



National Center for Health Promotion and  
Disease Prevention

# Health **POWER!**

## PREVENTION NEWS

Veterans Health Administration

Fall 2002

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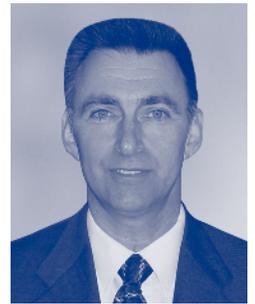
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## From the Director's Desk—

**V**A Preventionists – You are the VA Health-Guerilla Force! Night-fighters of the health-care scene. Yes, you're the ones who work beyond the front line, ideologically driven, using resourcefulness, innovation, and initiative. No harder mission to take on. No better place to be than beyond the Front! How are you!!!!??

What's the latest with the NCHPDP? I can't wait to tell you. I'll begin with the Center organization. I have a first-rate crew for which my pride is difficult to keep under humble constraints. The "A-Team", the "Dirty Dozen", Mission Impossible Force – all these monikers would be positive tributes to these guys who Never-Say-No. In fact, their attitudes are infectious – or they attract like-personalities – because all our work groups, students, associates and temp workers have a similar passion for Prevention and a desire to STOP disease. No arrogance; no elitism; no daintiness or squeamishness – they do what needs to be done to get the mission accomplished. I have to kick them out of the office every day!! What a luxury for a Director! You get the picture – so CHALLENGE US and join the team! Come on. Like a sports team, we want to play the hard teams to see how good we are, and to see where we need to improve. We have landed some new super-achievers on the team, and Chief of Staff (Dr. Burdick) will bring you up to date in this edition – new ways for us to get beyond the gravitational force.



New developments on the VA Prevention horizon? Every day brings a flood of more possibilities.

- 1) We're negotiating with AHRQ PPIP (Putting Prevention Into Practice) section to develop monthly packets of Prevention information on timely topics for PMPCs and VA Providers – and we're working with EES to get CEUs/CMEs assigned, too.
- 2) The Center is staffing an exhibit at AMSUS 11-13 NOV, and we're going to push Prevention, angle for cooperatives, and try to snare students, projects, and grants. Unconventional warfare. Guerillas in the bush!
- 3) Dr. Mary Burdick has been named the Prevention Consultant to the Office of the Nursing Service as an additional responsibility, and we'll be working to cinch a formal Nursing role in VA Prevention.
- 4) The NCHPDP represents the VHA on the President's HealthierUS initiative, and we're looking to get visibility for VA Prevention activities from the President and Mrs. Bush and the nation.
- 5) Have you been checking your VA pay stubs? We've had two Prevention messages printed (SEP and OCT) and have more in line for publication.

*Continued on page 2*

### **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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In this Newsletter issue, Susi gives an update on the NCHPDP/EES/CDC Flu/Pneumo Vaccine Toolkit that just hit the streets. We're already getting some good feedback from the kit, but remember, we need to evaluate the usefulness of this toolkit, and improve it or kill it, depending on provider, patient, and performance data.

That icon of Evidence-Based Prevention, Dr. Mark Helfand, gives a run-down on the USPSTF's osteoporosis recommendation. Along these lines, Susi, Rosemary and Connie put together the first Newsletter insert of VA Prevention recommendations. This will be part of the new PMPC Orientation Manual that the NCHPDP will be releasing soon, and updating constantly. It will be tied to the VA PMPC training course (still a secret).

Joe Streff provides the first of the Physician Assistant Consultant's column in the Newsletter, highlighting Becky Goldsmith for her work in Prevention. Joe and his army are experienced and staunch Prevention advocates, and we look forward to cementing further ties and cooperatives with the PAs.

This issue also includes articles in support of our Weight Management/Physical Activity push. Dr. David Leaf makes some key points about physical activity, mirroring the Center's attitude: "health" versus "buff"; physical activity vs physical exercise training; gym memberships ARE NOT NECESSARY; "lifestyle" is the key; "leisure time" is a time for physical activity, ...and "even fidgeting is exercise" – a now-clichéd comment at NCHPDP that captures the essence of our attitude towards activity. Just Move!!

Dr. Laurie LeMauviel provides an excellent submission dissecting Sweetness with history, science, and practical information. Just remember, "Shake it up!"

Dr. Rich Harvey keeps up the Center's strong commitment to addressing Behavior as the single greatest factor that can impact Prevention to the greatest extent. It is the traditional time of the year for Holiday Weight Gain, so proactively address it with the vets. Did you know what an important role the VA has played in the development of the field of Psychology? ...and, yes, Rich practices what he preaches, having led the way for VA participation in the AARP/NCHPDP Triumph Classic triathlon in Atlanta. Thanks to the assistance from the Atlanta VAMC (Brenda Sizemore, Cedrella Jones-Taylor, and Molly Reynolds), the NCHPDP staff manned a booth and passed out NCHPDP Triathlon T-shirts to participating VA employees.

Final thought for this edition. All VA healthcare workers are Role Models for the veteran patient population. You have to be CREDIBLE. You can't talk the talk if you don't walk the walk. Read on... You can't tell vets to get healthy if you don't show a desire to be healthy yourself; you can't tell vets to stop smoking if you're standing there smoking; you can't explain the need to lose weight and be physically active if you're not losing weight and being active yourself. HOW-EVER, along this vein, my best proponents for prevention are those who are fighting the problems themselves! Patients more readily identify with someone going through the same tribulations; credibility is instantaneous – therefore, use it to your advantage, and leverage your personal experiences to help others.

Drive! Drive! Drive!



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## Center Welcomes New Staff



*Mary Burdick, PhD, RN – Chief of Staff, NCHPDP; Prevention Consultant to the Office of Nursing Service (author)*

I am delighted and proud to introduce to you our two newest, and long awaited staff members at the Center, **Dr. Linda Kinsinger** and **Dr. Marie Richards**. Both Linda and Marie bring loads of expertise, energy and commitment to their respective programmatic areas in the VA National Center for Health Promotion and Disease Prevention (NCHPDP).

Dr. Linda Kinsinger is our Assistant Director for Policy, Programs, Training, and Education. Dr. Kinsinger is a warm and friendly person who listens well and is very wise. Linda was born in Ottumwa, Iowa and has three sons (Andrew, Peter and Jeff); ask her about her boys. And for those of you who know Dr. Russ Harris, Russ is Linda's husband. By the way, what famous TV character

from the MASH series was from Ottumwa, IA? Dr. Kinsinger is nationally known and well respected in the field of preventive medicine. She has developed and directed curriculum for preventive medicine training. In addition to her broad teaching experience with medical students, residents, and public health students, she has directed and tutored courses in epidemiology, prevention, and strategies of prevention for clinicians in a number of areas including elderly, colorectal cancer screening, smoking cessation, and preventive medicine updates. Her knowledge and wealth of experience is directly applicable to the veteran population. Dr. Kinsinger's research initiatives have focused on breast cancer prevention, adult immunizations and shared decision-making, to name a few. She already is a tremendous asset to VA NCHPDP as we develop health promotion and disease prevention programs based on quality outcomes and cost effectiveness. Linda keeps her word and delivers on her promises. At the NCHPDP, Dr. Kinsinger will develop and coordinate prevention training programs based from the National Center. She will be collaborating with academic institutions across the nation to establish training opportunities in preventive services for graduate students in various disciplines. She will also be responsible for developing a training course and materials about implementation of preventive services for the Preventive Medicine Program Coordinators. In addition, she will review and update policies for clinical preventive services, on an on-going basis.

Dr. Kinsinger joined the NCHPDP in October, 2002, after being on the faculty of the School of Medicine at the University of North Carolina at Chapel Hill for eleven years. She grew up on a farm in Iowa and is a graduate of Iowa State University in 1972 and the College of Medicine at the University of Iowa in 1979. She completed her internship in Internal Medicine at the University of Iowa and her second and third years of internal medicine residency at the University of Minnesota. She practiced general internal medicine with Park Nicollet Medical Center in Minneapolis-St. Paul from 1982 to 1987. She moved to North Carolina and completed her Master of Public Health degree in the Department of Health Behavior and Health Education in the School of Public Health at the University of North Carolina in 1990. She completed preventive medicine residency training at UNC in 1991 and



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

joined the faculty in the Department of Medicine. She held appointments in the Department of Social Medicine in the School of Medicine and the Public Health Leadership Program in the School of Public Health. She was Director of the UNC Preventive Medicine Residency Program, Co-Director of the Program on Prevention in the School of Medicine, and Director of the Health Care and Prevention MPH concentration in the Public Health Leadership Program in the School of Public Health, in addition to seeing patients in a UNC community-based practice. She also conducted research in implementing clinical preventive services in community practices.

Please contact Linda to discuss training about, policies for, and implementation of preventive services (919) 383-7874, ext. 222 (or email at [Linda.kinsinger@med.va.gov](mailto:Linda.kinsinger@med.va.gov)).



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

Dr. Marie Richards is our Assistant Director for Research. Dr. Richards is a Canadian transplant, originally from Pennsylvania, and now a longtime resident of North Carolina. She is one of eight children; three followed her to North Carolina, including one really adorable niece. Marie enjoys all types of dancing and has practiced most of them – medieval, ballet, ballroom, salsa, Argentine tango and belly dancing. She has settled on salsa, for now. Although generally quiet and reserved, she is not afraid to ask a guy to dance. In her spare time, she's also an "urban gardener", brown plants aside. Dr. Richards has expertise in many important prevention arenas,

including public health nutrition, cancer prevention, epidemiological population health studies, clinical trials, evaluation and data analysis. For the NCHPDP, Dr. Richards will spearhead prevention research collaborations and grant applications for NCHPDP, as well as mentor students in designing, funding, conducting and evaluating relevant preventive health services research efforts.

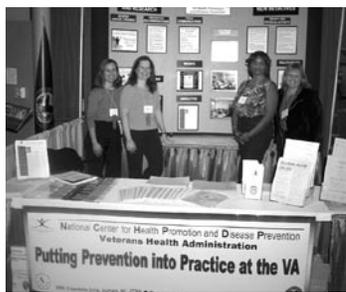
Dr. Richards received a MPH in public health nutrition (1995) and a Ph.D. in nutrition epidemiology (2000) from the University of North Carolina at Chapel Hill. She completed a National Cancer Institute fellowship in Cancer Prevention and Control at Wake Forest University School of Medicine in October of 2002. At Wake Forest University, Dr. Richards was involved in clinical trials related to prostate and colon cancer, follow-ups to community interventions, and population-based studies. Her research interests are diverse. She has focused on obesity, disease-related nutrition exposures, mental health, barriers to preventive health services access, tobacco control, complementary and alternative medicine, and obesity-related cancers. Dr Richards has experience with population-based studies and large data set management.

Please contact Marie to discuss your prevention research ideas at (919) 383-7874, ext. 237 (or email her at [Marie.Richards@med.va.gov](mailto:Marie.Richards@med.va.gov)).

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# VA National Center for Health Promotion and Disease Prevention “Walks the Walk!” for Prevention at AMSUS

The VA NCHPDP had a first-ever Prevention exhibit at the 108th annual meeting of the Association of Military Surgeons of the United States (AMSUS), November 11-13, in Louisville, KY. The Center’s presence along with the other booths represented by VA offices such as HSR&D, OAA, Knowledge Network, Center for Women Veterans, DOD/VA Clinical Practice Guidelines, etc. was noteworthy. In addition to showcasing our products and services to the almost 5000 attendees, we offered the Louisville VAMC use of the booth area to give flu shots right on the convention floor as a forum to opportunistically demonstrate Prevention in practice. You can’t get more convenient than that!



VA NCHPDP AMSUS display

After clearance by their general counsel and regional VISN Office, and local coordination by Vince Gayeski, Chief of Marketing and Consumer Affairs, Occupational Health staff Nyoka M. Emily, RN, and Brenda Warren administered a total of 226 flu shots over two hour intervals in two days. The overwhelming response again demonstrates that if Prevention is sold adequately, people will be interested in doing the right thing for their health.

In addition to providing flu shots, the NCHPDP booth highlighted prevention initiatives from the Center (including the NCHPDP/EES/CDC Flu vaccine toolkit), and distributed Center brochures, copies of the most recent VA and USPSTF prevention recommendations, information sheets and packets related to prevention, as well as pens with preven-



Charlotte F. Beason, EDD, Office of Nursing Service, receiving her flu shot from Nyoka Emily, RN, Louisville VAMC, while Susi Lewis, NCHPDP looks on

tion messages which change with each click. More than anything, however, the booth served to strengthen collaborative relationships between the NCHPDP and other DOD/federal offices, such as CHPPM, Hooah4Health, and the Office of the Surgeon General of the United States. Celebrated speakers and invited guests including Dr. Robert Roswell (USH VHA), Dr. Richard Carmona (Surgeon General of the United States) and his Deputy, RADM Ken Maritsugu, GEN James Peake (Surgeon General of the Army), MAJ Alfred Rascon (Congressional Medal of Honor recipient) visited our booth, offering the opportunity to discuss the importance of incorporating preventive health services in the VA and DOD health care systems, as well as highlight some of the Center’s prevention initiatives. Among the other numerous prominent visitors were Cathy Rick (Chief Officer Nursing Services), Dr. Irene Trowell-Harris (Director, Center for Women Veterans), Dr. Marianne Mathewson-Chapman, GEN Eric Schoomaker, and GEN Mike Dunn. During “VA-day”, Dr. Roswell addressed the critical importance of forging collaborative relationships and activities between the VA and the DOD, emphasizing the need to seek opportunities to synergistically capitalize on other governmental agencies’ on-going efforts to better address veterans’ health, while maximizing economy of effort and service. Our prominent participation at the meeting helped reinforce this imperative, and the success of this meeting for the Center has given us some ideas on how to promote PREVENTION at similar events in the future.



Dr. Robert Roswell, VHA Under Secretary of Health; Dr. Steven Yevich, VA NCHPDP Director



Dr. Steven Yevich, VA NCHPDP Director; Dr. Richard Carmona, US Surgeon General; Dr. Mary Burdick, VA NCHPDP Chief of Staff



Standing left to right: Pam Frazier, NCHPDP; Brenda Warren, Louisville VAMC; Dr. Steven Yevich, NCHPDP; Susi Lewis, NCHPDP; Ernest Emily, VA Volunteer, Louisville VAMC; Dr. Mary Burdick, NCHPDP. Seated left to right: Dr. Richard Harvey, NCHPDP; Eileen Ciesco, NCHPDP; Nyoka Emily, Louisville VAMC; Virginia Zele, NCHPDP

## The Exercise Challenge: Why Not The Physical Activity Alternative?



David A. Leaf, MD, MPH – Los Angeles, California VA Health Care System (author)

Participation in regular physical activity is highly recommended to improve our health and reduce disease risk. Unfortunately, for many people the term ‘physical activity’ is confused as synonymous with ‘physical exercise training’. Physical exercise training can be defined as participating in regular bouts of exercise aimed at improving physical performance, often with a competitive intent. Physical exercise training has two major performance components that can be grossly dichotomized as: 1) aerobic or 2) strength-based (resistive). Physical exercise training is a well-recognized modality that improves the important components of physical function.

High levels of aerobic exercise capacity, also known as aerobic fitness, are associated with increased longevity and reduced coronary artery disease risk. Physical strength is also recognized for its importance in health and well being. A recent study of 3,658 healthy men and women found the incidence of functional limitations after 5 years of follow-up, was lowest among those having higher levels of muscle strength. Physical exercise training may appear to be the most efficient way to increase human performance and improve health. Yet, promoting physical exercise training as a means of increasing physical activity from a public health standpoint has been unsuccessful: few, in fact less than 15% of us, are willing to participate in physical exercise training on a regular basis.

On the other hand, participation in regular physical activity is associated with increased longevity and improved health. Individuals who are more physically active have lower mortality and coronary artery disease risk than sedentary counterparts. This benefit extends to individuals who engage in regular physical activity of moderate intensity, that is without physical exercise training. Recent studies comparing ‘lifestyle’ physical activity intervention with conventional physical exercise training have found comparable benefits on weight loss, blood pressure and plasma lipids and lipoproteins. The benefits of regular physical activity can be accrued from regular participation in common leisure time activities such as walking, gardening, and tennis. Golfing has been shown to be a practical and safe form of physical activity with high adherence. Golfing improves aerobic fitness, promotes weight loss, and favorably effects plasma lipids and lipoprotein levels.

Should you join a gym to become more physically active? Current evidence indicates the answer is ‘No’! Long-term adherence to home-based exercise is virtually twice as high as group (i.e. gym)-based exercise. Therefore those who join a gym have a high likelihood of becoming ‘exercise drop-outs’ as is typically the outcome of New Year’s ‘join a gym’ resolutions.

The work place, although not a ‘leisure time’ environment, offers potential opportunities to increase your physical activity and can also serve as an opportunity for you to serve as a role model to co-workers and patients. People with busy work schedules who often complain that their

work activities leave them with little personal time for leisure activities might be able to squeeze in a few minutes for physical activity on a daily basis. Traditionally we have been advised that continuous, aerobic-based activity of 30 to 40 minutes each day is necessary to improve our physical health. Although this may be ‘optimal’, health benefits can also be gleaned by accumulating 30 to 40 minutes of aerobic physical activity during the course of each day.

Recent findings show that exercising 3 times a day for shorter periods of time results in more weight loss than exercising once a day for a longer period of time. In other words, you can lose significantly more weight by walking 10 minutes a day 3 times than 30 minutes each day non-stop. One way to get in 10 minutes before and after work is to park your vehicle in a lot that is distant to your work site. Your lunch break may also provide you with another walking opportunity. Participating in group walking activities can add components that can ensure long-term success:

- goal setting and self-monitoring;
- building social support;
- behavioral reinforcement through self-reinforcement and positive self-talk;
- structured problem solving; and
- relapse prevention.

Stair climbing is also another opportunity for physical activity. Some may be intimidated by potential safety issues in stairwells and put off when the location of stairways is inconvenient or inaccessible. Pro-actively identifying stairwell access can make this an excellent elevator-replacement that adds another dimension to your workplace armamentarium of physical activity resources. A quick climb up and down a flight of stairs will strengthen both your legs and your cardiovascular system.

The important message is if you feel exercise-challenged, why not consider a simple and effective exercise alternative? Why not become physically active?

**Additional information from the Task Force on Community Preventive Services regarding physical activity is available on the Internet at <http://www.thecommunityguide.org>.**

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## How Sweet It Is... Or How Sweet Is It?



Laurie LeMauviel, MD –  
Asheville, NC VAMC (author)

Anyone who's lived long enough to witness the explosion of the products created by the food industry can tell you life's sure sweeter than it used to be. The WWII vets talk about savoring a piece of penny candy, or the excitement of getting enough change together to treat a favorite girlfriend to a Coke. Now, any trip through the market can find you dwarfed by towers and surrounded by shopping carts of sugar-loaded foods and gallon-sized soft drinks. To many, especially diabetics, it's no secret that eating these foods - candy, soft drinks, donuts, sugar-coated cereals - sends blood sugar soaring. But many don't know that starchy foods and refined

grain products - chips, crackers, white bread, potatoes - do the same thing. The worrisome news is that a diet that chronically spikes blood sugar over time can lead to obesity and diabetes, and make these problems hard to control later. But this is not another "everything can kill you" message advocating that you amputate yet another entire category of foods from your diet. It's simple advice based on emerging scientific understanding of how we get fat and how we get diabetes. The story goes like this:

- In healthy people, the level of sugar in the bloodstream determines how much insulin is secreted. Sugar in the blood supplies all body tissues with vital energy. Insulin, a hormone made by the pancreas, regulates blood sugar, within safe limits. Insulin stashes excess blood sugar in storage to protect the body from the toxic sugar highs and lows, which can be deadly. How high the sugar gets in the blood after a food is eaten can be measured qualitatively by the *glycemic index* or **GI**, and quantitatively by the *glycemic load* or **GL**. When blood sugar levels are high, the body responds by making **lots** of insulin to lower the sugar level.
- **High levels of insulin over time dull the body's sensitivity to the hormone, requiring first more insulin to do the same job of storing sugar, and eventually wearing out the pancreas. Diabetes occurs when the pancreas can no longer keep up.**
- High insulin levels are being blamed for worsening obesity (especially that around the beltline); decreases in good cholesterol (HDL) and increases in triglycerides (another fat implicated in heart attacks); and even breast and colon cancer! Diets having a high glycemic index defeat attempts at weight loss by several means. They tend to be lower in bulk and fiber and are less satisfying. The insulin spike that follows a meal with a high GI results in blood sugar lows that send a signal that it's time to eat again. Both these responses lead to more eating.

**So, why not eliminate carbohydrates all together, in favor of foods with very low or no GI like some popular diets recommend?** Anything that advocates dietary extremes like whacking an entire group of nutrients from your diet should make you suspicious. Substituting foods containing high levels of saturated fat could be disastrous for an obese population already at high risk for heart disease and stroke. And high protein diets can be hard on the kidneys and lead to progression of

osteoporosis, especially in couch potatoes. Besides, carbohydrates from whole foods contain many other useful vitamins and minerals that you'd miss, and "carbs" are economical and abundant. Carbs are "in" again. So moderate, don't eliminate.

**So now, do I have to memorize a whole list of numbers - the GI of everything - to eat?** No. Eating the low glycemic way is simple and mostly common sense. While you can obtain books and articles that have GI measurements, you should know that the GI is an estimate. The GI varies slightly according to growing conditions and plant species, and greatly according to the production specs for a particular manufactured food product. Ocean Spray cranberry juice and Coke are sweeter in America than in Australia. So it is more useful to think in simple terms. Think moderation (remember that healthy eating is only part of a healthy lifestyle that includes exercise, connection with others, and activities that interest us). Think fiber. Think "whole" food - the way it occurs in nature - with its peeling, bran, wheat germ intact.

- 1) **Re-learn what a "treat" is.** Most of you will not eliminate birthday cake or an occasional soft drink from your diets. That's where the common sense comes in. Your daily habits are what will get you. Eating several pounds of sugar per week and lots of snack foods is a powerful and unnecessary way to destroy health. You have the power by your example to influence your family and better everyone's health by taking a stand on what's in the cupboards.
- 2) **Avoid added sugar.** Some of the popular cereals and instant oatmeals contain more sugar ounce for ounce than an average soft drink. Start reading package labels. Ratchet down your "glyco-stat" over time. You can start by mixing cereals or add a little of your own sweetener as you adjust your taste buds. Add fresh fruit to cereal or yogurt instead of sugar.
- 3) **Whole grain products contain fiber and other things white flour products lack that slow absorption and give a more moderate blood sugar response.** These whole grain pastas, breads, tortillas, rice, crackers and cereals, and flours are found increasingly in the local grocery, and at natural food groceries in bulk. Buy grain products like flour in quantities you can use in a reasonable amount of time. Store airtight or in the freezer. Again, if the family goes nuts when you switch to whole wheat pasta, start by mixing regular pasta with whole grain, gradually increasing the whole grain portion. This allows time to adjust to the texture. Don't be tricked by savvy marketing - not all brown bread or "wheat bread" or even "whole wheat bread" is made from the whole grain. If it doesn't say 100% whole wheat, read the ingredients to see what it's made from. Remember "organic" is not synonymous with "healthy." Check the sugar content and order of ingredients on the package.
- 4) **Get acquainted with lesser-known grain products:** brown rices (many different types), wheat bulgur, whole wheat couscous, quinoa, barley, oats and rye; and legumes like lentils, garbanzos and other beans. Many of these foods are being marketed in easy-to-prepare packages, but it's cheaper to do it yourself if you have a few tools. Learn how to use a rice cooker or pressure cooker to make whole food preparation fast and easy. Check out some cookbooks from the library and experiment with seasoning and flavors.

- 5) **Don't stop at "Five A Day" for servings of fruits and vegetables.** Expand your repertoire of choices by tasting some vegetables you haven't tried before. Splash your plate with color - as many different ones and as deep in color as possible. Opt for the whole fruit rather than the juice - it has a lower GI and is more satisfying.
- 6) **Shake it up!** Don't get stuck in a fast food or lunchbox rut. Substitute a piece of fresh fruit or some vegetable slices for your usual bag of chips or snack crackers in your lunch. Buy a thermos and take leftover soup or dinner foods with some fruit and vegetables instead of a sandwich; eat a salad; wrap leftovers or sandwich fixings in a whole-wheat tortilla - a "wrap."

Laurie LeMauviel, MD  
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## In future editions of the Health **POWER!** Prevention News, look for:

- **Mind/body/SPIRIT** prevention connection from the Chaplain Center
- **Updates on Education** activities from the Assistant Director: Policy, Programs, Training and Education
- **Updates on Research** endeavors from the Assistant Director, Research

# Surgeon General Report on Smoking and Women

A new report entitled "Women and Smoking: A Report of the Surgeon General" has been released, and is decidedly worthy of our attention. Conclusions of interest to the VHA:

- Smoking prevalence among women averaged 22% in 1998, but is almost three times as high (32.9%) among those with limited education and lower socioeconomic status than among women with high educational and socioeconomic status. There remain clear racial and ethnic differences in smoking prevalence.
- Lung cancer surpassed breast cancer in 1987 as the leading cause of cancer death among women, and it still is.
- Women are just as likely as men to want to stop smoking, and to successfully do so.
- Among women, fear of weight gain, depression, and the need for social support are all factors associated with continuing to smoke, cessation, or relapse.
- The effectiveness of smoking cessation interventions is NOT different among genders.
- The adverse health effects of smoking are similar among men and women, except that women who smoke also suffer from increased risks for cervical cancer, menstrual function problems and adverse reproductive outcomes.
- The severity of adverse health outcomes from smoking is directly dose related.
- Nicotine's addictive effects appear to be equal among both men and women. Severity of addiction is also directly related to dose.
- In 2000, 29.7% of high school senior girls reported smoking. Not much progress in initiation of smoking among youth has been made.



Richard T. Harvey,  
PhD – Asst. Dir.,  
Preventive Behavior

It is not surprising that smoking remains a major issue for female as well as male veterans. Access to smoking cessation services may be a significant barrier to female veterans' efforts to stop smoking. One could speculate that demands related to daytime childcare or work and home responsibilities might be significant barriers. Identifying and responding in creative ways to eliminate major barriers to accessing services deserves our attention.

The full report may be viewed at [www.cdc.gov/tobacco/sgr/sgr\\_for\\_women.htm](http://www.cdc.gov/tobacco/sgr/sgr_for_women.htm).

For questions, the point of contact at the VA National Center for Health Promotion and Disease Prevention is Dr. Richard Harvey, phone # below.

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## VA Participates in AARP “Triumph Classic” Triathlon

A strongly encouraging fact is that the American Association of Retired Persons (AARP) is, and has been, actively promoting prevention and health enhancement messages, education, and activities for its members. One such activity is the “Triumph Classic”, which is a mini-triathlon event that AARP sponsored at 15 sites throughout the United States this year. The events feature a 400 meter swim, a 20 K bicycle ride, and a 5 K run/walk, and are officially sanctioned by the USA Triathlon organization. Participants may complete the entire course themselves, or team up with others to complete one of the three courses each. Although it is an official race, the event is meant to be a fun way to highlight the joy of being physically active. VA Preventive Medicine Program Coordinators, and others interested in prevention throughout the VA, have all been made aware of these events, and some have responded by encouraging participation by VA patients and employees. At the Decatur, GA VAMC, Brenda Sizemore, Dr. Cedrella Jones-Taylor, and Molly Reynolds distributed Triumph Classic brochures, put up posters, and sent out e-mail messages to staff.



Triangle Classic in progress

Several staff members from the VA National Center for Health Promotion and Disease Prevention (NCHPDP) attended the Triumph Classic event on September 29th, held at Lake Lanier Islands, GA. One staff member competed in the triathlon, as well as another staff member’s spouse. To their delight, T-shirts emblazoned with the NCHPDP, AARP, and the HealthPOWER! Prevention Club logos were distributed to veterans who were competing in the event. And fun was had by all!! The course was challenging; the swim course was held in Lake Lanier, where the water was 74°! The bike course was hilly, with the run-



NCHPDP staff setting up the booth at the Triangle Classic

ning course somewhat less so- but the scenery there was really beautiful. People of all ages competed; some were seen wearing their VA/AARP/HealthPOWER! t-shirts, and the real joy of physical activity was seen everywhere! Participating in an event like this makes one know they are alive!

Upcoming Triumph Classic events are being held in Phoenix on December 8th, and in Honolulu on December 15th. The AARP plans to hold these fun events again next year as well, and veterans and VA staff are strongly encouraged to participate! Visit their website at [www.aarp.org/triumph](http://www.aarp.org/triumph).

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## Holiday Weight Gain – Oh Noooo!

Studies have consistently demonstrated that people tend to gain some weight over the holiday season. This is generally attributed to over-consumption of sweets, alcohol, and holiday meals, as well as disruption of physical activity routines. Nobody sets out to make this happen! So, what to do? Try these things:

- Constantly seek to **be mindful** of your freedom to **make sensible choices** about what to eat, drink, and spend your time doing.
- **Be prepared**; plan ahead with some alternatives to overeating and inactivity.
- Remember that **parties are about people**– not food!
- **Eat some healthful food** (fruit, cereal, etc) just **before** leaving for a holiday party or holiday meal. Don’t go there hungry...
- Serve yourself a **small plate** of (hopefully healthful!) food from the party table, and then move to another area for conversation. Try to avoid hanging around the food table.

- **Keep a (non-caloric?) drink** in your hand at parties instead of plates of food.
- Insist on **serving yourself** at holiday meals; take **small portions** of many food items if you choose. Avoid hanging around the table after the meal.
- Invite others to **take a walk** with you after a holiday meal. If nobody is willing, go anyway and be proud that you are a good example for the others!
- If you make doing some **physical activity a high priority** in spite of the busy holiday schedules, it will happen!

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## Osteoporosis Recommendations

The U.S. Preventive Services Task Force (USPSTF) recommends that women aged 65 and older be screened routinely for osteoporosis. The USPSTF recommends that routine screening begin at age 60 for women at increased risk for osteoporotic fractures.

In September 2002, the USPSTF recommended screening for osteoporosis in women 65 years of age or older and at age 60 for women at increased risk for osteoporotic fractures. They based their recommendation on the results of a systematic review, conducted by Dr. Heidi Nelson and Dr. Mark Helfand of the Portland VAMC. This review found that there were no studies that directly link screening for osteoporosis with improved outcomes. However, the reviewers found good evidence that accurate tests to diagnose osteoporosis are available and asymptomatic women over 65 who have osteoporosis have been shown to benefit from treatment.

For postmenopausal women who are younger than 60 or women aged 60-64 who are not at increased risk for osteoporotic fractures, the Task Force found that the balance of benefits and harms of screening and treatment is too close to make a general recommendation for this age group. Specifically, the short-term risk of fracture is low in these groups, and the long-term safety and effectiveness of drugs to prevent fractures is not clear.

Many tests are available to diagnose osteoporosis. Among different bone measurement tests performed at various anatomical sites, bone density measured at the femoral neck by dual-energy x-ray absorptiometry (DXA) is the best predictor of hip fracture. This test has the advantage that it was used to select women who participated in the randomized trials showing that treatment could reduce the risk of hip fracture. Other technologies for measuring peripheral sites include quantitative ultrasonography (QUS), radiographic absorptiometry, single energy x-ray absorptiometry, peripheral dual-energy x-ray absorptiometry, and peripheral quantitative computed tomography. Recent data suggest that peripheral bone density testing in the primary care setting can also identify postmenopausal women who have a higher risk for fracture over the short term (1 year). Further research is needed to determine the accuracy of peripheral bone density testing in comparison with dual-energy x-ray absorptiometry (DXA).

Bone density test results are expressed as Z scores or T scores. Good-quality studies indicate that clinicians do not always interpret bone density tests correctly. A T score describes a patient's bone density relative to that of healthy, young women. The average bone density of a 50-year-old woman is lower than that of a 20-year-old woman. For this reason, when expressed as a T score, a 50, 60, or 70-year-old woman who has **average** bone density for her age will have a "low" (negative) T score. A Z score expresses a patient's bone density relative to other women her age; therefore, by definition, a 50, 60, or 70-year-old woman who has average bone density for her age will have a Z score of zero.

Available trials that reported fracture outcomes have examined the efficacy of bisphosphonates (alendronate and risendronate), estrogen, and selective estrogen receptor modulators (raloxifene) and calcitonin. A meta-analysis<sup>16</sup> of 11 randomized trials<sup>17-27</sup> involving a total of 12,855 women, found that alendronate significantly reduced vertebral fractures (RR, 0.52; 95 percent CI, 0.43-0.65), forearm fractures (RR, 0.48; 0.29-0.78), hip fractures (RR, 0.63; 0.43-0.92), and other nonvertebral fractures (RR, 0.51; 0.38-0.69). There were nonsignificant trends toward reduction in hip fractures. No randomized trial of treatment for osteoporosis has dem-

onstrated an impact on mortality. One trial in women aged 70-79 with very low bone density (T-score less than -3) reported that risendronate reduced the risk for hip fracture (RR, 0.60; 95 percent CI, 0.40-0.90). To estimate the benefits of routine screening for women in different age groups, the USPSTF used estimates from recent studies to project the number of fractures that would be prevented over 5 years from screening and treatment of a hypothetical cohort of 10,000 postmenopausal women. For women aged 55-59, more than 4,000 would need to be screened to prevent 1 hip fracture and more than 1,300 to prevent 1 vertebral fracture. For women older than 60, the number needed to screen to prevent 1 hip fracture is 1,856 for women aged 60-64, 731 for women aged 65-69, and 143 for women aged 75-79. The benefits of screening improve substantially in older women because osteoporosis is both more prevalent and more likely to lead to a fracture in older women.

There are no direct comparisons of alendronate and estrogen or raloxifene that report fracture outcomes. Small randomized clinical trials of estrogen indicate mixed results for fracture outcomes. A good-quality study of raloxifene reported a reduced risk for vertebral fractures (RR, 0.59; 95 percent CI, 0.50-0.70). The strongest evidence about the ability of treatment to prevent fractures comes from the Fracture Intervention Trial (FIT), in which alendronate reduced the risk for hip fracture in the subgroup of women who had a T score of -2.5 or less. In selecting a treatment for an individual patient, the clinician should keep in mind that, while the risks of estrogen treatment have been proven by well-done randomized trials, the long-term risks of alendronate and raloxifene are not known.

**The USPSTF's recommendations, and the systematic review they are based on, are available at <http://www.ahrq.gov/clinic/3rduspstf/osteoporosis>**

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*Watch for information about  
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*Coming soon to our website:  
[www.nchpdp.med.va.gov](http://www.nchpdp.med.va.gov)*

## VA Influenza/Pneumococcal Resource Toolkit Phase II

The VA National Center Health Promotion/Disease Prevention (NCHPDP) has taken the lead in system-wide implementation of standing orders for pneumococcal and influenza vaccinations within VHA. Promotion of interventions such as “Standing Orders - Pneumococcal and Influenza Immunization Programs for Veterans” which will improve the rates of pneumococcal and influenza vaccination among veterans is entirely consistent with VA’s goal of promotion of veteran receipt of preventive services.



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

VA NCHPDP and Dr. Kristin Nichol at the Minneapolis VA collaborated with the National Immunizations Program of the Centers for Disease Control and Prevention (CDC) to develop a demonstration project aimed at increasing rates of influenza and pneumococcal vaccinations among veterans. One facet of the demonstration project was developing and disseminating the Resource Toolkit. With valuable and timely assistance from VA Employee Education Service (EES), thirteen VA staff volunteers from across the nation assembled with VA NCHPDP staff in July, 2002 in Durham, North Carolina to develop the Toolkit. There were three phases to the project.

The **first phase** involved the developing of a generic, high-quality, ready-to-use toolkit that included materials for local and national advertisement campaigns. The team’s enthusiasm and energy were evident throughout the process, which involved weekly conference calls, ongoing refinement of the contents, and the costing/production of the toolkits.

The **second phase** of the project was to promote and disseminate finished toolkits. Influenza/Pneumococcal Vaccination promotion activities included:

- Weekly e-mails from VA NCHPDP to key individuals;
- Announcement by Dr. Yevich presented on 9/27/02 Director’s Conference Call;
- Employee Leave and Earning Statement on pay period 17.

The Influenza/Pneumococcal Resource Toolkits were mailed to VAMCs on October 18, 2002. Each Medical Center received 2 toolkits and each CBOC received a CD Rom that included all manual contents and CDC posters. A new record was set – the toolkits were developed and disseminated in just 4 ½ months!

**Third phase: we want feedback from staff who implemented influenza vaccination programs at your site!** We intend to provide revised and improved materials based on your evaluations. Dr. Yevich encourages the team to evaluate if we are doing the right thing and spending money wisely.

Please give us your evaluative comments via the postcards (included in the toolkits), e-mails via Outlook (Susi Lewis, Rosemary Strickland, Connie Lewis), fax (919 383-7598) or phone (919 383-7874, ext. 233, 234, 239).

**Thanks again to all those who have helped in bringing this toolkit to fruition!  
A great health promotion effort!**

**Remember: protect yourself, your patients, and your family members by getting the influenza vaccination this fall!**

By Susi K. Lewis RN, MA; Rosemary Strickland RN, MSN; Mary Burdick RN, PhD.



Toolkit team members left to right: Herry Peters, Karen Allen, Joyce Frederick, Joan Foley, Sharon Kelley, Rose Mary Pries, Molly Aldassy, Linda Danko, Isabel Duff



Other members: Rosemary Strickland, Eileen Ciesco, Susi Lewis, Sue Sucharski, Geraldine Weiss, Sherry Peters, Karen Allen, Joyce Frederick

## Depression and Substance Abuse Toolkit

A comprehensive “toolkit” for the management and treatment of depression, and substance use disorders, has been produced as a joint effort of the VA and the Department of Defense, under the auspices of the VA/DOD CLINICAL PRACTICE GUIDELINE initiative. The “toolkits” have been sent to each facility prior to a satellite broadcast on those topics which occurs Sept. 4th. The materials include clinical guidelines, algorithms, implementation aids, and abundant information on these topics. Take a look! The VA National Center for Health Promotion and Disease Prevention recommends the use of these excellent materials, which are as follows:

- A large loose-leaf folder on management and treatment of substance use disorders, including the clinical guidelines, a bound manual on substance abuse among older adults, a bound manual on brief interventions for substance abuse in primary care, miscellaneous resource material, and some related reprints.
- Another bound manual on substance abuse among older adults, and a guide for substance abuse services for primary care clinicians.
- Large desk reference cards, and small pocket reference cards for diagnosis and treatment of substance use disorders.
- Another large loose-leaf folder on management and treatment of depression, with clinical guidelines for primary care, outpatient, and inpatient mental health settings. Also included are other related materials, manuals for implementation of clinical guidelines, and a separate manual on depression from the Institute for Healthcare Improvement.
- Large desk reference cards, and pocket reference cards for identification and treatment of depression.
- A third loose-leaf folder with guidelines for prevention of suicide.
- Pocket cards for assessing and managing suicide risk.
- Patient information brochures on depression.
- Several copies of 6 different posters about depression.
- Two videotapes on depression, and two on substance use disorders.
- A CD on depression from the VA, and a CD on evidence based medicine from the Department of the Army.

The point of contact at the NCHPDP regarding the use of the toolkit is Richard Harvey, Ph.D. The contact at EES is Donna Schoonover, Ed.D. at (314) 894-5735. Additional kits may be ordered through your Education Service.

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*October 4, 2002 was National Physician Assistant Day. On that day in 1967 the first class of PA's graduated from Duke University in North Carolina. "As of June 30, there were 1310 full-time physician assistants in the VA health care system. They are an important part of the VA health care team. They take medical histories, perform physical examinations, order and interpret lab tests, diagnose and treat illnesses, suture lacerations, assist in surgery, and write prescriptions in nearly all states. Because of all the tasks they perform, doctors are able to treat more patients. With waiting times a priority, physician assistants are proving to be a valuable asset for veteran's health care." (Information taken from 10/4/2002 VACO Broadcast)*

*PA's also have an important role in Prevention/Health Promotion. The next article highlights the activities of one PA practicing prevention.*

## Physician Assistant Promotes Prevention



*Rebecca Goldsmith,  
PA-C*

In April of 1995 Rebecca Goldsmith, PA-C, was appointed to the position of Preventive Medicine Program Coordinator (PMPC) by Dr. David Lee at the Boise, Idaho VA. Initially the position included improving on the delivery of preventive services to patients and filling out an annual written report. How quickly things changed! With Dr. Kizer's emphasis on the delivery of primary care and preventive services, this position would soon evolve into one of increased importance. Performance measures, EPRP reviews and Clinical Reminders soon evolved.

In August 1996, the VA's first annual Preventive Medicine meeting brought together all the local PMPCs and the Patient Health Education Coordinators. This meeting provided a great setting for collaboration between these two groups. Becky has been an active participant at all the annual meetings since 1996, with poster presentations, workshops and a didactic session.

Though she is Primary Care based, Becky also works in Dermatology and has applied her skills to skin cancer prevention. Since transferring to the Salt Lake City VA in the summer of 2000, she has diagnosed over 400 skin cancers, including 14 malignant melanomas. Early recognition is important with melanoma, since the cure rate approaches 95% if treated in the early stages. She has given talks on the early diagnosis of skin cancer to the primary care providers and placed melanoma handouts in the primary care areas in Salt Lake City and its staffed CBOCs. She also created a "Prevent Skin Cancer" poster for the clinic where she sees Dermatology patients. She is amazed by how many patients do not use sunscreen, even those who have been treated for skin cancer. The key to skin cancer is prevention and early recognition. This is best achieved by educating patients and providers. She always does a "waist up" skin examination since most skin cancers occur in sun exposed areas and melanoma has a prevalence for the back. Becky is one of several PAs that serve as PMPCs for their facilities.

*By Joseph O. Streff, PA-C*  
*PA Advisor to the Undersecretary of VHA*

## Prevention Champion of the Quarter Prevention Champion of the Year

The VA National Center for Health Promotion and Disease Prevention (NCHPDP) has established the Prevention Champion Award Program. This program gives Medical Centers and VISN's the opportunity to quarterly and annually recognize and reward Prevention Staff for their outstanding contributions. The NCHPDP has allocated 5 (quarterly and annually) "Prevention Champion" awards for the upcoming year. So, think for a moment about who the "Prevention Champions" are in your Medical Center and VISN - those people that "make a difference" in prevention or health promotion. Your "Prevention Champion" might be a leader, a helper, a shaker and a mover who makes the impossible happen.

### *Who should be nominated?*

- 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, had an impact and/or made a difference in prevention/health promotion to veterans served
- Someone you feel is worthy of such an award

### *The winners will receive:*

- a special contribution monetary award
- recognition in the HealthPOWER! Prevention News
- recognition at the DOD/VA Annual Prevention Training Conference in Albuquerque, New Mexico
- recognition on the NCHPDP website showcasing their prevention accomplishments and contributions

Stay tuned as the selection criteria, nomination form, and submission dates are announced via e-mail. For additional information, please contact Susi K. Lewis, Assistant Director, Field Operations via e-mail or phone, (919) 383-7874 ext. 234.

Watch for information about our exciting new  
**HealthPOWER! Prevention Club**

Coming soon to our  
website: [www.nchpdp.med.va.gov](http://www.nchpdp.med.va.gov)

## HealthPOWER! Prevention News Needs Articles

- Do you know of examples of Best Practices related to Prevention/Health Promotion?
- Do you have requests for specific topics?
- Are there specific VA or other Prevention experts to contact?

We would also like to start a section focusing on **Tips From the Field**.

Please send all suggestions/strategies that facilitate efficiency in provision of care and we will publish them in ongoing editions.

One question sent from a provider is:

*"How can we be efficient in completing all clinical reminders and required documentation as more reminders come on-line?"*

Look for answers in future newsletters.

Contact Rosemary Strickland at VA NCHPDP at (919) 383-7874, ext. 239 or via Outlook.

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**Putting Prevention Into Practice in the VA**