services before disease strikes!? Repeatedly, the NCHPDP hears about yet another one of the many bright VA heroes who has found an ingenious way to provide effective prevention to a particular veteran or group of veterans on a case-by-case basis in spite of the competing forces. Not necessarily the most optimal or reliable approach, right? It is truly great that we have heroes, but a healthcare system can’t continue to rely on individual heroism to accomplish routine services that are needed nation-wide. Someone, some group, needs to be formally designated to develop and spearhead Prevention at the front lines. But, who can accept ownership of preventive services? Everyone is busy. It is widely recognized that primary providers do not have the time nor, in many cases, the training to adequately address the full range of preventive services. This gap may be most apparent in the area of counseling for patients to modify personal health habits. Health promotion strategies often depend on motivating and assisting patients to adopt healthy lifestyle goals and plan daily routines to achieve those goals. Given that behaviors account for a majority of chronic

Continued on page 4

conditions and a majority of health care costs, behavioral interventions represent one of the few innovations that can improve services, enhance health, and decrease the disease burden and related costs to society.

Because of these constraints, and since Prevention overlaps all practice areas, nurses have the opportunity to become prevention's prime movers and to be formally tasked with the mission. The values, skills and knowledge inherent to the nursing profession prepare nurses to implement clinical preventive services that span the continuum of care. In addition, nurses are uniquely positioned in all practice areas and throughout the system to engage veterans in activities to maximize their health. Systematic enhancements are needed to support nurses' actions and to create models for providing preventive services that result in the improvement of health of veterans.

The VA National Center for Health Promotion and Disease Prevention (NCHPDP), as the central office for "all things prevention", with a vested interest in promoting all areas of prevention throughout the VA, created and shepherded a new initiative that will position mid-level clinical staff (e.g., nurses) to act as an implementation force for the delivery of comprehensive preventive services. To assist in its development, the Chief of Staff (COS) at NCHPDP was designated (11/2002) the Prevention Consultant to the Office of Nursing Service, providing a formal structure to align Nursing with Prevention. A Preventive Nursing Technical Advisory Group (PN TAG) was established on 1/6/03 to determine critical goals and outcomes and to develop and implement strategies. An initial planning conference call was held with the PN TAG members on 1/31/03. The PN TAG agreed to request the support of the VHA Health Systems Committee (reports to the VHA Leadership) in early February. The committee plans to hold the first face-to-face meeting in March or April 2003 to develop a strategic action plan.

Proposed activities include:

1. Establish systems to support efficient delivery of care for high priority clinical Preventive Services (e.g., standardize health risk assessment of patients)
2. Create innovative efficient models for delivery of effective Preventive Services
3. Create Preventive Nursing core competencies
4. Determine staff training needs
5. Develop VHA certification in "Prevention" (none currently exists)
6. Develop nursing protocols related to patients' health assessments
7. Create nursing standards of care for Preventive Services
8. Enhance linkage of Preventive Nursing practices to performance measures
9. Provide networking opportunities and collaboration related to best practices in effective clinical preventive services across disciplines
10. Collaborate with the Public Health Service, the Uniformed Services University of Health Sciences, and Academia (various) to provide training opportunities in clinical preventive services; create Prevention track in existing and new graduate nursing programs; create clinical practicum opportunities in Prevention in VA for nursing students
11. Collaborate both internally and externally with VA offices and other federal, private, professional and academic organizations to create, test and implement effective and far-reaching translational Prevention practices. (CDC, AHRQ, NIH, RWJ Foundation, Commonwealth, Partnership for Prevention, ANA and others)

12. Publish in healthcare journals

The outcomes from this initiative are anticipated to include:

1. Increase veteran satisfaction with preventive services
2. Increase employee satisfaction in ambulatory and primary care areas (including nurses and physicians)
3. Improve delivery of evidence-based preventive services; work to improve health outcomes
4. VA lead the nation in developing the first non-physician "Prevention Certification"
5. Publications that enhance the VA's public image as leading edge world-class health care system
6. Productive interagency collaborations (federal and non-federal, including strong working relationship with DOD and HHS)

The NCHPDP is confident that our VA will continue to generate and support a diversity of heroes and innovators who will create the future. We are honored to be guided by the enthusiasm, actions, and footsteps of the VA heroes at home on the front lines. The members of the Preventive Nursing Technical Advisory Group are:

- Dr. Mary Burdick (Co-chair), COS, NCHPDP
- Dr. Elwood Headley (Co-chair), Director, VISN 8
- Cathy Rick, Chief Nursing Officer, VACO
- Dr. Susan Mather, Chief Public Health & Environmental Hazards Officer
- Dr. Pam Reeves, CMO, VISN 11
- Audrey Drake, Program Director, Nursing Service
- Isabel Duff, SLM G&EC/Nurse Exec, Prescott, AZ
- Debbie Hagen, PC Division Manager, Milwaukee, WI
- David Przechlowski, Chief Nursing Service, Asheville, NC
- Valerie Robinson, Quality Manager, VISN 6
- Susi Lewis, Asst Director, Field Operations, NCHPDP
- Dr. Linda Kinsinger, Director Education, NCHPDP
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In the Fall, 2002 edition of *HealthPOWER!*, Laurie LeMauviel, author of "How Sweet It Is... Or How Sweet Is It?", was inadvertently listed as MD, rather than DO. We apologize for the error.

Update on Staff Activities

Education

The Assistant Director for Education, Dr. Linda Kinsinger, is working on a number of initiatives. Dr. Kinsinger and others in NCHPDP are beginning to plan a national training conference and workshop for all preventive medicine program coordinators and preventive medicine VISN leaders across the VA. This meeting, which will be held in conjunction with the DoD, will be in August in Albuquerque. The content of the training will include interactive sessions on organizing and delivering preventive services, updates on preventive service recommendations, and skills-building for patient counseling and shared decision making. More information about the meeting will be coming as the planning process moves forward.

Dr. Kinsinger and Ms. Strickland are developing content for the Prevention Topics section of the Center's web page. The web pages, designed for both patients and providers, will include a brief summary of information about each topic, current recommendations for appropriate services, and a few selected links to other informative sites.

NCHPDP is very interested in involving public health students and preventive medicine residents in its activities and projects. Dr. Kinsinger is spearheading the effort to bring students and residents into the Center. These learners will work on our research projects, the weight management initiative, and other activities. She will meet with preventive medicine residency directors who have VA-funded positions at the National Preventive Medicine Residency Directors' Workshop in San Diego in February.

The Education Assistant Director is also working with Ms. Susi Lewis, NCHPDP Field Liaison, to develop a VA version of a patient education booklet about preventive care and wellness. Several VA providers have modified a booklet available from the Agency for Healthcare Research and Quality. We will build on their ideas to produce a booklet that could be used in all VHA facilities.

Research

To acclimate Dr. Richards to research in the VA, she has attended two conferences since her appointment as Assistant Director of Research in November. The Seminars in Health Services Research Methods and the QUERI National Meeting were held this past November and December. Both the one-day seminar on "VA Databases in Health Services Research" and the introduction to the "Quality Enhancement Research Initiatives (QUERI) for Colorectal Cancer, Chronic Heart Failure, Diabetes, HIV, Ischemic Heart Disease, Mental Health, Spinal Cord Injury and Substance Abuse" proved to be very informative and revealed a wealth of research and collaborative opportunities in the VA.

Dr. Richards is working with others at NCHPDP to focus research on developing priorities for prevention programs and improving prevention services for veterans. Dr. Richards is working in collaboration with others in the VA to revive the Veterans Health Survey for 2003, a national survey of veterans assessing the availability of preventive services and the preventive health needs of veterans. Furthermore, Dr. Richards, others at NCHPDP, and prevention fellows are working on a number of papers and grant applications focusing on obesity prevalence among veterans, the cost of obesity to the VA, weight management practices of veterans, health-related quality of life among obese veterans and prioritizing preventive services in the VA. NCHPDP is working on providing updates on the latest research information in health promotion and disease prevention for dissemination among VHA personnel. NCHPDP is pushing forward on research initiatives and is the leading VA resource for prevention information.



Linda Kinsinger, MD, MPH – Asst. Dir., Policy, Program, Training and Education



Marie Richards, PhD, MPH, RD – Asst. Dir., Research

National Observances

April

Cancer Control Month

www.cancer.org

Foot Health Awareness Month

www.apma.org/footmouth02.htm

National STD Awareness Month

www.ashatd.org

National Public Health Week (7-13)

www.apha.org

May

Healthy Vision Month

www.aao.org

National High Blood Pressure Education Month

www.nhlbi.nih.gov

National Osteoporosis Prevention Month

www.nof.org

Older Americans Month

www.aoa.gov

Skin Cancer Awareness Month

www.cancer.org

National Women's Health Week (11-17)

www.4woman.org

National Running and Fitness Week (11-17)

www.americanrunning.org

Buckle Up America! Week (19-26)

www.nhtsa.dot.gov

National Senior Health and Fitness Day (28)

www.fitnessday.com

June

Vision Research Month

www.preventblindness.org

National Cancer Survivors Day (1)

www.cancer.org

National Men's Health Week (9-15)

www.menshealthweek.org

Spirituality: An Essential Ingredient in Health Care Promotion and Disease Prevention

Modern medicine increasingly acknowledges that maintaining health and preventing illness require more than treating just the body. The mind, we have known for a long time, influences how we feel. But there is also the profound impact that the spirit has on health maintenance.

The English word “spirit” comes from the Latin spirare, meaning breath. Its counterparts, which mean also “breath” and “spirit” in Hebrew are ruah and in Greek pneuma. Spirituality can therefore be understood, like breathing, as the animating force in human beings. Spirituality may also be used in a general sense to refer to that which gives meaning and purpose to life; or the term may be used more specifically to refer to the practice of a philosophy, religion, or way of living.

Over the past several decades, there has been a broad revival of interest in spiritual healing and religious practice and health. Physicians and other caregivers no longer ignore the return to spirituality and religion by patients as an adjunct to their physical healing. In a sense, religion can be considered a form of complementary therapy. Why do people seek out alternative/complementary therapies, including religion and spirituality? Patients may be discouraged and in despair about the realities of conventional treatment. Fear, adverse effects, and a desire by the patient for more supportive care are other reasons. (See Fred Rosner, Religion and Medicine at: <http://www.mercola.com/2001/aug/25/religion.htm>).

Over the years, we have seen an upsurge in epidemiological studies—over 300 in fact—that attempt to discern a connection between religion and health. (Among many, see for example Jarvis and Northcutt, (1987) Religion and Differences in Morbidity and Mortality, *Social Science and Medicine*; Levin and Schiller (1987) Is there a Religious factor in Health? *Journal of Religion and Health*; gerontology (Witter, Stock, Okum, and Haring, (1985) Religion and Subjective Well-being in Adulthood: a Quantitative Synthesis, *Review of Religious Research*, 26, 332-342, and the behavioral sciences and health behavior.)

Matthews and his colleagues reviewed many epidemiological studies about the relationship between religious factors (e.g., frequency of religious attendance, private religious involvement, relying on one’s religious beliefs as a source of strength and coping, prayer, community worship and fellowship) and physical and mental health status in the areas of prevention, coping, and recovery. Empirical studies from the published literature that contained at least one measure of subjects’ religious commitment and at least one measure of their physical or mental health status were used. In particular, studies that examined the role of religious commitment or religious involvement in the prevention of illness, coping with illnesses that have already arisen, and recovery from illness were highlighted. A large proportion of published empirical data suggests that religious commitment may play a beneficial role in preventing mental and physical illness, improving how people cope with illness, and facilitating recovery. The available data suggest that practitioners who make several small changes in how patients’ religious commitments are broached in clinical practice may enhance health care outcomes. (Matthews DA, McCullough ME, Larson DB, Koenig HG, Swyers JP, Milano MG. “Religious commitment and health status: a review of the research



Chaplain Hugh A. Maddry, DRE, BCC

and implications for family medicine”. Archives of Family Medicine Mar-Apr; 7[2] [1998]: 118-24.)

One of the co-authors of this study was Harold G. Koenig, Director of the Center for the Study of Religion/Spirituality and Health located at Duke University. He writes that people have had their lives changed by “faith in a transcendent Spirit with a power to heal emotionally, mentally, and physically.” “Healing can include dramatic, sudden physical cures, but is not confined to the ‘miraculous’ or the spectacular. Perhaps for most people, the healing power of faith involves a healing of the mind and emotions, the intangible spirit, and of relationships with others... Faith can put physical illness beneath us, where it belongs, return dominion to us, and give us power to live victorious and fulfilling lives... People who regularly attend church service, pray individually, and read the Bible are 40% less likely to have diastolic hypertension than those who seldom participate in these religious activities... People who attend religious services regularly may have stronger immune systems than their less religious counterparts. Those who never or rarely attend church or synagogue tend to have the highest levels of Interleukin-6, perhaps indicating a weakened or overactive immune system... People who attend church regularly are hospitalized less often and leave the hospital sooner than people who never or rarely participate in religious services. The deeper a person’s religious faith, the less likely he or she is to be crippled by depression during and after hospitalization for physical illness... Religious people live longer and physically healthier lives than their non-religious counterparts.” (Koenig, Harold. THE HEALING POWER OF FAITH: Science Explores Medicine’s Last Great Frontier. New York: Simon and Shuster, 1999.)



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Most people who are suffering from medical problems place high value on their faith. (Weaver, A. J, Flannelly, L. T, Flannelly, K. J, Koenig, H. G, Larson, D. B. “An analysis of research on religious and spiritual variables in three major mental health nursing journals.” (Issues in Mental Health Nursing 19 (1991-1995): 263-276.)

Family caregivers often rely heavily upon their religious faith to cope with the burden of caring for their loved ones. (Picot S, Debanne SM, and Namazi K, Wykle M. “Religiosity and Perceived Rewards of Black and White Caregivers.” The Gerontologist; 37 (1997): 89-101). At Johns Hopkins University, Rabins et al (1990) sur-

veyed caregivers of persons with Alzheimer’s disease and of those with end-stage cancer. They found that successful coping was associated with only two variables: number of social contacts and support received from religious faith. (Rabins PV, Fitting MD, Eastham J, Zabora J. “Emotional adaptation over time in care-givers for chronically ill elderly people.” Age and ageing. May; 19 3 (1990): 185-90). Thus, having support from one’s religious community appears to be one of the most important factors responsible for success in the caregiver role. Hundreds of scientific findings link religious involvement to prevention of “at risk” behaviors and increased pro-social values among youth (Weaver AJ, Samford JA, Morgan VJ, Lichten AI, Larson DB, Garbarino J. “Research on religious variables in five major adolescent research journals: 1992 to 1996.” Journal of Nervous and Mental Diseases Jan; 188(1) (2000): 36-44). Commitment to religious communities reduces the risk of alcohol and drug abuse, premature sexual behavior, depression, suicide, and anti-social behavior, as well as enhancing positive coping strategies among teens (Weaver et

al., 2000). In a society with epidemic levels of social problems that put adolescents "at risk" for psychological problems, premature death, and disability, this is no small finding.

Here are some other studies that demonstrate the positive impact of religion, faith, and spirituality on positive health and illness prevention:¹

Contemporary research confirms what Plato said: "And this which you deem of no moment is the very highest of all: that is whether you have a right idea of the gods, whereby you may live your life well or ill." (Laws, Sec. 888). That ancient wisdom is likely to serve us well in the 21st century.

(Footnotes)

¹ Harris, R. C., Dew, M. A., Lee, A., Amaya, M., Buches, L., Reetz, D., & Coleman, G. "The role of religion in heart transplant recipients' health and well-being." *Journal of Religion and Health*, 34(1) (1995): 17-32. Kass, J. D., Friedman, R., Leserman, J., Zuttermeister, P. C., & Benson, H. "Health outcomes and a new index of spiritual experience." *Journal for the Scientific Study of Religion*, 30 (1991): 203-211. Koenig, H., George, L., Meador, K., & Ford, S. "Religious practices and alcoholism in a southern adult population." *Hospital and Community Psychiatry*, 45(3), (1994): 225-231. Levin, J. S., Lyons, J. S., & Larson, D. B. "Prayer and health during pregnancy: Findings from the Galveston Low Birthweight Study." *Southern Medical Journal*, 86(9) (1993): 1022-1027. McBride, J. L., Arthur, G., Brooks, R., & Pilkington, L. "The relationship between a patient's spirituality and health experiences." *Family Medicine*, 30(2) (1998): 122-126. Muldoon, M. H., & King, J. N. "A spirituality for the long haul: Response to chronic illness." *Journal of Religion and Health*, 30 (2) (1991): 99-108. O'Neill, D. P., & Kenny, E. K. "Spirituality and chronic illness. Image: *Journal of Nursing Scholarship*, 30 (3) (1998): 275-280.

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VA INPUT WANTED: 2003 DOD Tobacco Use Cessation On-line Survey

The United States Army Center for Health Promotion and Preventive Medicine (USACHPPM) is conducting its 2003 on-line survey to measure various aspects of tobacco use cessation (TUC) in primary care clinics in the Army, Navy and Air Force, as well as the VA. Previous survey was conducted from 4 January – 31 January 2002.

USACHPPM is specifically interested in three aspects of the implementation process of the Clinical Practice Guideline (CPG) for Tobacco Use Cessation in the Primary Care Setting: the satellite broadcast, the toolkit and whether pharmacies restrict TUC medications to formal cessation classes (which would hinder the Primary Care Provider from helping individual tobacco users).

In order to obtain more feedback from VA providers, the survey deadline date has been extended to March 15, 2003.

Please provide your input by going to:
<http://chppm-www.apgea.army.mil/doem/survey/tobacco>

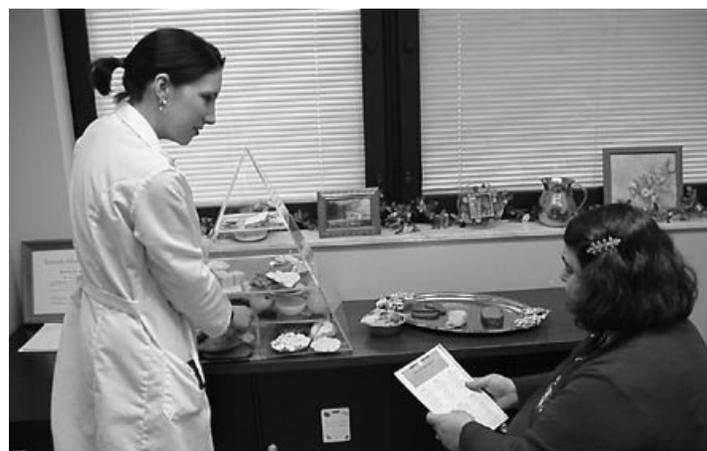
If problems, please contact Dr. Christine Scott directly at christine.scott2@apg.amedd.army.mil

Taking Steps to a Happy Healthy Heart

Before the days of super-size meals and all-you-can-eat buffets, Americans had an easier time practicing self-control when it came to food. Now, with all the high fat, high cholesterol, calorically dense, easy to grab foods at our fingertips, Americans are constantly encouraged to consume these foods in excess. This lifestyle will greatly increase the likelihood of obesity, hyperlipidemia, and hypertension, all of which are independent risk factors of cardiovascular disease. No wonder heart disease is America's number one killer. Fortunately, we also live in a society that has made great medical advances and can treat many heart problems. However, medical procedures cannot always fix every problem and contrary to popular belief, there is not always a pill that will fix everything. It is imperative that health care professionals and patients alike are aware of the importance of monitoring how much and what types of foods are consumed. Early nutritional intervention is recommended to prevent heart disease from occurring.

Obesity: The primary concern of being overweight or obese has turned from appearance to one of overall health. The Surgeon General reports that the incidence of heart disease (heart attack, congestive heart failure, sudden cardiac death, angina or chest pain, and abnormal heart rhythm) is increased in persons who are overweight or obese. In addition, high blood pressure is twice as common in adults who are obese than in those who are at a healthy weight. Finally, obesity is also associated with elevated triglycerides and decreased HDL cholesterol and diabetes, which complicates and exacerbates heart disease.

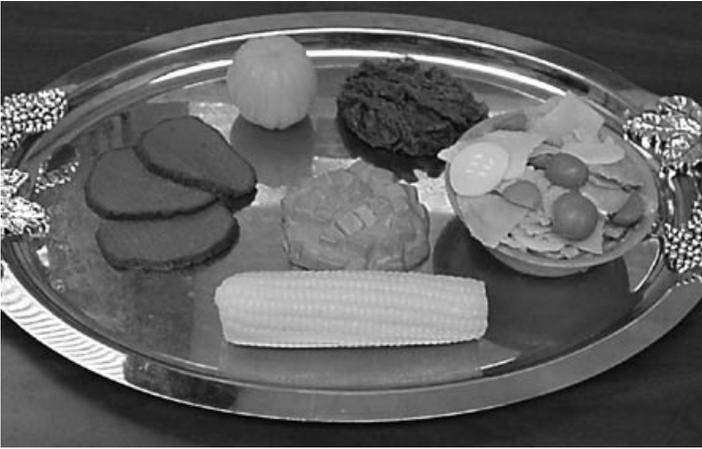
Obesity is a chronic condition that many people battle their entire lives. Motivation to lose weight often only arises after a cardiac patient has already undergone heart surgery. However, continually emphasizing the consequences of obesity, before a heart attack occurs, can also help to motivate a patient to begin thinking about controlling his or her weight.



Eating a variety of food in moderation will help to keep your heart healthy. Khandra Faulkner, RD, is instructing Carolyn Smith how to include low fat foods from all food groups daily in her diet.

Include protein and carbohydrates at each meal.

Continued on page 8



Fill up on fruit and vegetables for a low fat, low calorie meal.

Once patients realize the need to lose weight, the next step is putting it into practice. Changing lifetime eating habits is not always an easy task, but many veterans do it every day one small step at a time. Losing weight all comes down to one simple concept: eat less and exercise more. All “diets” use this concept to help people lose weight. The key is making lifestyle changes in eating habits and losing the weight gradually (1/2-2 lbs/week).

Fat: The relationship between eating a high fat diet and an increased chance of heart disease continues to be a large concern as Americans turn to fast food for daily meals. Our bodies simply are not made to ingest large amounts of high fat products each day. For example, the average American 2000 kcal diet needs only about 65 grams of fat per day. If that same American grabs a Big Mac™, a super size order of fries, and a large cola, they are consuming about 1400 calories and 57 grams of fat just in that one meal.

Fats and oils should be used sparingly and should consist mainly of unsaturated fatty acids. Unsaturated fats help lower blood cholesterol and are found in fats from plant sources. Saturated fatty acids, found in animal fats, are the main culprits to increasing blood cholesterol levels. An individual can find saturated fats lurking in many processed foods, butter, lard, and fatty meats, just waiting to clog a victim’s arteries. On the other hand, a notable polyunsaturated fatty acid is the omega-3 fatty acid.

When combined with a healthy eating pattern, omega-3 fatty acids may provide a protective effect against heart disease. Swimming around in seafood, like mackerel, albacore tuna, salmon, sardines, and lake trout, are greater amounts of omega-3 fatty acids. Generally speaking, all Americans should avoid frequently adding fats to foods. When using fats, use liquid oils like olive or canola oil, peanuts, walnuts, almonds or pecans. Make all dairy choices low-fat or fat-free and choose lean meats. Snack on fruits and vegetables instead of chips and cookies.

Cholesterol: Not only is fat one of the culprits contributing to clogging healthy arteries, but elevated cholesterol also increases the chances of heart disease. Consuming excess amounts of animal products increases the amount of LDL or “bad” cholesterol floating around in blood. With that excess LDL cholesterol, there may not be enough HDL or “good” cholesterol to rid the blood of that artery clogging cholesterol.

One way to help cholesterol levels is to add fiber to the daily diet. Slowly increase fiber by adding whole grains, fruits and vegetables to your daily diet. High fiber foods may help to take cholesterol away before it can be absorbed into your bloodstream.

Blood pressure: Another leading cause of heart disease and premature death in America is high blood pressure. A diet high in sodium can contribute to hypertension. Lowering salt intake in the diet may lower blood pressure in some hypertensive individuals. Leaving the salt shaker off the table and avoiding processed foods may be challenging, but you can retrain your taste buds to enjoy lower sodium foods. Flavor can often be enhanced using herbs, spices, and salt-free seasoning blends.

Accepting personal responsibility for your own health is especially important in practicing preventive medicine. It is imperative for patients and health care professionals to realize the impact that lifetime dietary and exercise habits have on heart health. Diet and exercise monitoring can influence maintaining a healthy weight, fat intake, cholesterol intake, and blood pressure. Moderation is the key to success. Combining healthy diet and exercise habits while avoiding smoking, reducing stress, and limiting alcohol consumption will help an individual lead a long and productive life.

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Mental Health Weight Management/Eating Disorder Task Force

Chalmers P. Wylie Outpatient Clinic, Columbus, Ohio

The Mental Health Weight Management/Eating Disorder Task Force was charged with examining issues with obesity and disordered eating for patients of the Chalmers P. Wylie Outpatient Clinic, Columbus, Ohio. (There was the initial issue of medication noncompliance on the part of patients for whom a weight gain was a side effect of certain medications). They asked: What are the needs, what services were being offered, what treatment protocols and best practices are recommended in the VA, in the literature, and from experience? It was determined that there was a great unmet need. Hence, the Weight Management Clinic was established for treatment of obesity and, given the available resources, recommended that the best method of treatment for patients with eating disorders would be one-on-one counseling, in addition to the services of the Clinic.

The Weight Management Task Force became the Weight Management Clinic Advisory Committee and members consist of Dr. Makino, clinical psychiatrist; Joy Midkiff, MS, RD, LD, Mental Health dietitian; Carolyn Abbruzzese, MSW, LISW, CCDC I, Addictive Disorders Social Worker; Virginia Collins, MS, RN, patient education coordinator; and Deborah Tirpak, RD, LD, Primary Care dietitian. These committee members also act as the clinical staff in the program.

The following are topics discussed/measured/evaluated during class sessions:

- overview and objectives
- anthropometrics
- Food Guide Pyramid
- fats/cholesterol
- fast food
- medication side effects
- set - point theory
- menu planning
- fad diets/dangers of dieting
- barriers to exercise
- planning healthy snacks
- prevention of relapse
- stress management
- lifestyle change readiness test
- goal-setting
- portions
- food label reading
- health consequences of overweight and obesity
- Binge Eating Disorder screen
- metabolism
- grocery shopping
- physical fitness
- dealing with social situations
- eating out
- tips for healthy eating during the holidays
- elements of successful weight maintenance

Homework is given weekly and covers such topics as:

- walking five minutes for three days a week
- drinking five or more eight ounce glasses of water daily
- what patient wants from weight loss
- noting "why I am eating"
- list ways to be creative about increasing daily physical activity
- program evaluation
- keeping daily food diary
- writing about dislikes with being overweight
- bringing in a food label to share
- identifying emotions and feelings
- bringing lunch or snack



The Mental Health Weight Management Advisory Committee at the Chalmers P. Wylie Outpatient Clinic in Columbus, Ohio. Pictured L to R are Debbie Tirpak, Joy Midkiff, Carolyn Abbruzzese. Not pictured, Virginia Collins.

Preparation for these classes began in November of 2001, with the first class beginning in April 2002; the second one began September 2002. The first class was only six weeks in length with a class time of 60 minutes. It was decided attendance at the first class was mandatory, as this class painted both a vision as well as a plan for work to be done in future classes. Graduates were encouraged to participate in an already established ongoing monthly weight control support group.

Following completion of the first session, the advisory committee decided that the second class session, offered in fall 2002, would extend from six to 12 weeks in length, with each class being 90 minutes. Other changes made to the second session include: adding a midway evaluation, which allowed a one-on-one meeting between providers and patients; and changing the certificate of completion to be more patient-focused and more official looking to acknowledge the patients' hard work. It was also decided that these patients would be invited to repeat the session, if desired, but also had the option to attend the monthly weight control support group.



Dr. Makino, Clinical Psychiatrist

The average weight loss in the first session (four patients) was 2.1 pounds with a total of 2.4 inches lost from waist and hips. Very little change was seen in waist/hip ratio and percent body fat for the group dropped by 1.3 percent. The second session (four patients) average weight loss was 13.8 pounds and a total of 13.5 inches from waist and hips. There was a total of 8 percent body fat lost and waist-to-hip ratio improved slightly. Even though the first session was only six weeks, patients did find improvements in diabetes self-monitored blood sugar results, lipid profiles, control over binge-eating behaviors, and improved self-esteem, as did the second session. The providers learned that screening for appropriate group interaction is as important as patients' level of motivation.

The third session is now underway and began Thursday, January 9, 2003. There are 15 patients, which is a dramatic increase in size from the first two sessions.

As for disordered eating issues, the lifestyle change readiness test has revealed there may be a need for further program development to appropriately serve the needs of this patient population.

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Mental Health Physician Assistant Addresses Integration of Preventive Health Issues

The VA North Texas Health Care System in Dallas has employed Physician Assistant John T. Weed since October 1977. He has been assigned to the Psychiatry/Mental Health Service for his entire VA career. Mr. Weed has been assigned to the Post Traumatic Stress Disorder Clinical Team (PCT) at his VA since January 1987 where he performs Post Traumatic Stress Disorder (PTSD) assessments and provides individual and group counseling to combat veterans from WWII, Korea, Vietnam, Somalia, and Desert Storm. Mr. Weed was a Navy Combat Corpsman assigned to Echo Company, 2nd Battalion/1st Marines in Vietnam from November 1966-November 1967. He has been an Instructor and Clinical Instructor at the University of Texas Southwestern Medical School's PA Program and is a former House Officer for the American Academy of Physician Assistants (National Professional Organization for PAs).

Mr. Weed, during his 15 years of individual and group counseling with PTSD combat veterans, observed that they had gained weight and developed co-morbid health problems such as diabetes, arthritis, cholesterol/triglyceride abnormalities, and heart disease (all aggravated by the weight). The scattered individual attempts by the vets or clinics at the VA had not been successful in changing the problems of obesity or co-morbid illnesses. Further, he observed that food had become the method of self-medication for many of the PTSD symptoms these combat veterans reported. Too much anger, sleeplessness, loneliness, and fear led to them eating more. Unfortunately the more weight they gained, the worse their self-esteem was and the more they became isolated. This created a cycle of increased PTSD symptoms involving an increase in eating.

He discussed the observations with the PTSD staff and sought volunteer help to create an outpatient PTSD/Obesity program. He found cooperation from the ACOS for Ambulatory Care to medically screen prospective veterans. Baseline data for these veterans included recent physical and routine labs and EKG. He measured their waists, weight (underwear only), height and calculated their BMI using the calculator at the Calorie Control Council's web site: <http://www.caloriecontrol.org/bmi.html> and then he calculated their target and maximum heart rates for the exercise portion of the program. He identified six veterans from individual or group counseling who had a problem with weight, had demonstrated compliance with weekly counseling sessions, and had expressed an interest in participating. The BMI's of the six ranged from a lowest of 35.08 to a high of 57.30. Waist measurements ranged from 43.7 to 70.25 inches. All the men were in an Obesity Class II to III with risks of Very High to Extremely High in terms of additional illness and sudden death. The initial weights ranged from a low of 250.7 to a high of 425.2 pounds.

The staff who volunteered are: Sandra Wollerton, Aquatic Therapist; K.C. Murphy, Kinesiotherapist; Elizabeth Hayden, Nutritionist; Devilen Jones, LMSW-ACP (PTSD Therapist); Lynda Smith, Occupational Therapist;

and Jamie Zabukovec, PhD (Psychologist). The group discussed what to do and then involved the six patients in helping to design the program.

The program runs Tuesdays, Thursdays, and Fridays. On Tuesday, they meet in Occupational Therapy for 1.5 hours (self image via art, task planning and completion, and low calorie meals/recipes with cooking and eating same); followed by 1 hour in the pool for range of motion and cardiovascular exercise in the water where joint problems are not aggravated. On Thursday, they continue with 1.5 hours of Occupational Therapy followed by 1 hour of nutrition information - portion sizes, types of food preferences, food exchanges. Additionally, they get behavioral therapy for making some of the changes necessary during that hour. After those two sessions, they repeat 1 hour in the pool. On Friday, they have 1 hour in Kinesiotherapy on mainly stationary bicycles (again to minimize aggravating joint problems). Friday ends with a 1.5-hour long PTSD Group, which ties the eating, craving and such with their PTSD symptoms. Mr. Weed co-leads this group and attends the two pool/Aquatic therapy sessions. All of this is done with only the cohort of these six present during each session at each site. Each of the six has been required to Journal their daily activities by headings, including: Thoughts/emotions/What and amount of food eaten, and What is physical activity and Time done.

The program started in June 2002. Since initiating the program, three men have dropped out. Two of the men who quit had experienced weight loss and increased self-esteem, but had outside interference requiring them to leave the program. One man who dropped out had gained weight and had new traumas in his life, which interfered. The other three continuing have lost from 10-30 lbs. All three report increased self-esteem, increased energy and one has had a reduction in blood pressure medication as well as his oral hypo-glycemics.

There are plans to involve the spouse/significant others and to include field trips to a cafeteria (monitor choices and portions) as well as to a grocery store (shop for healthier choices). Mr. Weed reports he is currently screening four more men to replace the ones who dropped out. Mr. Weed has made plans to consult Surgery for skin fold removal, if and when these men lose significant amounts of weight. He has found that, despite all involved being busy (and having no specific funding available with which to work), and with a little initiative, veterans and staff are creating an Integrated Program where the veterans are given permission to succeed.

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*John T. Weed, PA
PCT, VA North
Texas HCS*

Psychology and the VA

(Adapted with permission from an article by Dr. Raymond D. Fowler, APA Monitor on Psychology, September 2002)

Prior to WW II, the practice of psychology was poorly defined, lacked guidelines for training, and consisted primarily of scientists who investigated matters relating to human and animal behavior. Clinical practice was uncommon, and clinicians were not admitted to membership in the American Psychological Association (APA). The VA did not employ doctoral level psychologists.

WW II changed all of that. The enormous number of casualties with mental and emotional disorders demonstrated the need for skilled personnel to provide psychotherapy and rehabilitation. In 1943, Col. William Menninger, a prominent psychiatrist, advocated for mental health teams of psychiatrists, psychologists, and social workers. After the War, the VA was faced with 17 million veterans, many of whom needed mental health services, and set about trying to recruit psychologists to fill those positions. This was a difficult task, as the number of available positions exceeded the total of all qualified psychologists in the country! In 1946, the VA asked the APA to identify university psychology programs that could train clinicians at the doctoral level, and funded 200 graduate stipends for students in these programs. The APA began to admit clinical psychologists to membership.



*Richard T. Harvey,
PhD*

Thus began an explosive growth in the development of clinical psychology training programs throughout the country. By 1950, nearly half of all psychology interns were VA-trained, and 700 students were being supported by VA stipends. The number of VA psychologists had doubled to 300. The original 22 programs identified by the APA have now grown into 351 accredited doctoral programs, 461 internship programs, and nine postdoctoral programs. Today, the VA continues to fund graduate stipends in accredited clinical and counseling training programs. It employs 1200 psychologists, making the VA by far the largest employer of psychologists - a position it has maintained for decades. Despite pressures to lower standards, the VA was the first major employer to recognize and maintain the doctoral level for the employment of psychologists. Because of the size and prestige of the VA, that decision has had a profound impact on how the professions of clinical and counseling psychology were defined throughout the country. VA psychologists provide a wide range of services to patients, including preventive services such as smoking cessation, weight control, stress reduction, and other interventions aimed at health enhancement behaviors.

VA psychologists have been very active in the APA, and the partnership between the VA and the APA has been mutually beneficial. VA psychologists and the APA share common goals: helping psychologists provide the best services to their clients; promoting research on those services; advancing psychology through the promotion of psychologists to positions of influence; and supporting training for the next generation. This partnership has endured for more than five decades, and is likely to continue for many more.

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Monthly Prevention Topics

The NCHPDP will be sending monthly prevention topics to the field which will coincide with the National Observances. We hope these "patient-focused" prevention materials are useful. If you have ideas or questions, please contact Susi Lewis, Assistant Director, Field Operations at 919-383-7874, ext. 234.

January – Weight*

February – Heart*

March – Colorectal Cancer

April – Alcohol, STDs/AIDS

May – Mental Health

June – Vision/Glaucoma

July – Fitness

August – Immunizations

September – Gynecological/Prostate Cancers

October – Dental Health

November – Smoking

December – Drug/Drunk Driving & Accident Prevention

**These Patient Health/Prevention materials can be accessed on our website at www.nchpdp.med.va.gov.*

What is it I'm Supposed to Do? PMPC/VISN Leader Role Guidelines

Preventive Medicine Program Coordinator (PMPCs): The designated VA advocate for health promotion and disease prevention initiatives, programs, and activities at the local facility level.

VISN Preventive Medicine Leaders: The designated VA advocate for health promotion and disease prevention initiatives, programs, and activities at the local, state and national level.

Communicate, Initiate, Coordinate, and Champion Health Promotion and Disease Prevention



*Susi Lewis, MA, RN
Asst. Dir., Field
Operations*

Continued on page 12

Guidelines for Prevention Role – 20 Ways to Build Prevention in the VA

PMPCs

VISN Preventive Medicine Leaders

1. Provide health promotion and disease prevention information to appropriate and “need to know” parties throughout the medical center.	1. Provide health promotion and disease prevention information to appropriate and “need to know” parties throughout the VISN/nation.
2. Role model health promotion and prevention.	2. Role model health promotion and prevention.
3. Champion at least ONE major health promotion/disease prevention campaign per year.	3. Champion at least ONE major health promotion/disease prevention campaign per year, VISN-wide.
4. Coordinate/facilitate/delegate/support as many Health Promotion and Disease Prevention initiatives, programs & activities as possible: (Examples: health fairs; nutrition and obesity education and counseling; melanoma screening; healthy eating day; self breast and prostate exams education day; BP screening; flu shots; walk the stairs day; stop smoking campaigns; disseminating NCHPDP prevention topics; seat belt safety; depression screening day, cholesterol screening, etc).	4. Coordinate/facilitate/delegate/support as many Health Promotion and Disease Prevention initiatives, programs & activities as possible VISN-wide (Examples: health fairs; nutrition and obesity education and counseling; melanoma screening; healthy eating day; self breast and prostate exams education day; BP screening; flu shots; walk the stairs day; stop smoking campaigns; disseminating NCHPDP prevention topics; seat belt safety; depression screening day, cholesterol screening, etc).
5. Participate in NCHPDP education needs assessment.	5. Participate in NCHPDP education needs assessment.
6. Attend NCHPDP annual conference.	6. Attend NCHPDP annual conference.
7. Dial in to the monthly NCHPDP conference calls, to maintain connectivity with the VA Prevention community.	7. Dial in to the monthly NCHPDP conference calls, to maintain connectivity with the VA Prevention community.
8. Seek ways to become involved in health promotion activities outside your medical center/facility and into your community.	8. Seek ways to become involved in health promotion activities outside your medical center/facility/VISN and into your community.
9. Exchange successes/failures/best prevention practices with others, via NCHPDP conference calls.	9. Exchange successes/failures/best prevention practices with others, via NCHPDP conference calls.
10. Keep NCHPDP updated as to PMPC changes (roles, transfers, retirement, etc.). NCHPDP website and database updated monthly.	10. Keep NCHPDP updated as to VISN Preventive Medicine Leader changes (roles, transfers, retirement, etc.). NCHPDP website/database updated monthly.
11. Keep current on NCHPDP Website information on health promotion and disease prevention.	11. Keep current on NCHPDP Website information on health promotion and disease prevention.
12. The word is “Preventive,” not “preventative.”	12. The word is “Preventive,” not “preventative.”
13. Initiate communication with fellow PMPCs and others in your facility and VISN regarding prevention practices.	13. Initiate communication with fellow VISN PrevMed Leaders and others regarding prevention practices.
14. Champion the NCHPDP initiative “Putting Prevention Into Practice” (PPIP—Coming Soon)!	14. Support/Champion the NCHPDP initiative “Putting Prevention Into Practice” (PPIP— Coming Soon)!
15. Provide input and feedback on how the Center can improve prevention to veterans and other ways we can assist you.	15. Share your ideas about how our Center can help you promote prevention to veterans and other ways we can assist you.
16. Nominate a prevention colleague for “Prevention Person of the Year/Quarter.”	16. Nominate a prevention colleague for “Prevention Person of the Year/Quarter.”
17. Send us your picture electronically (JPEG) so we can post it on our website.	17. Send us your picture electronically (JPEG) so we can post it on our website.
18. Learn as much as you can about prevention. Become the expert.	18. Learn as much as you can about prevention. Become the expert.
19. Use the NCHPDP newsletter to share your successes/failures/best prevention practices with others.	19. Use the NCHPDP newsletter to share your successes/failures/best prevention practices with others.
20. Post a prevention question or comment on the NCHPDP website bulletin board.	20. Post a prevention question or comment on the NCHPDP website bulletin board.



Making a Difference in the Year 2003 Prevention Champion

*The VA National Center for Health Promotion and Disease Prevention is pleased to announce the quarterly **National Prevention Champion Award**, which will 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.*

Name of Nominee: _____

Where Employed: _____
Service, Department, Unit
Work Phone #
Email Address

Immediate Supervisor: _____
Name
Work Phone #
Email Address

Nominated By: _____
Printed Name
Signature
Work phone #

Please write a brief description regarding your nomination (on reverse side/blank sheet).

Some justification factors you may consider include:

- 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, has an impact and/or made a difference in prevention/health promotion to veterans served
- Someone you feel worthy of such an award, maybe a leader, a helper, a shaker and a mover who makes the impossible happen

The winners will receive:

- A Special Contribution Award
- Recognition in the HealthPOWER! Prevention News and the Magazine of Ambulatory and Primary Care
- Recognition at the DOD/VA Annual Prevention Training Conference in Albuquerque
- Recognition on the NCHPDP Website showcasing accomplishments
- An opportunity to visit the National Center for Health Promotion/Disease Prevention in Durham
- A BIG SURPRISE

1st Quarter:

Submission deadline: October 30, 2002
Award announcement: December 15, 2002

2nd Quarter:

Submission deadline: January 30, 2003
Award announcement: March 15, 2003

3rd Quarter:

Submission deadline: April 30, 2003
Award announcement: June 15, 2003

4th Quarter:

Submission deadline: July 30, 2003
Award announcement: September 15, 2003

You may submit nomination forms via:

*WEBSITE: www.nchpdp.med.va.gov
 EMAIL: susi.lewis@med.va.gov
 FAX: 919-383-7598
 MAIL: NCHPDP
 3000 Croasdaile Drive
 Durham, NC 27705
 ATT: Susi Lewis*

Questions? Please call (919) 383-7874 ext. 233 (Connie), or 234 (Susi).

Smallpox

“Smallpox is a serious, contagious, and sometimes fatal infectious disease. There is no specific treatment for smallpox disease, and the only prevention is vaccination.” (CDC)

Smallpox is caused by the variola virus. To transmit smallpox, direct (six feet or less) and prolonged (more than an hour) face-to-face contact is required. The incubation period following exposure averages 12 to 14 days.

About the disease:

Initial symptoms include malaise, head and body aches, sometimes vomiting, and fever (in range of 101 to 104 degrees Fahrenheit). An early rash appears, lasting about four days, with small red spots in the mouth and on the tongue. At this time, the person is most contagious. Around the same time, a rash appears on the skin, beginning with the face and spreading to arms, legs, and then hands and feet, usually within 24 hours. By day 3, the rash changes to raised bumps. By day 4, bumps fill with thick, opaque fluid and may have a depression in the center that resembles a bellybutton (a major distinguishing characteristic of smallpox). At this time, the fever may rise again and stay high until scabs form over the bumps. The bumps develop into pustules---sharply raised, round, firm to touch, as if there is a small round object under the skin. The person is contagious during this stage, lasting about 5 days. Pustules next form a crust and then scab. Most sores have scabbed over by the end of the 2nd week after the rash appears. As scabs fall off, they leave marks on the skin which become pitted scars. Scabs usually fall off within 3 weeks after the rash appears. Until all scabs have fallen off, the person is contagious. (Smallpox is most infectious during the first 7 – 10 days following onset of rash.)

About the vaccine:

- Smallpox vaccine contains live vaccinia virus (not smallpox virus) and is the same vaccine that was given until the 1980s.
- A single smallpox vaccination protects 95% of people within 10 days.
- If taken within 3 days after exposure, the severity of smallpox will be prevented or reduced in most people.
- Vaccine administered 4 to 7 days after exposure gives partial protection.
- Protection lasts 3 – 5 years after first vaccination.
- Protection after revaccination lasts about 10 years.

(NOTE: As a plug for Prevention, vaccines have saved more lives than any other medical invention, including antibiotics or surgery. Only clean water has saved more lives than vaccines.)

Physicians and other health care providers administering the vaccine will determine if someone should be medically exempted from vaccination, according to CDC, FDA, and other expert recommendations.

Possible vaccine side effects:

- Side effects are usually mild and include sore arm, fever, headache, body ache, fatigue, peaking 8 to 12 days after vaccination.
- In the past, approx 1000 of 1 million vaccinated people had serious, but not life-threatening reactions, usually by spread of vaccine virus elsewhere on the body.
- In the past, 14 – 52 of 1 million vaccinated had potentially life-threatening reactions, including serious skin reaction and encephalitis. Compared to first vaccinations, serious side effects are generally less common following revaccination.

VA Plans:

HHS is considering a possible 3-phase approach to pre-event vaccination program. The first phase will involve 500,000 health care workers. An estimated 10,000 of these are VA employees who would serve on Smallpox Response Teams and vaccination teams so that VA medical centers would be prepared to handle early smallpox cases. These plans are reviewed and revised regularly and are explained in various conference calls.

Website sources include:

- CDC website (www.cdc.gov/)
- The Military Vaccines Website (www.vaccines.army.mil/)
- To read more on the disease, go to <http://www.bt.cdc.gov/agent/smallpox>
- To read more about the vaccine, go to <http://www.bt.dcd.gov/agent/smallpox/vaccination/facts.asp>
- To read more about medical conditions that make pre-vaccination unadvisable, go to <http://www.bt.cdc.gov/agent/smallpox/vaccination/contraindications-public.asp>

The CDC has produced a 5 CD-ROM set based on satellite broadcasts from December 2002, providing basic information needed to implement a smallpox vaccination preparedness program which can be obtained via <http://bookstore.phf.org/prod250.htm>.

The CDC has also published guidance for clinicians on Smallpox vaccination and adverse reactions which can be accessed via: <http://www.cdc.gov/mmwr/preview/mmwrhtml/di52chal.htm> (for HTML version) or <http://www.cdc.gov/mmwr/pdi/wk/MMWRDispatch1-24-03.pdf> (for a camera-ready (PDF) version).

NCHPDP Staff

Weight Management/ Physical Activity Workshop

April 10 – 11, 2003

The NCHPDP is developing a **Weight Management/Physical Activity Training Workshop** to be presented **April 10 – 11, 2003**, in Durham at the Millennium Hotel.

The Minnesota Center for Obesity Research and Education (CORE) will present a 4-hour obesity training workshop, which will provide participants with state-of-the-art knowledge and skills in diagnosis and treatment of obesity. The NCHPDP will also present new materials developed for the VA national weight management and physical activity initiative (M.O.V.E. – Managing Overweight/Obesity for Veterans Everywhere). An opportunity to practice using these materials will be included in the workshop agenda as well.

The intended audience includes those VA staff who are interested in creating weight management programs at their facility or enhancing the content of existing programs.

The goal of the workshop is for participants to return to their facilities with resources needed to start new or enhance existing programs. Strategies will also be developed for possible barriers to implementation.

CME/CEU credits will be awarded for participation.

Registration forms will be emailed within the next few weeks.

Contact Rosemary Strickland at the NCHPDP if you have not heard about the program and are interested in attending.

National Women's Check-Up Day

May 12, 2003

The US Department of Health and Human Services (HHS) is planning the first **National Women's Check-Up Day** on **May 12, 2003**. This day is anticipated to help underserved women gain access to important preventive health care services and promote the President's long-range initiative to expand health care services for people without health insurance through local health centers. This day is expected to become a signature event for National Women's Health Week that begins the day after Mother's Day yearly.

National Women's Check-Up Day is being planned by a team of over 40 representatives from across HHS working together to improve the health of women throughout the nation. This team has identified potential service providers and related organizations, including 162 Veterans Administration Medical Centers, 840 CBOCs, etc., which will be encouraged to participate by offering preventive health services to women. The services may be offered in a variety of formats that can provide screenings as well as preventive health education and counseling. Participation in the event is voluntary.

The roles of the VA National Center for Health Promotion/Disease Prevention (NCHPDP) in this event will include:

- sharing information related to this event with the VHA facilities, primarily via the Preventive Medicine Program Coordinators (PMPCs);
- linking communication efforts between Women Veterans Program Managers and PMPCs to encourage planning of related events;
- sharing via the newsletter a "snapshot" of how the event was experienced across the nation.

The contact person for the NCHPDP is Susi Lewis, MA, RN, Assistant Director, Field Operations. She can be reached by email and by phone at (919) 383-7874, ext. 234.

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