MANAGING OVERWEIGHT AND/OR OBESITY FOR VETERANS EVERYWHERE (MOVE!) PROGRAM

1. REASON FOR ISSUE. This Veterans Health Administration (VHA) Handbook provides procedures for a comprehensive, evidence-based, population-approach, tiered, multidisciplinary weight management program at each Department of Veterans Affairs (VA) Medical Center and Community Based Outpatient Clinic (CBOC). ***NOTE:*** *Existing weight management programs that include all specified elements in this Handbook are acceptable.*

2. SUMMARY OF CONTENTS. This is a new Handbook defining the responsibilities and implementation of VHA's MOVE! Program. It designates the minimal core elements and the reporting mechanism and process required, whether MOVE! or an existing local program.

3. RELATED ISSUES. VHA Directive 1101 (to be published). ***NOTE:*** *See the website at:* http://vaww.move.med.va.gov/ .

4. RESPONSIBLE OFFICIALS. The Office of Patient Care Services (11) and the VA National Center for Health Promotion and Disease Prevention (NCP), are responsible for the contents of this VHA Handbook. Questions may be referred to 919-383-7874; FAX communication may be sent to 919-383-7598.

5. RESCISSIONS. None.

6. RECERTIFICATION. This VHA Handbook is scheduled for recertification on/or before the last working day of March 2011.

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MANAGING OVERWEIGHT AND/OR OBESITY FOR VETERANS EVERYWHERE (MOVE!) PROGRAM

1. PURPOSE

This Veterans Health Administration (VHA) Handbook defines the procedures for implementing a comprehensive, evidence-based, population-approach, tiered, multidisciplinary weight management program at each Department of Veterans Affairs (VA) Medical Center and Community-based Outpatient Clinic (CBOC), the Managing Overweight and/or Obesity for Veterans Everywhere (MOVE!) Program. ***NOTE:*** *Existing weight management programs that include all specified elements in this Handbook are acceptable.*

2. BACKGROUND

a. As part of Patient Care Services, the VA National Center for Health Promotion and Disease Prevention (NCP), located in Durham, NC, was established in 1995 as a field-based unit of VA Central Office per Public Law 102-585 (Ch 73, Sub II, Sec 7318, dated November 4, 1992), which mandates the NCP to:

(1) Provide a central office for monitoring and encouraging the activities of VHA with respect to the provision, evaluation, and improvement of preventive health services; and

(2) Promote the expansion and improvement of clinical, research, and education activities of VHA with respect to such services.

b. The United States (U.S.) Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity published in January 2001, stirred intense governmental and academic interest in research and the development of programs to address the nation's growing obesity epidemic. Poor diet and physical inactivity are presently a leading cause of preventable illness in the U.S. population, and these two behaviors contribute greatly to the development of overweight and obesity. The health care costs resulting from excess weight and physical inactivity are estimated at greater than $100 billion annually.

c. In the largest obesity prevalence study to date (a review of 1.8 million veteran medical records) in VA, the study found that "Obesity among American veterans is highly prevalent." Specific findings included the following:

(1) "Of the 93,290 women veterans receiving outpatient care at VA medical facilities in 2000, 68.4 percent were at least overweight (31.0 percent were classified as overweight, and 37.4 percent were classified as class-I to III obese)."

(2) "In the 1,710,032 men, the combined prevalence of overweight and obesity was 73 percent (40.1 percent were classified as overweight, and 32.9 percent were classified as class-I to III obese)."

d. The estimates of overweight and obesity in this study and other recent estimates suggest that the enrolled veteran population shows a higher prevalence of overweight and obesity than the general population.

e. Obesity contributes to the development and/or worsening of many conditions, such as diabetes, heart disease, and sleep apnea. VHA's mission is to provide quality, cost-effective medical care to all eligible veterans through its comprehensive, integrated health care system.

(1) In testimony before the Committee on Veterans' Affairs on March 17, 2005, Jonathan B. Perlin, MD, PhD, MSHA, FACP, then-acting Under Secretary for Health, stated, "VA's approach to the provision of health care, in general, is guided by an emphasis on the principles of health promotion and preventive care."

(2) In April 2005 at the Strategic Planning Summit, Dr. Perlin addressed this epidemic of overweight and obesity as a priority, considering all aspects of care including treatment and prevention of disease. "VHA will improve its enhanced preventive health with MOVE! to combat the epidemic of obesity (and diabetes)." Failure to assist veterans in managing weight and sedentary lifestyle affects current treatment and future demand for VA health care services.

f. Currently, there is no standard VHA weight management program. In accordance with its mission, NCP has assessed the status of overweight and/or obesity in VA and has developed a comprehensive, evidence-based, population-approach, tiered, multidisciplinary weight management program tailored to the VA population, based on the National Institutes of Health (NIH)-National Heart, Lung and Blood Institute Guidelines for Identification, Evaluation and Treatment of Overweight and Obesity in Adults. ***NOTE:*** *A detailed description of MOVE! can be found at: http://vaww.move.med.va.gov/.*

g. Existing weight management programs that include all specified elements in this Handbook are acceptable. MOVE! (Levels 1 and 2) can be implemented in facilities without a current weight management program to achieve compliance with VHA policy. Facilities with existing weight management programs can use MOVE! as a complement to ensure presence of the minimal core elements as described in this Handbook.

h. Evidence indicates that effective weight management programs must contain a combined focus on behavior, nutrition, and physical activity. In addition, minimal core elements include: population screening for overweight and/or obesity, multi-factorial patient assessment, multidisciplinary team approach, several intensities of patient-centered treatment, a lifetime approach to overweight and/or obesity consistent with the chronic care model (emphasizing maintenance and relapse prevention), consistent use of stop codes, station appropriate Information Technology (IT) representation, staff training, and programmatic reporting.

i. Ongoing national weight management program evaluation, with subsequent improvement and refinement based on accumulated data, field feedback, and the most current science, is necessary. Facility weight management program evaluation is monitored by periodic reporting mechanisms as identified in paragraph 8. ***NOTE:*** *Information from the reports is used to enhance best practices sharing.*

3. DEFINITIONS

a. **Body Mass Index (BMI).** The BMI adjusts weight for height using the following formula: weight (kilograms (kg))/height (meters $(m)^2$).

b. **Obesity.** Being obese is when there is an excessively high amount of body fat or adipose tissue in relation to lean body mass. Individuals with a BMI of 30 or more are considered obese.

c. **Overweight.** Being over weight is when there is increased body weight in relation to height, when compared to some standard of acceptable or desirable weight. Individuals with a BMI of 25-29.9 are considered overweight.

d. **MOVE!** Managing Overweight and/or Obesity in Veterans Everywhere.

4. SCOPE

A comprehensive, evidence-based, population-approach, tiered, multidisciplinary weight management program must be implemented within primary care clinics at each VA medical center and CBOC. Existing programs that include all specified elements in the Handbook are acceptable; they must:

a. Meet minimal core elements of an effective weight management program (identified in Section 7) , and

b. Provide timelines and expectations for reporting the weight management program updates.

5. RESPONSIBILITIES OF THE VETERANS INTEGRATED SERVICES NETWORK (VISN) DIRECTOR

The VISN Director is responsible for:

a. Relaying information to NCP regarding:

(1) The name, job title, address, fax, phone number, e-mail address, and other locator information of the VISN Weight Management Program Coordinator; and

(2) Any changes in that assignment.

b. Designating a VISN Weight Management Program Coordinator, who is required to provide a compiled annual report to NCP by October 30 of each year (see par. 8).

6. RESPONSIBILITIES OF THE FACILITY DIRECTOR

The facility Director is responsible for:

a. Relaying information to NCP regarding:

(1) The name, job title, address, fax, phone number, e-mail address, and other locator information of the facility Weight Management Program Coordinator; and

(2) Any changes in that assignment.

b. Designating a facility Weight Management Program Coordinator, who must submit an annual report to the VISN Weight Management Coordinator.

c. Ensuring Information Resource Management Service activates the mechanism that converts height and weight into BMI alongside other vital signs on the cover page.

7. WEIGHT MANAGEMENT PROGRAM REQUIREMENTS

The following have been determined to be the minimal core elements for implementation of VHA Weight Management Programs.

a. **Leadership.** To facilitate coordination, communication, and a consistent implementation of weight management programs across each VISN, the VISN Director designates a Weight Management Program Coordinator (at VISNs initiating MOVE!, this can be the VISN MOVE! Coordinator). At each facility, the medical center Director designates a facility Weight Management Program Coordinator (at facilities initiating MOVE!, this can be the MOVE! Program Coordinator) and a Weight Management Physician Champion (for facilities initiating MOVE!, this can be the MOVE! Physician Champion). The VISN and facility Weight Management Coordinators serve as facilitators for implementation of weight management programs at the VISN and local level. Coordinators also serve as principal points of contact for all Weight Management Program communications and reporting among the facility, the CBOCs, the VISN, the NCP, and other program offices.

b. **Multidisciplinary Team Approach.** Effective weight management programs include a three-pronged focus with patients: behavior, physical activity, and nutrition, in conjunction with overall medical care coordination. A multidisciplinary approach is essential and includes representatives from the following disciplines: Medicine, Nursing and Dietetics as well as disciplines with expertise in Physical Activity and Behavioral Health. A Weight Management Program Coordinator should be designated to oversee the activities of the team.

c. **Population Screening for Overweight and/or Obesity.** Veterans are screened for overweight or obesity at least once every 2 years during a primary care clinic visit. BMI is used to classify veterans as underweight (less than (<) 18.5 kg/m^2), normal weight (18.5 to 24.9 kg/m^2), overweight (25 to 29.9 kg/m^2), or obese (more than (>) 30 kg/m^2). The BMI calculation can be done automatically in the Computerized Patient Record System (CPRS) after staff inputs height and weight; however, intervention by the local facility Information Resource Management Service (IRMS) may be needed to activate the mechanism that converts height and weight input into BMI and displays BMI alongside other vital signs on the cover page. ***NOTE:*** *Clinical reminders may be helpful for staff to assign a BMI classification and add overweight or obesity to the problem list.* Overweight and obese veterans who would benefit from weight loss need to be counseled as to the risk of overweight and obesity and, if not contraindicated, offered participation in a weight management program.

d. **Multifactorial Patient Assessment.** In order to ensure an individualized treatment program for the overweight and/or obese veteran, a thorough inventory of food and beverage intake, physical activity habits, as well as personal and family history, self-efficacy, self-perceptions, and readiness to change with regard to weight management, must be assessed. In addition to major medical conditions, complicating factors and barriers to changing eating and physical activity behaviors need to be assessed also. ***NOTE:*** *At medical centers initiating MOVE!, the MOVE!23, a 23 item multifactorial patient questionnaire, may be used.*

e. **Several Intensities of Patient-centered Treatment.** Evidence indicates that the greater the intensity of intervention, the greater the impact in changing patient behavior. However, patient-determined intensity of treatment is essential. Stepped (tiered) care includes a variety of options from individual consultation with a provider to periodic group sessions. Ultimately, more intensive and invasive options can be offered, such as pharmacological agents, if medically appropriate.

f. **Maintenance and/or Relapse Prevention.** Maintenance strategies need to be developed since there should be a lifetime and lifestyle focus to any weight management program consistent with a chronic care treatment model. ***NOTE:*** *Consider establishing a sustained mechanism to track and follow-up patients.*

g. **Consistent Use of Stop Codes**

(1) In order to ensure consistency and to monitor workload, it is important to utilize MOVE! (Weight Management) stop codes for each encounter. Clinic profiles for MOVE! need to be established. After the first visit, return appointments for individual follow-up are to be credited to Stop Code 372.

(2) Use the following stop codes to identify a visit as MOVE!-related. These stop codes established in collaboration with members of the Decision Support System (DSS) council, can be used in either the primary or secondary (credit stop) position.

(a) 372 – MOVE! Individual Patient Visit,

(b) 373 – MOVE! Group Session, and

(c) 324 (physician) and 372, or 147 (nurses or ancillary) and 372 are the codes to capture weight management-related telephone activities.

(3) In order for workload data to be captured in national databases, it is important that MOVE! Clinics are set-up as "count" clinics (as opposed to non-count clinics) and that all MOVE!-related visits are checked-out.

(4) Suggested corresponding progress note titles include:

(a) Weight Management MOVE! Outpatient Initial Evaluation Note. This is to be used for the veteran's initial MOVE! visit, and include the MOVE!23 patient questionnaire or other designated assessments (in the absence of a designated assessment tool; the provider's narrative assessment); notation of discussion of the patient questionnaire with the patient; setting of initial weight management goal(s); scheduling of follow-up, either telephone or face-to-face.

(b) Weight Management MOVE! Outpatient Consult Note. This is to be used to close the consult for those facilities implementing MOVE! via consults. It may also be used for Level 1 or Level 2-related individual specialty consultations (dietetics, psychology, physical therapy (PT), medical specialists, etc.).

(c) Weight Management MOVE! Outpatient Group Note. This is to be used to document group sessions.

(d) Weight Management MOVE! Outpatient Individual Note. This is to be used to document an individual office visit. It can be used for Level 1 individual visit or Level 2- related individual specialty consultations (dietetics, psychology, PT, medical specialists, etc.).

(e) Weight Management MOVE! Telephone Note. This is to be used to document telephone follow-up.

h. **Facility and VISN-level IT Representatives.** The facility and VISN level IT representatives resolve problems at the local level and serve as liaisons with NCP to monitor weight management program efficacy. The representatives may include Clinical Application Coordinators (CACs), Chief Business Office (CBO) staff, Health Information Management (HIM) and/or IRMS staff, or others.

i. **Staff Training.** Training in weight management principles and techniques needs to be offered prior to program implementation, and periodically thereafter to provide updates and train new staff.

8. REPORTING REQUIREMENTS

The facility and VISN Weight Management Program Coordinators are expected to submit an Annual Report via: http://vaww.move.med.va.gov/srLaunch.asp (Report Control Number (RCN) 10-912). The report will include elements electronically extracted from clinical data sources. NCP provides VISN- and facility-level data on basic processes and clinical outcomes in a "scorecard" format on a quarterly basis. These reports will continue as long as the information is relevant.

9. REFERENCES

a. Managing Overweight and/or Obesity For Veterans Everywhere (MOVE!) Program Guide

b. Public Law 102-585 Ch 73, Sub II, Sec 7318, November 1992

c. MOVE! intranet website: http://vaww.move.med.va.gov/

d. Das, S. R., Kinsinger, L. S., Yancy, W. S. Jr., Wang, A., Ciesco, E., Burdick, M., Yevich, S. J. "Obesity Prevalence Among Veterans at VA Medical Facilities," American Journal of Preventive Medicine, 28, 291-294: 2005.

e. Statement of Jonathan B. Perlin, MD, PhD, MSHA, FACP, then-Acting Under Secretary for Health Department of Veterans Affairs before the Committee on Veterans' Affairs, United States Senate, March 17, 2005.

f. "Veterans' Health Care at a Crossroads: A Critical Assessment and Recommendations," VHA Strategic Planning Summit, Washington, DC, April 19, 2005, Jonathan B. Perlin, MD, PhD, MSHA, FACP, then-acting Under Secretary for Health, Veterans Health Administration, Department of Veterans Affairs.