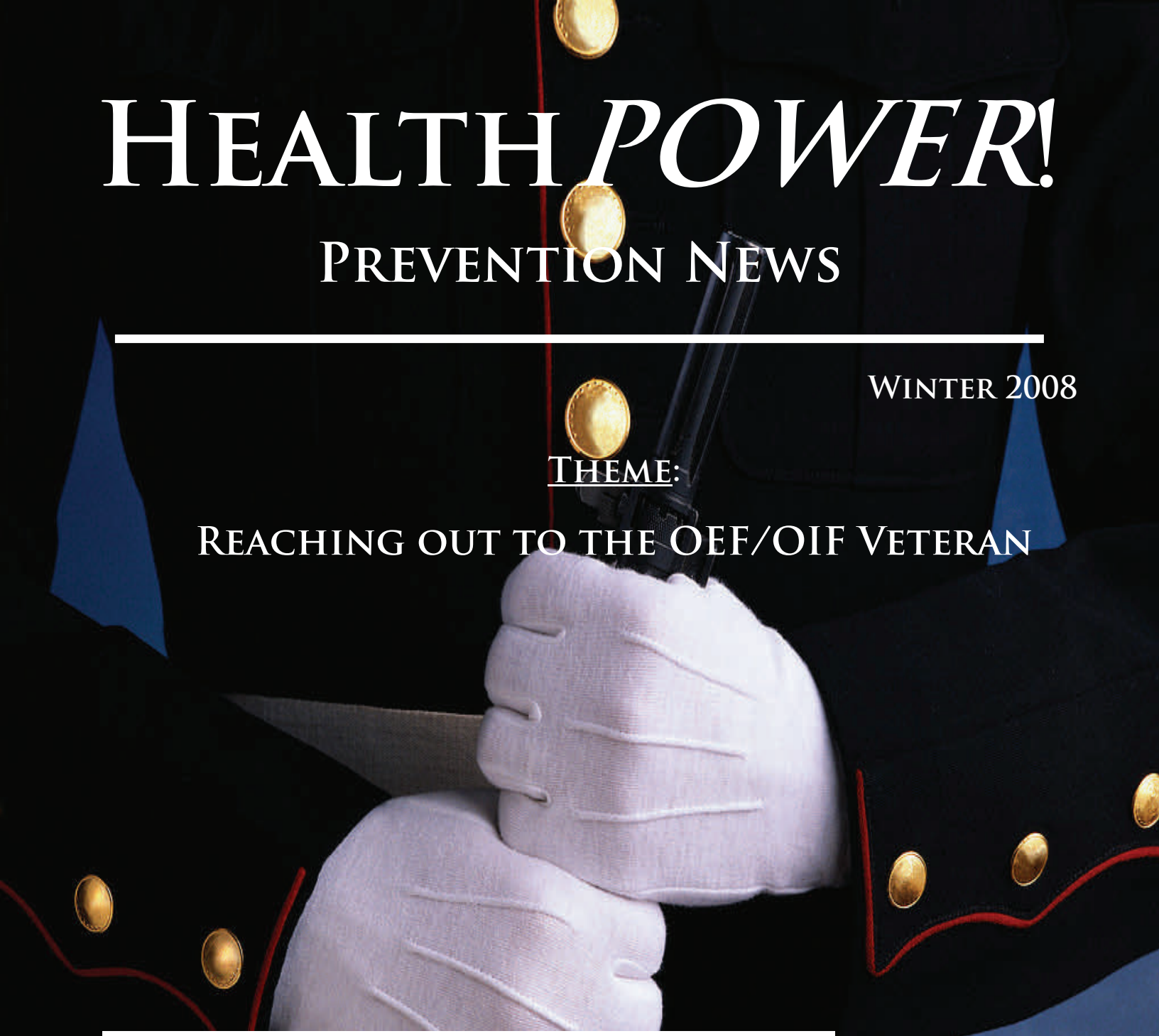
# HEALTH*POWER!*

## Prevention News

Winter 2008

**Theme:**

## Reaching out to the OEF/OIF Veteran



**In this newsletter:**



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# Letter From the Chief Consultant

Abraham Lincoln's pledge "to care for him who shall have born the battle…", made during his Second Inaugural Address in 1865, continues to be the guiding mission of the Department of Veterans Affairs (VA). VA honors the commitment and service and sacrifice made by all who serve our country (today that's both men and women). Veterans who receive VA health care now include a growing number of those who served in the current conflicts, termed Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF).

As discussed so well in this issue of Health*POWER!* Prevention News, these new veterans are facing myriad health challenges, some common to all veterans in combat situations and others that are more frequent among OEF/OIF veterans. VA staff are working hard to better understand these challenges and health needs and to find better ways to meet them. Dr. Straits-Tröster and colleagues describe their findings from conducting several focus groups with Active Duty and Reserve Component veterans in North Carolina. In addition to the treatment of physical and mental health conditions associated with deployment, these veterans also need a special focus on prevention – support to develop and maintain healthy behaviors to stay physically active, to eat in a healthy way, to quit smoking and drinking excessively, to adopt injury-preventing habits (such as wearing seat belts and not driving while drinking), and so on. These health-promoting behaviors will help both to mitigate other current physical and mental health conditions and to ward off the development of long-term chronic conditions, so common among older veterans.

Dr. Hunt describes the Post-Deployment Integrated Care Initiative, an approach being implemented across the VA healthcare system to provide integrated care for returning combat veterans. Whether delivered in discrete "Post-Combat Care Clinics" or by multi-disciplinary teams of providers in primary care clinics or by a multi-disciplinary consultation team, this system of integrated care is designed to comprehensively and efficiently meet the wide-ranging health needs of these veterans. By working together, VA providers and veterans can ensure that all their health needs are being addressed.

Here in the National Center for Health Promotion and Disease Prevention, a section within VACO's Office of Patient Care Services (PCS), we are also focusing our attention on this important cohort of veterans. Dr. Jones describes several new innovative products being developed by the *MOVE!* team to expand our ability to reach veterans with support for weight management outside of clinic appointments. Dr. Pries provides some valuable tips to keep in mind when writing health education materials for OEF/OIF veterans. Dr. Kahwati discusses important considerations for involving veterans in research opportunities. And Dr. Harvey reminds all of us of the way that we, as staff, can promote healthy living to these new veterans – by practicing healthy behaviors ourselves.

Other sections within PCS are also playing leading roles in the care of OEF/OIF veterans. The Office of Mental Health Services has initiated a nation-wide effort to prevent suicides among veterans, including a toll-free number for veterans to call when they need urgent help and suicide prevention coordinators in every facility. Rehabilitation Services has developed a network of polytrauma care centers across the VHA system, providing state-of-the-art care for veterans with multiple injuries and conditions. Dentistry Services has a program to provide dental care to recently-discharged soldiers. In April 2007, Primary Care initiated universal screening for traumatic brain injury for OEF/OIF veterans. Those who screen positive receive further evaluation by specialists in Neurology and/or Physical Medicine and Rehabilitation. Care Management and Social Work Services works with the Fisher House Foundation to provide families of veterans and service members a comfortable place to stay while their family member recovers in a military or VA facility.

VHA is committed to providing the whole continuum of care to our newest veterans, from prevention to comprehensive treatment to long-term care, when needed, just as we do for all eligible veterans. Meeting the special needs of OEF/OIF veterans is a challenge we are eager to take on every day.

*Linda*

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# Post-Deployment Prevention Needs and Health Concerns Among OEF/OIF Veterans



## Who are Our Newest Veterans?

As the Global War on Terror moves into its seventh year, 1.6 million men and women have served in Iraq or Afghanistan as part of America's all-volunteer fighting force.[1] Up to 75% of deployed troops have endured two or more deployments during the current conflict, which has continued longer than World War II. Repeated and extended deployments have been associated with increased physical and mental health concerns.[2]

Over 40% of eligible veterans from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) have already been seen in VA clinics and hospitals. Although only 3%–9% of veterans seen across VA healthcare networks are OEF/OIF-era veterans, they are an important and growing cohort of VA patients. They are ethnically diverse (over 35% minority), and include many more women (12%) than served in the Vietnam War (only 0.5% of Vietnam veterans were women). The OEF/OIF veterans range from 18 years of age to over 65, with an average age of 24. As they return from war zone deployments and/or separate from Active Duty components, they immediately become eligible for VA health care for 5 years for any condition potentially related to their service, and veterans with service-connected disabilities continue receiving benefits after 5 years. Because the VA has not been part of the culture of the Reserve component, VA outreach efforts through Post-Deployment Health Reassessment events (PDHRA), in collaboration with the Department of Defense (DoD), have been implemented to provide information about VA services to new veterans 30–90 days after their return from deployment. Currently about half of OEF/OIF veterans seen in VA facilities have served in National Guard or Reserve components. The combination of early VA enrollment, repeated post-deployment health assessments, improved communication with DoD and community partners, and novel outreach efforts presents the VA with a unique opportunity to help this new cohort of veterans with a variety of service-related health concerns. Similarly, we have a unique opportunity to identify prevention issues and provide early interventions to promote health and prevent chronic disease.

## What are Their Health Concerns?

The two most frequent diagnoses among OEF/OIF veterans presenting to VA clinics are: (1) musculoskeletal disorders, including joint and back pain often associated with military duties such as carrying heavy equipment and body armor over uneven terrain, and (2) mental health disorders, including post-traumatic stress disorder, depression, and substance abuse, usually first identified by a primary care provider.[3] The impact of acute and chronic pain may be associated with both of these presenting conditions. Most war veterans successfully transition to civilian life, yet all are affected by their war experiences.

Through a series of six focus groups with OEF/OIF veterans from both Active Duty and Reserve components residing in North Carolina, several themes representing common health concerns emerged. Participants reported sleep problems and difficulties with anger, irritability, concentration, and memory. Many described chronic joint pain, hearing loss, digestive problems, and weight changes—most frequently weight gain. Some digestive problems were attributed to

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**This month's feature article was contributed by : Kristy Straits-Tröster, PhD, ABPP; Brianna Gillikin; Harold Kudler, MD—Mid Atlantic Network's Post-Deployment Mental Illness Research, Education and Clinical Center (MIRECC)**

"When I get home I don't even want to be with my family. It's like I just go into my office area and work on my computers and stuff. Anybody really talks to me or anything like that, it just aggravates me."

# Post-Deployment Prevention Needs and Health Concerns Among OEF/OIF Veterans *(cont'd)*

*(Continued from page 3)*

bouts of dysentery while deployed, and concerns were voiced about food safety, exposure to smoke and toxins, mandatory vaccines and malaria prophylaxis, and exposure to desert insects and animals. Several women expressed concern about post-deployment fertility and miscarriages.

Changes in mood and frequent anger or irritability were often associated with marital and employment problems stemming from interpersonal conflict. In addition to direct impact on relationships with family and co-workers, the potential impact of readjustment problems, including depression and post-traumatic stress disorder (PTSD), on employment and related financial stress has emerged as a key issue for returning veterans. Further, exposure to blasts and other injuries have resulted in traumatic brain injury (TBI). It has been estimated that about 19% of returning service members may have experienced a TBI while deployed, and in one study 12% reported symptoms of mild TBI or post-concussive syndrome following deployment.[4] Symptoms of mood and memory problems overlap in mild TBI and PTSD, including difficulties with attention, concentration, recall, and temper, which can affect employment and educational options. Unemployment rates among veterans aged 20–24 years is 15%, three times the national average for this age group. These veterans may face difficulty transferring military skills to the civilian workforce or resuming their prior employment, also placing them at risk for homelessness.

"My wife has threatened to leave me if I don't see somebody about my anger issues."

## Behavioral Health Factors and Prevention Targets

Some of the same strategies that service members may use initially to celebrate homecoming or to cope with deployment or readjustment problems may emerge later as behavioral health risks. Recent analysis of longitudinal data from the Millennium Cohort study (June 2004–June 2006) revealed that heavy drinking, binge drinking, and alcohol-related problems were more prevalent among deployed troops with combat exposure.[5] New-onset binge drinking rates were greater than 25% among Reserve/National Guard troops; overall, younger service members and reserve component personnel with combat exposures were at highest risk of new-onset weekly drinking, binge drinking, and alcohol-related problems. Among OEF/OIF veterans seen at VA hospitals and clinics in 2005 who completed the Survey of Healthcare Experiences of Patients, 40% screened positive for potentially hazardous alcohol use on the 3-item AUDIT-C, and only 31% of these reported having been advised by their doctor to reduce their drinking.[6] Due to increased risky behaviors associated with alcohol use, including aggressive driving and inconsistent seatbelt use, routine assessment of alcohol and other substance use provides an excellent prevention target. Further, high rates of tobacco use have been reported both within active duty cohorts (up to 35%) and within VA OEF/OIF cohorts (31% smoked within past year, 24% currently smoking at time of clinic visit).[7] Tobacco is the most lethal and costly substance use disorder in the US, and routine tobacco use screening and effective smoking cessation treatment can promote health and well-being among this cohort of veterans, many of whom may be cared for by the VA for many years to come.

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# Post-Deployment Prevention Needs and Health Concerns Among OEF/OIF Veterans *(cont'd)*

*(Continued from page 4)*

Finally, the transition of fighting forces to civilian life includes drastic changes in dietary and physical activity routines. Widely reported post-deployment weight gain may present increased risk for chronic and acute joint problems, particularly for backs, knees, and ankles already worn or injured by extended physical duties with heavy gear and traversing uneven terrain. Support for healthy eating and routine physical activity are indicated for this cohort of veterans, and may mesh with their personal goals to reconnect with family, jobs, and peers as they transition to civilian life. Their health concerns warrant careful attention and the full range of programmatic health promotion support that VA can offer in collaboration with our DoD and community partners.

"My knees just started hurting when I got home."

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# *MOVE!* Weight Management Program for Veterans

## *MOVE!* Update

Our DoD colleagues tell us that our nation's heroes who are serving in OEF/OIF are some of the most technically savvy people they have seen. For example, during breaks in training, it is very common to see nearly all of the participants using technology to check and reply to emails, social networking website services, and cell phone/PDA text messages. Many of these veterans grew up in an era in which the Internet and wireless communication have been part of everyday life, not a new technology, and this has implications for *MOVE!*.

The basis of *MOVE!* is supporting veterans in the self-management of their weight, with VA staff providing support, guidance, and assistance with problem solving. We know that regular contact with the health care team is a predictor of success in weight management. In our evaluation of the provision of *MOVE!* care, we have found that facilities are struggling to provide this support, especially to veterans residing in rural settings who cannot readily participate in *MOVE!* groups due to transportation costs.

In preparing to assist these veterans with weight management, we must also prepare for the expectations of our "new" veterans—that support will be readily accessible and will use contemporary communication technologies. Congress has already recognized the value of providing web-based care. Focusing on the treatment of substance abuse disorders, Congress has directed the VA to establish web-based care for substance use disorders. Congress found that: "(3) Computer-based self-guided training has been demonstrated to be an effective strategy for supplementing the care of psychological conditions. (4) Younger veterans, especially those who served in Operation Enduring Freedom or Operation Iraqi Freedom, are comfortable with and proficient at computer-based technology. (5) Veterans living in rural areas find access to treatment for substance use disorder limited. (6) Self-assessment and treatment options for substance use disorders through an Internet website may reduce stigma and provides additional access for individuals seeking care and treatment for such disorders" (HR 5554, Sec. 4a; 2008).

The *MOVE!* team at NCP is working on "Tele*MOVE!*," through which *MOVE!* will use a variety of systems to communicate with patients. Three products are under development.

The first of these is **Home Telehealth Tele*MOVE!***, offered in conjunction with the Office of Care Coordination. **Home Telehealth Tele*MOVE!*** uses communication devices with a conventional telephone connection and provides a simple screen display, response buttons, and ports for medical devices such as electronic scales. The devices can interact with patients on a daily basis, providing information, asking questions, and prompting patients to refer to additional printed information provided with the devices. As with telephone calls, each device will prompt for weekly weigh-ins and will assess progress toward eating, physical activity, and behavioral goals. We are just now beginning to test the first vendor's device, and we expect these to be available to VISNs and Facilities soon.

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# *MOVE!* Weight Management Program for Veterans (cont'd)

*(Continued from page 6)*

On the horizon, we are working with VISN 2 to develop and examine what we call *MOVE!* Telephone Lifestyle Coaching or ***MOVE!* TLC**. In a clinical demonstration project, the Behavioral Health Assessment Center of the VISN 2 Center for Integrated Healthcare will receive funding for two health coaches to provide care to 600 patients for six months. Based on the findings of this project, we will provide guidance to other VISNs or facilities that wish to provide centralized care of *MOVE!* patients.

Finally, we have long-range plans to develop a **web-based *MOVE!*** program of care that would be hosted on My Health*e*Vet and integrated with CPRS. Although this project poses many technological, security, and logistical challenges, we are excited about the opportunity to expand our care to meet the needs and expectations of our current and new veterans.

Regardless of the technology used, the *MOVE!* Program is committed to maintaining the staff–patient relationship, or "human touch," that is so important in supporting lifestyle change and maintenance.

***Contributed by: Kenneth Jones, PhD***

**Upcoming Conference Calls**

*MOVE!* VISN and Facility *MOVE!* Coordinators Call
2nd Tuesday of the First Month of each Quarter
3:00 PM ET
1-800-767-1750, Access Code #59445

January 13


## *MOVE!* Weight Management Program for Veterans News

View a recent broadcast (Getting A MOVE On) by Keloland Television (Sioux Falls, SD) highlighting the MOVE! program:

http://www.keloland.com/videoarchive/index.cfm?VideoFile=1218086hb

# Prevention Practice and Policy

## Health Recovery For Returning Combat Veterans: Post-Combat Integrated Care

This article was written by:
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Co-Chair, National Technical Assistance Team and
National Director, Post-Deployment Integrated Care Initiative
VA Central Office

Individuals returning home from war face numerous health and readjustment challenges that must be addressed effectively to ensure successful re-integration into the community. Exposure to combat often results in both physical and mental health concerns (Table 1). Certain of these concerns are generic to all wars, while others are unique to specific conflicts (Table 2). Combat exposure can also affect veterans' marriages, family life, financial stability, vocational endeavors, and social functioning. Effective approaches to post-combat care must be systematic, and take into account all of these concerns.

Of the 1.6 million US military personnel deployed to Iraq and Afghanistan since 2003, over 850,000 are now eligible for VA health care and other benefits. The need for effective post-combat services for these veterans has been recognized by the Department of Veterans Affairs and is being addressed through innovative and effective programs for polytrauma/ rehabilitation care (for severe head and spinal cord injuries, amputations, burns, and serious mental health disorders), enhanced mental health services, comprehensive social work/case management, and suicide prevention programs.

Recently, to clarify and support the role of primary care provider in our system of post-combat care and to integrate and consolidate existing resources, VA Primary Care Services launched the Post-Deployment Integrated Care Initiative. This unique, systematic approach to post-combat care is being implemented in VA clinics and medical centers nationwide. In late 2007, an interdisciplinary Technical Assistance Team (TAT) representing all of the core service lines in the VA (rehabilitation/polytrauma medicine, mental health, social work, nursing, primary care, women veterans health, pain management, and addictions treatment) undertook a survey of "best practices" programs in the VA system. The TAT identified a number of programs using interdisciplinary approaches to provide integrated care for returning combat veterans. Such approaches, particularly when based in primary care settings, are well supported in the medical literature as being effective in treating individuals with physical/mental health co-morbidities, substance use disorders, and chronic pain concerns.

Using these "best practice" programs as templates, the TAT identified three effective variations of a post-combat care delivery model, all of which use interdisciplinary, integrated care teams to provide comprehensive initial assessments, collaborative treatment planning, and team-based follow-up. One approach is to have an integrated care team operate in a designated and discrete "Post-Combat Care Clinic" within the medical center; another is to have such teams formed from cadres of primary care medical providers, mental health providers, and social workers within primary care clinics; and the third is to have such a multi-disciplinary team provide assessments and consultation to mainstream primary care and mental health providers caring for returning combat veterans in mainstream primary care or mental health clinics.

Funds were provided through Primary Care to support the development and implementation of one of these three models in each VA medical center nationwide. In August 2007, a national training for post-combat primary care providers from each VISN was held in Seattle. Similar conferences are currently being held in each VISN to train clinical champions (designated teams composed of a primary care provider, a mental health provider, and a social worker in each medical center) to set up integrated post-combat care services in their centers.

These integrated care teams will provide initial post-combat assessments,

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# Prevention Practice and Policy *(cont'd)*

## Health Recovery For Returning Combat Veterans: Post-Combat Integrated Care *(cont'd)*

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collaborative treatment planning, and integrated long-term follow-up for returning combat veterans. Care is patient-centered and begins with an acknowledgement of the veteran's combat service. The initial post-combat assessment involves three components: a medical evaluation, a mental health evaluation, and a social work intervention. The medical assessment focuses on in-theater health risk exposures (Table 1). Risk exposures are documented and discussed with the veteran; in-theater and post-deployment health status are assessed and documented. A physical exam is conducted to determine both deployment-related and non-deployment–related conditions. The mental health assessment focuses on pre-deployment history, in-theater psychological trauma exposures, and post-deployment psychological and emotional functioning. The social work intervention includes a psychosocial inventory and identification of current psychosocial needs; information and assistance in accessing benefits are provided. Care management is instituted on the basis of the individual veteran's needs. A collaborative treatment plan is formulated and follow-up care is initiated. The team continues to provide direct care or ongoing consultation for the combat veteran until he or she is ready for transition into mainstream VA health care.

This approach to post-combat care has several key features and potential advantages. First and foremost, care begins with an acknowledgement of the veteran's combat service, establishing a sense of appreciation, common purpose, and mutual respect. The approach normalizes the post-combat re-integration experience, using a rehabilitative approach with goals of health recovery and successful re-integration of the combat veteran into the civilian community. Consolidating care enhances accessibility and acceptability of care. Returning combat veterans face a number of demanding challenges in their family, work, and social lives, and have limited time for medical appointments and treatments. Offering consecutive same-day appointments reduces resource-intensive trips that place unnecessary demands upon a veteran's valuable time. Integrating mental health care into overall care reduces the stigma often associated with receiving such care. Integrated post-combat care is transitional in nature, rehabilitative in orientation, global in scope, and collaborative in delivery; it is based on principles of health recovery, health maintenance, and preventive medicine. Integrated care programs generally can be implemented by restructuring existing primary care, mental health, and social work resources as well as enhancing integration of these services with polytrauma programs, mental health programs, suicide prevention coordinators, pain management assets, and addiction treatment services.

Collaborative care creates an environment of teamwork that models connection and integration for these individuals, many of whom have returned from war feeling as if their lives have "fallen apart." They feel disconnected from family, friends, and community. Combat veterans know full well the importance of coordinated teamwork when taking on a complex, important mission. Experiencing such teamwork among their health care providers as they navigate the challenging readjustments to post-war life may, in itself, offer a critical therapeutic contribution to the process of our combat veterans truly and fully coming home from war.

Our experiences caring for veterans from earlier conflicts have taught us a great deal about how war affects the health and lives of combat veterans. We have improved our approaches for treating the full spectrum of post-combat health concerns and we have the opportunity to

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### Table 1: Health Risks/ Exposures Associated with Combat

**Physical Factors**

Physical injury

High-intensity noise

Temperature extremes

Sleep deprivation

Diet

Austere conditions

Toxic agents

Infectious agents

Immunizations

Blast wave exposure/ concussions

**Psychological Factors**

Anticipation of combat

Combat-related psychological trauma

Non-combat–related psychological trauma (including military sexual traumas)

Separation from family, home, and other loved ones

**Psychosocial Factors**

Marital and family disruption

Financial challenges

Vocational impacts

Impairments in social networks

# Health Recovery For Returning Combat Veterans: Post-Combat Integrated Care *(cont'd)*

*(Continued from page 9)*

prevent and/or limit the long-term health impacts of combat on veterans returning from Iraq and Afghanistan. As a Department of Veterans Affairs and as a nation, we are positioned to provide the most effective post-combat care ever offered to individuals returning home from war. What greater tribute could we pay to those who have served and sacrificed so much in Iraq and Afghanistan than to do just that?

For more information or for assistance in establishing integrated post-combat care capabilities in your VA facility, please contact:

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or

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## Table 2: Common Health Problems Experienced by Combat Veterans

**Seen in all wars**

Physical injuries with associated chronic pain
Substance abuse disorders
Hearing loss and tinnitus (ringing in the ears)
Marital/family problems
Challenges in social functioning
Mental health conditions with elevated suicide risk
Non-specific physical symptoms
Dental concerns
Job-related and financial difficulties

**Unique to specific conflicts**

**WWII and Korean conflict:**

Cold weather exposure with cold related injuries due to deficiencies in equipment/protection

Flat feet: due to deficiencies in footwear

Peptic ulcer disease: due to lack of effective medications

**Vietnam War:**

Residuals of Agent Orange exposure

**Gulf War:**

Elevated rates of medically unexplained symptoms due to the nature of the conflict and associated toxic agent exposures

**Iraq/Afghanistan conflict:**

Memory and concentration difficulties (due to PTSD, concussions from blast waves, and non-specific causes)

**News from VA's Infection: Don't Pass it On (IDPIO) Campaign:**
The IDPIO team has developed a new brochure on hand cleaning. This brochure is intended for a general audience such as patients, their families, employees and others within the VA community. **NOTE**: This brochure is NOT intended to address specific hand decontamination requirements for health professionals caring for patients. The brochure is available for order through www.lms.va.gov. The order number for this brochure is F60754. IDPIO is pleased to announce that all the resources available for order are listed in a new catalog. A print copy of this catalog will be mailed in December to the same recipients of this year's "flu" manual (flu coordinators, occupational health, and infection control professionals).

**News from the US Preventive Services Task Force (USPSTF)**
The Task Force issued updated recommendations in three clinical areas in October 2008:

Screening for Colorectal Cancer (10/2008)
The USPSTF updated the previous 2002 recommendations for colorectal cancer screening. They now recommend that adults age 50 to 75 be screened for colorectal cancer using annual fecal occult blood testing, or sigmoidoscopy every five years with fecal occult testing between sigmoidoscopic exams, or colonoscopy every 10 years. Previously, there was no upper age limit for the screening. According to the Task Force, good evidence exists that using these methods for the age group of 50-75 saves lives. The Task Force recommends against *routine* colorectal cancer screening in adults between the ages of 76 and 85 because they found that the benefits of regular screening are small compared with the risks. The Task Force also recommends that adults over the age of 85 not be screened at all because the harms of screening may be significant, and other conditions may be more likely to affect their health or well-being. For people of all ages, the Task Force found insufficient evidence to assess the benefits and harms of computed tomographic (CT) colonography and fecal DNA testing as screening methods for the disease. Further, these Task Force recommendations don't apply to people with a personal history of certain types of polyps who are being monitored regularly for the condition or to those who have a family history of rare syndromes that increase a person's chances of getting colon cancer. For more information see http://www.ahrq.gov/clinic/uspstf/uspscolo.htm

The other recommendations that were issued include:

Behavioral Counseling to Prevent Sexually Transmitted Infections (10/2008). See http://www.ahrq.gov/clinic/uspstf08/sti/stirs.htm for details.

and

Primary Care Interventions to Promote Breast Feeding (10/2008). See http://www.ahrq.gov/clinic/uspstf08/breastfeeding/brfeedrs.htm for details.

**News from Agency for Healthcare Research and Quality (AHRQ)**
A new 2008 version of The *Guide to Clinical Preventive Services* is now available. The *Guide* includes U.S. Preventive Services Task Force (USPSTF) recommendations on screening, counseling, and preventive medication topics and includes clinical considerations for each topic. This new pocket guide provides general practitioners, internists, family practitioners, pediatricians, nurses, and nurse practitioners with an authoritative source for making decisions about preventive services. Single print copies of the pocket guide are available free from the AHRQ Publications Clearinghouse at: 1-800-358-9295 or AHRQPubs@ahrq.hhs.gov. Ask for *The Guide to Clinical Preventive Services,*

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**Upcoming Conference Calls**

**VHA Monthly Prevention Call**

2nd Tuesday of the Month,
1:00 PM ET
1-800-767-1750, Access Code #18987

January 13, February 10, March 10

# Prevention Practice and Policy News (cont'd)

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*2008* (AHRQ Publication No. 08-05122). You may also order single copies online at http://gold.ahrq.gov/eorders3/displayorderpage.cfm?prod_num=AHRQ%2008-05122

Two new AHRQ guides can help consumers and clinicians prevent and treat deep vein thrombosis. *Your Guide to Preventing and Treating Bloods Clots* is an easy-to read resource that helps both patients and their families identify the causes and symptoms of dangerous blood clots and how to prevent them. The guide is available in both English and Spanish. The clinician guide, *Preventing Hospital-Acquired Venous Thromboembolism: A Guide for Effective Quality Improvement*, is a comprehensive tool to help hospitals and clinicians implement processes to prevent blood clots.
Consumer Guide (English): http://www.ahrq.gov/consumer/bloodclots.pdf
Consumer Guide (Spanish): http://www.ahrq.gov/consumer/spblclots.htm
Clinician Guide: http://www.ahrq.gov/qual/vtguide/vtguide.pdf

*Checklists for Health*, available in English and Spanish. AHRQ and the American Association of Retired People (AARP) released two new checklists and an accompanying wall chart designed to help men and women over the age of 50 learn what they can do to stay healthy and prevent disease. *Men: Stay Healthy at 50+, Checklists for Your Health* and *Women: Stay Healthy at 50+, Checklists for Health* are available on the AHRQ web site at:
English: http://www.ahrq.gov/ppip/men50.htm and http://www.ahrq.gov/ppip/women50.htm
Spanish: http://www.ahrq.gov/consumer/men50sp.htm and http://www.ahrq.gov/consumer/women50sp.htm

New studies examining ways to improve the delivery of colorectal cancer screening in primary care settings were reported in the September supplement to *Medical Care*. The research featured in this supplement, *Improving Colorectal Cancer Screening Through Research in Primary Care Settings*, was funded by AHRQ and NIH's National Cancer Institute. Summaries of the articles are available on the AHRQ web site at: http://www.ahrq.gov/research/nov08/1108RA22.htm

### News from the Centers for Disease Control and Prevention (CDC):

Several Vaccine Information Sheets (VIS) have received minor updates. None of these changes affect the mandated purpose of VISs (i.e., to inform parents or patients about the benefits and risks of vaccines). **It is not necessary to replace existing stocks.** Some of the affected VISs are DtaP, hepatitis A, hepatitis B, Hib, HPV, pneumococcal conjugate, pneumococcal polysaccharide, polio, rabies, rotavirus, shingles, Tdap, typhoid, Td, and yellow fever. See http://www.cdc.gov/vaccines/pubs/vis/default.htm for more information.

### News from the Department of Health and Human Services (HHS):

An improved version of healthfinder.gov, a federal Web site, is designed to help people stay healthy and uses everyday language (English and Spanish) to tell users how taking small steps to improve health can lead to big benefits. It provides tools and encouragement, such as personal health calculators, menu planners and recipes. A new tool offered on the site is myhealthfinder, which provides personalized recommendations for clinical preventive services specific to the user's age, gender, and pregnancy status consistent with USPSTF guidelines. http://www.healthfinder.gov/

## The Key to Advances in Care for OEF/OIF Veterans

The Veterans Health Administration (VHA) has always been at the forefront of health care research, including biomedical, clinical, and health services research. This is particularly true for conditions related to military service. The VHA Office of Research and Development (http://www.research.va.gov) has four active research programs that represent a diverse array of projects investigating the spectrum of combat-related illness and injury. Further, the VHA is like few other organizations in that its portfolio spans all the way from basic bench science to the clinical bedside to systems of care delivery.

OEF/OIF veterans who choose to participate in research studies deserve a second round of thanks for their service. Because of them and the tireless efforts of VHA researchers, advances in the areas of traumatic brain injury, prosthetic limbs, post-traumatic stress disorder, military sexual trauma, are made possible. Patients are motivated to participate in research studies for lots of different reasons. But, deciding to participate in a research study can be difficult for some veterans. This may be particularly true for returning OEF/OIF veterans who are in the process of transitioning back to civilian life and who may be relatively new to the VHA health care system.

To assist, the VHA Office of Research and Development's Center on Advice and Compliance Help (COACH) is distributing updated versions of materials originally developed by the VHA Office of Research Oversight (formerly known as ORCA) to help veterans think through the process of volunteering for a research study. These materials include the following:

- Tri-fold brochures (3 ½ X 8 ½ ) in English or Spanish
- An 8-minute video in English (DVD, VHS) or Spanish (VHS)
- Posters (11 X 17 and 8 ½ X 11) in English or Spanish

These materials explain the basics of volunteering in research in general, including the following:

- What is a research study?
- Are there benefits to being in a research study?
- Are there risks or side effects in a research study?
- What questions should I ask before I agree to take part in a research study?
- What is informed consent?

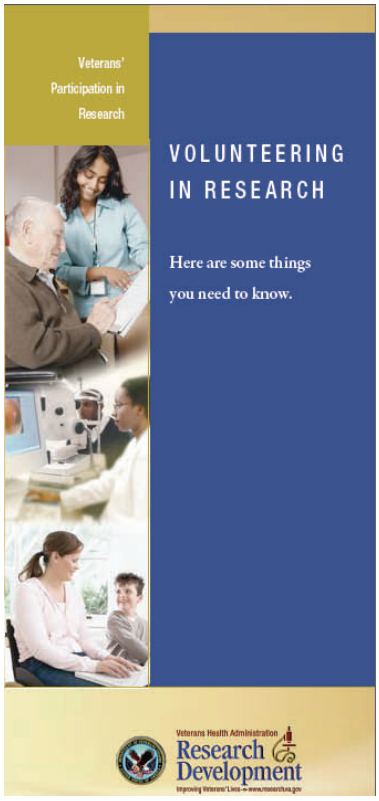
In the VHA health care system, veterans have the opportunity to participate in a wide variety of research projects that have the potential to improve health and quality of life for future generations of veterans. Advances in health care depend on the conduct of high-quality research and high-quality research depends on the adequate protection of human subjects. While the primary burden of obtaining informed consent for a specific study may fall on the shoulders of the principal investigator and his or her research staff, all of us can play a role in helping veterans better understand about volunteering in research.

To order these materials, please visit the following website: http://www.research.va.gov/programs/pride/veterans/default.cfm

***Contributed by: Leila C. Kahwati, MD, MPH***

"These brochures provide veterans with a balanced view of VA research and summarize veterans' rights and welfare if they decide to participate as subjects."

- Description from COACH website



# News Research and Evaluation News

## Contracts Awarded

NCP competitively bid and awarded two contracts at the end of FY08 related to *MOVE!* Program Evaluation and Research. The first contract was awarded to RTI International, Inc. for technical assistance associated with the national *MOVE!* Program Evaluation. RTI will assist the NCP with further developing technical specifications and analysis plans to identify program structure and processes associated with the best patient outcomes. Once identified, these "best practices" will be disseminated throughout the VHA system.

The second contract was awarded to Synovate to conduct the logistics associated with a survey of patients who have received treatment with the MOVE! Program. This research project is being conducted in collaboration with a number of VHA researchers with interests in the area of obesity and weight management. Findings from this survey will inform the *MOVE!* Program and be a useful contribution to the existing literature in the field of weight management, which is largely dominated by studies of younger, healthy, women.

## MOVE! Annual Report

Thank you to all facilities who submitted *MOVE!* Annual Reports for FY08. We received reports from 100% of facilities. We are currently in the process of summarizing this data and preparing FY08 Evaluation Summaries. These are anticipated to be available via the *MOVE!* intranet site in early February 2009.

## Survey of Facility Prevention Coordinators

VHA Handbook 1120.02 "Health Promotion and Disease Prevention Requirements" paragraph 4h specifies that reports on the status of prevention programs and special initiatives be submitted to NCP. We will be conducting the first collection of reports from all VISNs, VA Health Care Systems, and VA Medical Centers in January 2009. The purpose of the report is to help NCP assess the status of programs nationally to identify gaps, needs, and requirements for future policy, programs, and support for the field. Further instructions will be sent in January through the Office of the Under Secretary for Health for Operations and Management (10N) to VISN Directors, VISN Chief Medical Officers, Facility Directors, and Chiefs of Staff. While Directors are ultimately responsible for ensuring that reports for their facilities are submitted, we recommend that the VISN Preventive Medicine Leader (for each VISN) and the facility Prevention Coordinator (for each facility) complete the report. For a current listing of VISN Preventive Medicine Leaders and facility Prevention Coordinators go to the NCP intranet website:

VISN Preventive Medicine Leaders:
http://vaww.prevention.va.gov/ppractice/VPML_05_2008.pdf

Facility Prevention Coordinators:
http://vaww.prevention.va.gov/ppractice/FacilityPCs_05_2008.pdf

Please notify Kathy Pittman (Kathleen.pittman@va.gov) for any updates to these listings.

# Veterans Health Education and Information (VHEI)

## Issues to Consider in Developing Materials for OEF/ OIF Veterans

Caution! Before developing new health education materials for returning soldiers, check local, community, and national resources. A plethora of materials already exists for this group. The VA, DoD, and other military affiliated groups have developed a broad range of materials unique to this population.

In some cases, OEF/OIF veterans are being overwhelmed with such written materials as health education pamphlets, forms to fill out, benefit brochures, and screening check lists. PTSD, TBI, life-threatening injuries, pain, sleep problems, anxiety, and other challenges faced by these returning soldiers can impair the retention of new information and make it difficult to concentrate on the written word. Furthermore, returning to one's community, family, job, and way of life is already complex enough without having to wade through pages and pages of written (or web-based) materials to find what's needed. OEF/OIF veterans want easy-to-understand, targeted materials to meet their needs, when they want them, how they want them, and where they can find them quickly.

OEF/OIF veterans have grown up during the age of expanding technology. In combat, soldiers may have used high-tech devices like digital tracking programs, sophisticated night goggles, and smart weapons. Before they left for war and while in theater they may have used YouTube, iPods, MySpace, and other web-based activities for both business and pleasure. Upon returning home, technology is still an integral part of their lives. In fact, a VA web site may be the first contact an OEF/OIF veteran has with our organization. Use the questions below to review your current web site(s) to determine how appealing, user-friendly, and informative vets might find your information.

1. Is there a special page, site, or area for OEF/OIF vets? If so, how will they know where to find it?
2. If veterans have to link from the medical center's main page to another page, is this apparent and easy to do?
3. Is the site laid out in a way that's easy to read, understand, and navigate?
4. Who checks and monitors the web site to assure that it's functioning? If it's not working, does staff know who can fix the problem?
5. What does the layout of the page look like and convey?
   a. Does it include photos or pictures of OEF/OIF veterans—both in combat-related scenes and now at home?
   b. Are there pictures of the staff they might meet at the facility (OIE/OIF designated staff, others)?
   c. Are other types of media used in addition to the printed word, such as video, flash, and stories, to appeal to this group?
   d. Does the site honor veterans' service on behalf of a grateful nation?
6. How easy is it for veterans to find immediate help like suicide prevention numbers, emergency help, and hospital phone numbers (where an actual person will talk with them)?
7. Are common questions and answers specific to this group easy to find?
8. Does the site contain materials for family members?
9. How are topics of interest listed; can they be accessed easily?
10. If a veteran has a question or wants to make contact after reading the resources, is there a link or a way to do this?

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# Veterans Health Education and Information (VHEI) *(cont'd)*

*(Continued from page 15)*

11. Are materials timely and to the point?
12. Does the staff know about the site and the content of materials? Can staff help veterans navigate the site? Can they help veterans understand what the content means?
13. Are materials updated/changed to keep up with OEF/OIF concerns?
14. Are materials interactive?

Many of the tips used above to evaluate web materials can also be used to assess written materials. Simply giving a veteran a pamphlet or a link to a web site is not education. The educational materials should support, complement, and augment ongoing health education. Education can be enhanced when materials from the web are reinforced during a follow-up visit, phone call, letter, or e-mail.

More may not be better. A study by the Agency for Healthcare Research and Quality (AHRQ) reports that those health care providers who select only a few handouts are more likely to use them. Having a limited number of educational materials allows staff to become familiar with the content, know the important points to cover, and individualize information for each patient. Matching health education materials to the needs of the veteran requires that staff know the content of all materials they plan to use.
The following are a few examples of VA national websites for OEF/OIF Veterans:

(a) Operation Enduring Freedom / Operation Iraqi Freedom (OEF/OIF) Home - http://www.oefoif.va.gov/

(b) National Center for Posttraumatic Stress Disorder - http://www.ncptsd.va.gov/ncmain/index.jsp and

(c) My HealtheVet, Separation from Active Duty -https://www.myhealth.va.gov/mhv-portal-web/anonymous.portal?_nfpb=true&_pageLabel=healthyLiving&contentPage=healthy_living/oef_oif_intro.htm

To locate an example of an interactive health education booklet, see "Returning Home: A Guidebook for Service Members" at the following web site: http://www.ohiocares.ohio.gov/downloads/return.pdf

Remember: save time and effort before you develop new materials. Get input from your OEF/OIF veterans about which materials are most suited to their needs. Then pilot test the selected materials to ascertain if your modifications meet the target. Veterans want to help you care for them.

Effective communication with our returning soldiers means we treat them with dignity and respect (they tell us they want to us to do a better job in this area), invite them to be a partner in the health care treatment process, and use materials that are tailored to their specific needs. Incorporating all of the above into clinical practice provides a cogent, more effective, efficient, and compassionate way of providing care to our nation's newest heroes.

***Contributed by: Rose Mary Pries, DrPH***

## Upcoming Conference Calls

**VHEI Patient Education Hotline—1st Tuesday of the Month, 1:00 PM ET (1-800-767 1750 Access Code 16261#)**

January 6, February 3, March 3

**VHEI Patient Education Conference Call (1-800-767-1750 Access Code 19630#)**
Fourth Fridays of January, April, July and October, 1 pm ET

January 23

## Give the Gift of Wellness

The young men and women returning from the wars in Iraq and Afghanistan, as well as those having served in other locations and our reservists returning from deployment, are our newest class of veterans. Their unique needs will inform the future medical and psychosocial care provided by the Veterans Health Administration. Evidenced by the sadly pervasive, preventable chronic illness we see in our clinics every day, it is clear that a significant subset of past veterans were unable to maintain their good health, much of which would have been due to practicing a healthy lifestyle. Therein lies our challenge for the future! This holiday season, and every season, we can give the gift of wellness to our new veterans! We can assist and motivate our veterans, including those who have been seriously injured, to maintain or return to good health through engaging in frequent and robust physical activity, adopting healthy eating habits, maintaining a healthy weight, eliminating use of tobacco and abuse of alcohol or drugs, reducing excess stress, and enjoying healthy relationships.

Many of these new veterans are concerned with major problems such as unemployment, physical injuries and limitations, possible minimal brain dysfunction from blast exposure, troubled family relationships, PTSD, depression, other mental health issues, and more. They may not be thinking about a healthy lifestyle and how that relates to their future well-being. So how can we possibly give the gift of wellness to our new veterans? We know that a pill or a shot or a "procedure" or a "treatment" just won't get it. There is no magic pill. Use of motivational communication and educational strategies can help. But we also have the power of example! We can demonstrate a strong "wellness culture" in everything we say and do in our practice and in our contact with patients. This means we talk with our patients about healthy living in a non-judgmental fashion at every opportunity. Of course, talk is cheap. We must *show* our patients what it means to live a healthy lifestyle by our own example! We can use ourselves as models. Research has clearly shown that "modeling" (setting an example) is a powerful force and encourages others to imitate. There is no harm in telling a bit of our own story about how we came to change our health habits, so that we now engage in habits that support our good health and well-being. Perhaps the biggest challenge is actually to live the wellness lifestyle ourselves. If we don't do so, we certainly can't expect to motivate our patients to adopt and maintain health-promoting behaviors.

Just having the opportunity to tell others (briefly—remember, the attention is to be on the patient, not us) about how we maintain our good health through healthy habits is self-reinforcing and will encourage us to continue those habits. Having the support of our family and our peers also helps keep us motivated, as do talking often about our wellness lifestyle and simply noting how good our healthful behaviors make us feel. We must never take feeling so good for granted, and thinking often about how our health behavior contributes to feeling so alive and robust keeps us aware of that fact. Keeping a written record of our healthy behaviors—such as physical activity, what we eat, and so on—has also been

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# Employee Health and Wellness (cont'd)

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found to maintain motivation. At a very basic level, we know that behavior is supported by its consequences. Accordingly, we can give ourselves rewards that are contingent upon our behavior. For example, if we were to participate in a total of at least 150 minutes of moderate intensity activity for a week, we might reward ourselves by going to a movie, going shopping, going out to dinner, or doing some other desired activity.

In any case, living a wellness lifestyle is a matter of personal and professional pride. It greatly enhances our quality of life and our professional practice as well. Let's all give our patients the gift of wellness by giving it to ourselves first! Only then can the gift be given honestly and without reservation.

***Contributed by: Richard Harvey, PhD***

## Upcoming Conference Calls

**General Employee Wellness**
Bi-Monthly, 4th Tuesday—
2:00pm ET
1-800-767-1750 #63047

February 24

## NCP Staff Update:

**Angela Gathright** was recently selected for the position of Program Support Assistant. Angela is currently a Staff Sergeant in the Army Reserves and has previously held several positions with the Department of Defense. Angela comes to NCP with assets that include a BS Degree in Biology/ Chemistry and a myriad of highly creative skills in Administration. We're glad you're here Angela!

## New HHS Physical Activity Guidelines

The US Department of Health and Human Services recently released the new Physical Activity Guidelines for all Americans. HealthierUS Veterans is proud to be listed as a federal partner is support of the guidelines. Sue Diamond and Linda Kinsinger attended the HHS sponsored launch of the new guidelines in Washington DC on October 7, 2008. The basic message of the guidelines (for adults) is:

- For all individuals, some activity is better than none, but more is better.
- For substantial health benefits, do at least 150 minutes each week of moderate-intensity aerobic activity, or 75 minutes each week of vigorous-intensity aerobic activity.
- All adults should include muscle strengthening activities that work all the major muscle groups on two or more days per week.

To access the Guidelines and for information about how to promote them in your community, please visit: www.health.gov/paguidelines/

## Get Ready to Be Active Your Way VA!!!

NCP is planning to partner with Veterans Canteen Service again to sponsor another Champions Challenge. The 2009 Champions Challenge is being designed to promote awareness of the new Physical Activity Guidelines. The 2009 event will challenge participants to complete 150 minutes of moderate intensity physical activity for 8 out of 12 weeks between March 29, 2009 and June 20, 2009. We plan to launch the 2009 Champions Challenge at the 23rd National Disabled Veterans Winter Sports Clinic in Snowmass Village, Colorado.

## HUSV Mini Grant Update

The 41 HealthierUS Veterans mini grant recipients are submitting final reports on their projects during the month of December. These creative projects encourage healthy eating, physical activity and getting fit for life. Projects include stairwell enhancements, establishment of indoor and outdoor walking trails, fitness classes and equipment, healthy cooking demonstrations, health education projects and many others. NCP is working with a contractor to develop a digest of all the projects. Grant recipients have enthusiastically been reporting on their projects on monthly HUSV conference calls. For a complete list of grant project click on the following link: http://vaww.prevention.va.gov/HealthierUS_Veterans_Mini_Grants.asp

### Upcoming Conference Calls

**HealthierUS Veterans National Call**
3rd Tuesday of the Month, 3:00 PM ET
1-800-767-1750, Access Code #35202

January 20, February 17, March 17

**VA National Center for Health Promotion and Disease Prevention**
**Office of Patient Care Services**

**Chief Consultant for Preventive Medicine**—
Linda Kinsinger, MD, MPH

**Executive Assistant**—
Gregory Moore, SPHR
**Administrative Officer**—
Pamela Frazier, BS
**Program Support Assistants—**
Bobby Lucas
Angela Gathright
**Program Analyst**—
Connie Lewis
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**Program Manager for Community Health**—
Sue Diamond, RN, MSN
**Research and Evaluation Analyst**—
Trang Lance, MPH
**Program Manager for Health Promotion**—
Richard Harvey, PhD

**National Program Director for Weight Management—**
Kenneth Jones, PhD
***MOVE!* Project Coordinator, Contractor—**
Susi Lewis, MA, RN
***MOVE!* Dietitian Program Coordinator—**
Lynn Novorska, RD, LDN
***MOVE!* Physical Activity Coordinator—**
Sophia P. Hurley, MSPT
***MOVE!* Program Management Analyst** —
Tony Rogers

**Program Manager for VHEI—**
Rose Mary Pries, DrPH
**Health Education Coordinator—**
Pamela Hebert, DrPH, CHES
**Health Educator—**
Barbara Hebert Snyder, MPH


## Recent Events:

**November**
**11/6-7/08—US Preventive Service Task Force Meeting—Gaithersburg, MD—Kinsinger, Murphy**

**11/13-14/08—TBI Meeting—Washington, DC—Pries**

**11/17/08—National Commission for Prevention Priorities—Atlanta, GA—Kahwati**

**December**
**12/10/08—PCS Retreat—Warrenton, VA—Kinsinger, Kahwati, Jones**

**12/11-12/08—QUERI Meeting Phoenix, AZ Kinsinger, Kahwati**


VA National Center for Health Promotion
and Disease Prevention (NCP)
Office of Patient Care Services
Suite 200
3022 Croasdaile Drive
Durham, NC 27705


Postage

### NCP Mission Statement

The VA National Center for Health Promotion and Disease Prevention (NCP), a field-based office of the VHA Office of Patient Care Services, provides input to VHA leadership on evidence-based health promotion and disease prevention policy. NCP provides programs, education, and coordination for the field consistent with prevention policy to enhance the health, well-being, and quality of life for veterans.