

Put Prevention Into VA Practice

A Step-By-Step Guide to Successful Program Implementation



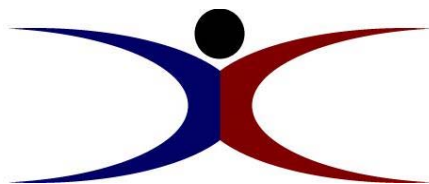
**VA National Center for Health Promotion
and Disease Prevention**

www.vaprevention.com

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A Step-by-Step Guide to Successful Program Implementation

**VA National Center for Health Promotion
and Disease Prevention (NCP)**



May 2004

Acknowledgements

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Foreword

VA is already performing well in the delivery of measurable prevention services to our veterans. However, we're not just settling for a good grade. We're on our way to establishing Prevention in the VA with its own identity, credibility and singular attentive focus – all glued together with a Prevention esprit de corps. This will be the modern (and future) face of Prevention throughout the healthcare industry, and VA will take the lead in defining the proactive role Prevention should play in total healthcare.

VA Prevention Coordinators (PC) represent the full spectrum of health specialties – from social workers, dietitians, RNs, PAs, NPs, physicians, to Board Certified Preventive Medicine physicians. Traditionally, many who are assigned the PC duty have had highly variable guidance in the performance of their duties – as well as equally disparate, non-standardized training in Prevention. It would not be faulty reasoning to expect that VA preventive services would be highly sporadic and variable across the nation. If it were not for the exceptional innovation, energy, and initiative of our PCs, this would be true. Indeed, the quality of work done by the VA PCs has been exemplary, especially given that they perform their jobs as an additional duty.

However, we can't assume that this high level of personal dedication will always be present in our PCs. Veterans should be guaranteed a high standard of preventive services across the nation, regardless of VAMC or the health specialty background of the PCs. To ensure such a standardized level throughout the VA, the NCP is addressing the formal development of the Prevention workforce.

This manual represents the initial step in Prevention workforce development. It is a Herculean, and first ever, comprehensive effort by the authors to capture the essence of establishing, implementing, and running a Prevention program at a VA medical facility. Utilizing the principles researched and published by the AHRQ, this manual has been

extensively personalized, tailored specifically to a nuts-and-bolts approach for VA. The driving vision was that, using this guidance, a new PC should literally be able to sit down on the very first day of the job and begin to put together a great Prevention program.

Use it! This manual is very good, but we'll never settle on laurels! Give us your lessons-learned, hard-earned experience, and any suggestions you might have for improvements!

Save Lives; Prevent Disease!

A handwritten signature in black ink, appearing to read 'S. Yevich', with a stylized flourish at the end.

Steven J. Yevich, MD, MPH
Director, NCP

Continuing Education Credit

Educating Your Prevention Team

There are several ways to use the contents of the “Put Prevention Into VA Practice” manual to provide more formal education credits for staff:

1. Break the content into a series of “lunch and learns” or at other times in one hour segments (perhaps by chapter) and lead (or assign group members to lead) the group in reviewing the content of that chapter. Keep a roster of all attendees and submit to your TEMPO tracker for input of education credits, or
2. Plan a daylong seminar focusing on the content in the manual. Assign team members to share in presenting the content from the manual. Keep a roster of all attendees and submit to your TEMPO tracker for input of education credits, or
3. Divide the content into 2 sessions in which half the content is presented in one session, and half in the next session. You can even do a little research, (involve your team QI person in this part) and share data specific to your clinic/facility to make the information pertinent to your facility.
4. Set up the training as an ongoing series. Develop a mechanism for crediting staff with education and a continuous review process all in one by:
 - Devoting the first 6 sessions to reviewing manual content and the next 6 sessions to taking each chapter’s content and personalizing it to your facility.
 - Guiding staff in this process, by using the questions at the end of each chapter to help your team focus on key elements.
 - Involving your team and the Quality Improvement staff in the initiation of a continuous review process.
5. Prepare certificates for those who complete the entire review, either in one-hour sessions or one day or the two session option.
6. Provide appropriate education credit for team training. If you are unsure about the mechanism for doing this, you should contact your service chief or your facility’s education office for guidance and for assistance.

How to Use This *Guide*

This *Guide* is written for Prevention Coordinators (PCs) and their prevention teams in VA medical centers. PCs who have been in the role for many years and have prevention programs well in place may find the *Guide* to be a useful resource for new ideas only. Newer PCs may find all the chapters helpful in providing guidance about setting up and maintaining a prevention team and a prevention program. All VAMCs have local characteristics that make them unique, the suggestions in the *Guide* may work better in certain settings and not as well in others. Please adapt these materials to your facility, as needed.

The *Guide* is organized into six chapters, based on the Plan, Do, Check, Act (PDCA) process. *Chapter 1, Initiate and Maintain a Prevention Team*, and *Chapter 2, Assess Preventive Services*, pertain to the Plan step. *Chapter 3, Implement the Prevention Program*, and *Chapter 4, Get Buy-In From Staff and Management*, pertain to the Do step. *Chapter 5, Measure Outcomes*, pertains to the Check step, and *Chapter 6, Share Information and Best Practices*, pertains to the Act step. The cycle is continuous.

The figure on the following page outlines the steps covered in each chapter.

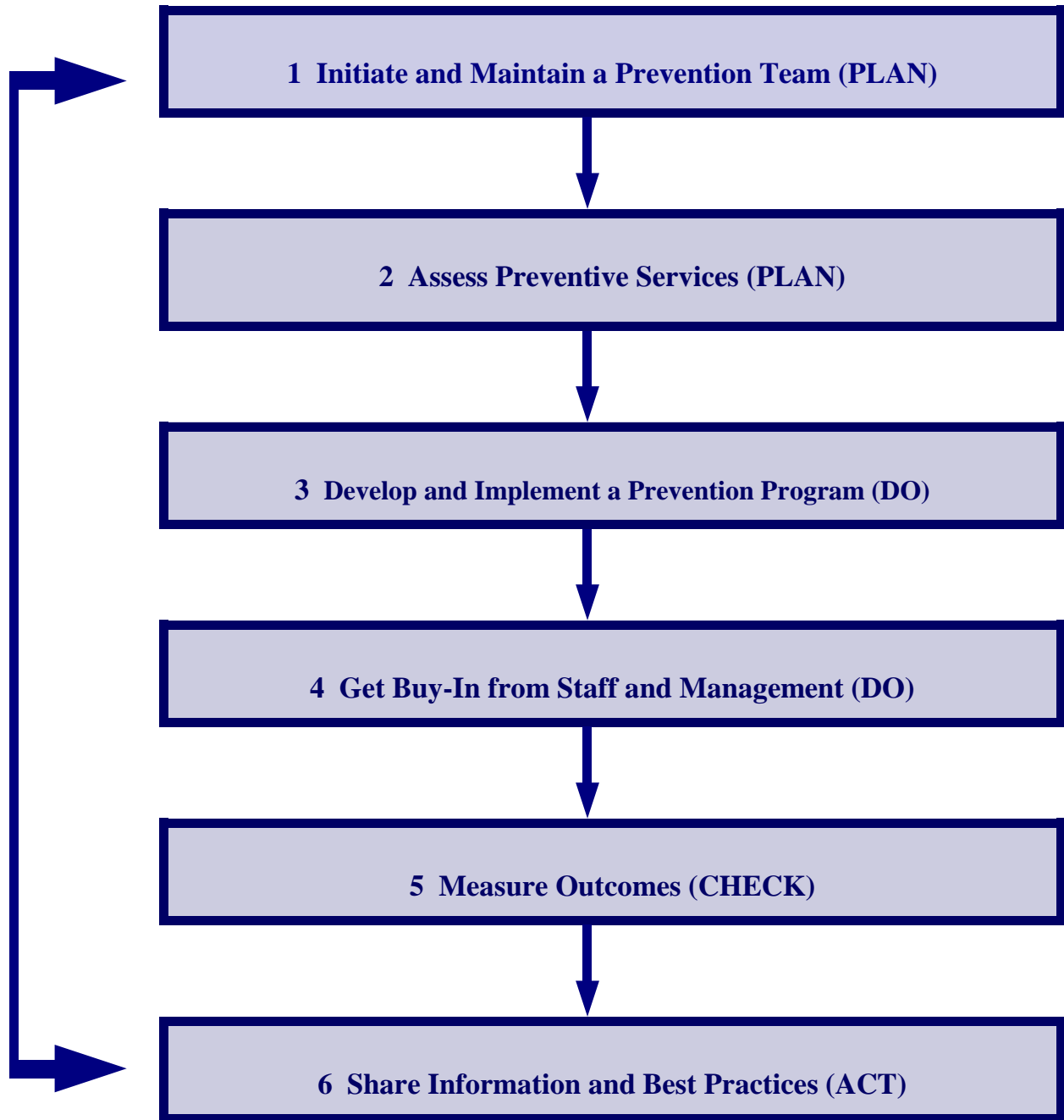


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Introduction

The landscape of American medicine has undergone a remarkable change in the past decade or two. As a result, disease prevention strategies are receiving increasing emphasis. Beginning in 1979, with the first publication of the Canadian Task Force on the Periodic Health Examination, and continuing in 1984, with the creation of the US Preventive Services Task Force (USPSTF), expert groups have issued recommendations for preventive services, based on evidence of effectiveness in the medical literature.

Historical Perspectives

The VHA has responded with a remarkable sequence of innovations that have moved health promotion and disease prevention for the veteran to a position of prominence. Public Law 96-22 in June 1979 established the VA “Preventive Health Care Pilot Program” with funds for merit review research. The Veterans Health Care Amendments contained in Public Law 98-160 in November 1983 authorized the provision of preventive health services to any veteran under care at VA facilities. To implement the law, VA established: (a) The Preventive Medicine Field Advisory Group (PMFAG), (b) The Preventive Health Care Task Force, and (c) The Preventive Medicine Policy Council. VA published a list of health promotion and disease prevention recommendations. The exact nature of services and the documentation of delivery of each service were decided at the local level. Every VA facility was required to appoint a Preventive Medicine Coordinator to monitor the implementation of services and to provide a link between VA Headquarters’ Preventive Medicine Program staff and the field site.¹

Further expansion of the Preventive Medicine Program followed passage of Public Law 102-585 in November 1992, which called for the creation of a VA National Center for Health Promotion and Disease Prevention (NCP). This legislation was enacted to “promote the expansion and improvement of clinical, research, and educational activities of the Veterans Health Administration” with respect to preventive services for

the veteran population. In 1995, the NCP was based in a remote headquarters facility at Durham, NC, as a national field-based program of the Medical/Surgical Services Strategic Health Group of VHA's Patient Care Services. NCP staff assumed responsibility for functions previously accomplished by the Task Force and Policy Council, which were disbanded. Preventive Medicine Leaders were named in each Veterans Integrated System Network (VISN) in 1997. The mission of NCP became defined as the central resource for "All Things Prevention," to provide 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. The PMFAG was disbanded in 2000 when the Chief Consultant for Primary and Ambulatory Care began to enhance the leadership roles of the VISN Preventive Medicine Leaders with the facility prevention coordinators.

Prevention in VHA

The overall goal for prevention programs is to link relevant VHA strategic goals to every day practice. Preventive medical services are provided in primary care settings. Delivery of specific preventive services is closely monitored by a system of performance measures, based on chart audits, with reports generated at the facility, VISN, and national levels. The performance measures indicate that, for the most part, the preventive services under evaluation are being delivered with high frequency in many VA facilities. However, the performance measures do not include all recommended preventive services, so other means of monitoring the delivery of those services are needed. Accomplishing all recommended preventive services for every eligible patient is a daunting task and one that is not easily done by health care providers alone. Because the ideal VA medical center prevention program would be comprehensive, coordinated, interdisciplinary, patient-centered, goal and accountability-driven, and able to provide integrated preventive services for all target groups, a multidisciplinary team (including clinicians, nurses, health educators, behavioral psychologists, dietitians, social workers, and others) is more likely to be successful.

Prevention Coordinators (PCs) have responsibility for monitoring preventive services and coordinating prevention activities in VA medical centers. Because the role is often a collateral duty, PCs don't have dedicated time, support, or resources for the position. The team approach spreads out the prevention task list while also attaining the input from a variety of specialties, thus allowing for a more comprehensive prevention program. This manual, designed for prevention coordinators and clinicians, provides step-by-step instructions for development and implementation of prevention programs. The information is designed to be generalizable from the development of a specific

program activity, such as increasing influenza immunizations, to an overall “big picture” prevention program. Evidence-based recommendations for preventive services are based on those issued by the U.S. Preventive Services Task Force (USPSTF) and by the Task Force on Community Preventive Services, sponsored by CDC. By representing VA as a liaison member of the USPSTF and the Task Force on Community Preventive Services, the NCP participates in the decision making process and endorses their recommendations. The NCP is also a member of the VA/DoD National Clinical Practice Guidelines Council and the Performance Measure Working Group, participating in the clinical guideline and performance development process for preventive services within VHA.

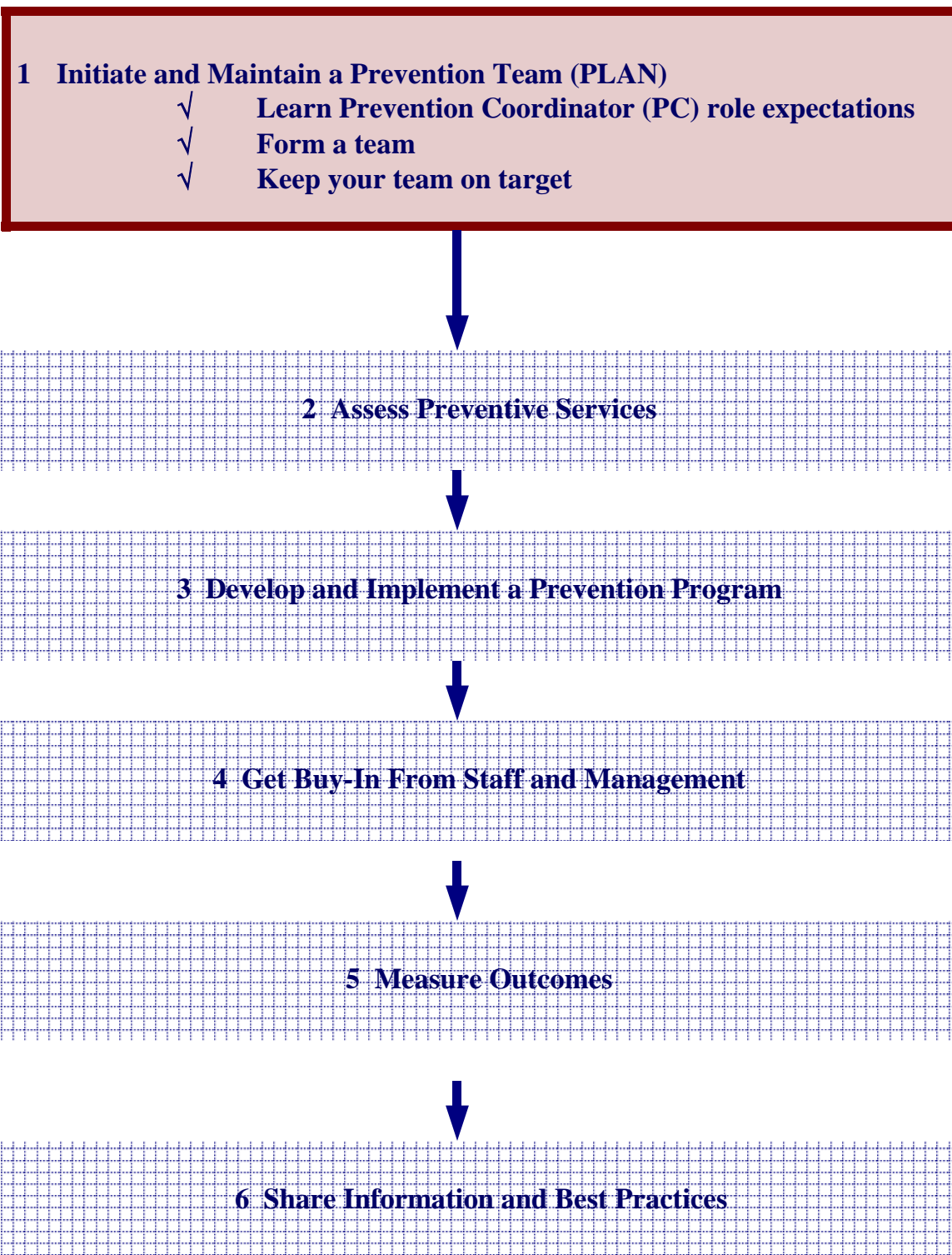
References

- 1. National Center for Health Promotion. Preventive Medicine Program Information Bulletin, IB-89. October 1996.**

1

Initiate and Maintain a Prevention Team





1

Initiate and Maintain a Prevention Team

POINTS TO CONSIDER:

- *Be a role model.*
- *Passion for prevention is contagious.*
- *There is something for everyone to do.*
- *Keep the target in front of you (protect health).*

Beginning in the early 1980's, each VA facility designated a staff person as Preventive Medicine Program Coordinator (PMPC) whose principal duty was to prepare information for an annual report to Congress. Over the years, responsibilities were expanded to facilitate activities in support of annual "Special Initiatives" that focused on a particular prevention topic. The PMPC (currently referred to as PC) role is often held by Registered Nurses, Advanced Practice Nurses (Nurse Practitioners, Clinical Nurse Specialists), Physician Assistants, and Physicians.

Learn Prevention Coordinator Role Expectations

The Prevention Coordinator (PC) is the designated VA advocate for health promotion and disease prevention initiatives, programs, and activities at the local facility level. The PC communicates, initiates, coordinates and champions health promotion and disease prevention. Often, the PC role is in addition to the clinician's regular position. This reality further supports the need for a well-functioning prevention team. PCs are encouraged to find an interested colleague to share the role, as co-leader in prevention.

Examples of how to fulfill the PC Role

Patient-related examples:

- Champion local health promotion and disease prevention initiatives, programs and activities. Examples include: health fairs; nutrition and obesity education and counseling; “healthy eating” day; BP screening; flu shots; “walk the stairs” day; stop smoking campaigns; disseminating NCP prevention topics; seat belt safety; “depression screening” day; cholesterol screening, review of disease prevention services and how these are delivered;
- Champion at least ONE major national health promotion/disease prevention campaign per year. Examples include: National Public Health Week (April); Women’s Health Week (May); Weight Management/Physical Activity (July); Veteran’s Day (November).

Staff-related examples:

- Provide health promotion and disease prevention information, including the latest prevention recommendations, to appropriate “need to know” parties throughout the medical center.
- Exchange successes/failures/best prevention practices with others, via NCP conference calls/website/e-mail, etc.
- Nominate a prevention colleague for “Prevention Champion of the Quarter.”
- Have your prevention team compete for “Prevention Team of the Quarter.”

Prevention Coordinator examples:

- Role model health promotion and prevention.
- Learn about prevention. Become the expert.
- Champion the NCP initiative “Put Prevention Into VA Practice – A Step-By-Step Guide to Successful Program Implementation.”
- Seek ways to become involved in health promotion activities outside your medical center/facility and into your community.
- Initiate communication with fellow PCs and others in your facility and VISN regarding prevention practices.
- Use the NCP newsletter or Website to share your successes/failures/best prevention practices with others.
- Submit prevention questions to NCP to be included in the HealthPOWER! Prevention News – if you need an answer, it’s a sure bet there’s someone else who also needs the answer.

Initiate and Maintain a Prevention Team

- Send your picture electronically (JPEG) so it can be posted on the NCP website to the Center att: Program Analyst (refer to Staff Directory on website).
- Use the word “Preventive,” not “preventative”.
- Use NCP Website as a resource to stay current on health promotion and disease prevention topics.
- Participate in NCP education needs assessment, as requested.
- Attend NCP annual training conference.
- Participate in monthly NCP conference calls, to maintain connectivity with the VA Prevention community.
- Keep NCP updated as to PC changes (roles, transfers, retirement, etc.).
- Provide input and feedback on how the National Center can improve prevention to veterans and other ways to assist the PC and Prevention Team.
- Assist in data collection of surveys requested by the Center.

Form a Team

The Prevention Coordinator is a clinician who often wears several different hats with the PC role as a collateral assignment. To have a successful prevention program, it is essential to utilize a team approach. It is important for the entire staff to be involved in delivering preventive services so that the various tasks/programs/initiatives are distributed among many staff members.

An effective approach to providing a wide range of preventive services in diverse clinical settings is through the formation of a prevention team. The increasing complexity of the task of delivering preventive services at a high level of performance calls for cooperation and teamwork among many staff in primary care (Stone et al., 2002). The Institute of Medicine has called for the development of effective multidisciplinary teams, or organized work groups, as a critical step in the formation of “a new health system for the 21st century.” Key elements of team building include:

- Having defined goals, with measurable objectives;
- Having clinical and administrative systems in place;
- Having clear definitions of tasks and assignments of roles;
- Training of team members; and
- Establishing communication structures and processes (Grumbach and Bodenheimer, 2004)

Research in clinical settings has shown that groups with better teamwork tend to perform better than those without teamwork. Thus, establishing multidisciplinary teams to carry out preventive services is an important component of health promotion and disease prevention programs in VHA.

Organized work groups, or multidisciplinary teams, have become a common way to organize health care and much attention has been focused on their value and successful functioning. Effective work teams must be created and maintained. Characteristics of effective teams include:

- Team makeup
 - Appropriate team size
 - Appropriate team composition
 - Ability to reduce negative effects of status differences between team members-every team member is important.
- Team processes
 - Communication structure
 - Conflict management
 - Leadership that emphasizes excellence and conveys clear goals and expectations
- Team tasks
 - Matching roles and training to the level of complexity
 - Promoting cohesiveness when work is highly interdependent
- Environmental content
 - Obtaining needed resources
 - Establishing appropriate awards

Effective teams have a culture that encourages and fosters openness, collaboration, teamwork, and learning from mistakes (Fried et al., 2002)

Identify key players

Engage selected individuals who are able to influence major groups of staff and/or command resources for prevention. Think who they might be in your medical center. Literature shows ideal team size is between 6 to 12 people. Here is a list of suggested team members:

- **Essential:** Ideally based in primary care - Physician, Registered Nurse and/or Advanced Practice Nurse, Physician Assistant, Psychologist, Dietitian, Patient Health Educator, Quality Management representative, Leadership representative, IT Clinical Applications Coordinator, Employee Wellness Coordinator
- **Optional:** Social Worker, Pharmacist, Women's Health Coordinator, Occupational Medicine representative; Specialty area representatives: Visually Impaired Service Team, HIV Coordinator, Infection Control Practitioner, Homeless Coordinator, Chaplain, Volunteers, etc.

Initiate and Maintain a Prevention Team

- **Co-leader:** Choose someone who has commitment, motivation, desire and the abilities to carry on with or without the leader. A co-leader can substitute for the leader and/or co-lead the team with the leader.
- **Field experts:** *Call in your local experts as you need them.*

References:

Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press; 2001.

Grumbach K, Bodenheimer T. Can health care teams improve primary care practice? *JAMA*. 2004;291:1246-1251

Stone E, Morton S, et al. Interventions that increase use of adult immunization and cancer screening services: a meta-analysis. *Ann Intern Med*. 2002; 136:641-651.

Identify team roles and responsibilities

A chart of sample roles and responsibilities appears below.

Roles	Responsibilities
Leader/Co-leader	<ul style="list-style-type: none"> • Establish the agenda. • Keep discussion focused on the topic and on accomplishing objectives. • Encourage participation and involvement from everyone. • Plan and conduct team meetings by staying focused on the agenda. • Maintain open, two-way communication among team members. • Assist the team in implementing action to accomplish results
Facilitator	<ul style="list-style-type: none"> • Intervene if the discussion loses focus or moves off track. • Consult with the leader about team building, effective meetings, and other skills. Provide feedback and suggestions. • Observe team in action and help them build strengths and overcome weaknesses. • Assist leaders in processes such as team problem solving, decision making, and conflict management. • Be a resource to team for Total Quality Improvement methods, tools and techniques.
Recorder	<ul style="list-style-type: none"> • Assist the leader and facilitator with preparing the agenda. • Write important information on a flip chart to keep facts, issues and ideas visible. • Record data, decisions, and team activities to use as a resource. • Monitor member attendance.
Team Member	<ul style="list-style-type: none"> • Understand the team’s mission and how to make a contribution to it. • Participate by attending meetings, listening, sharing ideas, making suggestions, etc. • Volunteer for action items and follow through with them. • Share resources, knowledge, skills, and experience. • Get along with team members by respecting their opinions and avoiding negative comments. • Build team cohesiveness through participation. • Represent work group. • Communicate team activities to work group.

Prepare for first meeting

An example of a meeting agenda follows.

Sample Meeting Agenda

July 1, 2003

1. Welcome members
2. Announcements
3. Review agenda and time limits
4. Items to be discussed:
 - Immunization campaign Nancy 5 min
 - Health fair briefing/summary Julie 5 min
 - Policy update Sam 10 min
 - Chart review findings Sue 10 min
5. Next steps/Action Plan/Review Assignments 10 min
 - Form sub-team for immunization campaign Nancy Target Date 7-7-03
 - Send out thank you notes to health fair participants Ed 7-14-03
 - Write newsletter article re: health fair Julie 7-17-03
 - Recommend policy changes to Sam All 7-7-03
 - E-mail policy to members Sam 7-20-03
 - Recommend persons to do chart reviews to Sue All 7-28-03
6. Evaluate Meeting 2 min
7. Adjourn

The Team Memory Jogger – A pocket guide for team members, First Edition GOAL/QPC and Joiner Associates Inc.

Tips for running an effective meeting

- Set an agenda and stick to it.
- Put someone in charge of the meeting - this could be a shared responsibility.
- Put someone in charge of recording all decisions.
- Make each member of the group accountable.
- Make sure tasks are clear.
- Make sure assignments are clear.
- Come to the next meeting prepared and expect that everyone else will do the same.
- Take five minutes at the end of the meeting to debrief.

Conduct first meeting

Provide “prevention” introduction.

- Prevention is important.
- Prevention aligns with the clinical setting’s values.
- “Put Prevention into VA Practice – A Step by Step Guide to Successful Program Implementation” reference can help the group realize its goals for delivering preventive care.

Discuss purpose of the team.

Establish group rules to include how team will make decisions.

Have each member introduce self, and explain involvement in prevention.

A guide for group rules and examples of decision-making methods follow.

Sample Group Rules

Agreeing on Group Rules and Why They Are Important to the Team

Group rules, ground rules or team rules are guidelines for how the team will function.

Having group rules can:

- Improve effectiveness and efficiency
- Minimize confusion, disruptions, and conflicts that can be disruptive and take away from the real work
- Provide role expectations
- Avoid conflict with others

Each team should discuss and agree to its own rules/guidelines.

All teams may violate their own ground rules once in a while. If a ground rule is broken repeatedly, the team needs to decide whether or not it's a problem. If it is a problem, feedback to the rule breaker is necessary, or it can be discussed as a team. If it is not a problem, change the group rule.

Examples of group rules:

1. Meeting rules

- Attendance: we will meet only when a majority of the members can attend (2nd Thursday of the month)
- Starting on time: we will start promptly at 9 am. Everyone is expected to be respectful of others' time and be on time, with all the materials and information they need
- Rotation of roles and responsibilities: we will rotate the responsibility for recording the minutes at each meeting
- Keep to time limit
- Try not to cancel meetings

2. Decision making – we will make important decisions by consensus and will use the level of consensus tool

3. Use of data – whenever possible, we will base our decisions on data

4. Confidentiality – information shared in team meetings can be shared with others in the organization unless a team member specifically requests confidentiality

5. Assignments – all members will complete assignments on time. If you can't get them done, notify the team leader as soon as possible

6. Participation – everyone will respect each other and all will get a chance to voice their ideas and opinions

7. Meeting evaluation – the last 5 minutes of each meeting will be spent discussing ways to improve the next meeting

Examples of Decision Making Methods

- 1. Consensus** means finding an option/solution that **all team members** will support.
 - Consensus does **not** mean that all members are totally happy with the decision.
 - To reach consensus you must consider the ideas and feelings of **all team members**, not just of a few or even just of the majority.
 - Consensus usually takes a lot of discussion time and requires skill in addressing differences of opinion.
 - The investment in time is usually worth it, as many times, the consensus decisions can often be implemented smoothly since the entire team supports them.
 - Use consensus for complex and/or important decisions that require the coordination and understanding of the entire team.

Tool to Use to Determine Consensus

When it is time to discuss and identify agreement among team members, you can distribute or ask team members which level of agreement they are (below). If members say a 1, 2, 3, or 4, it is fine for the team to adopt the decision and move forward. If even one member votes a 5 or a 6, the team must go back to the drawing board, as additional discussion is required. It is much better to take the time required to gain consensus, instead of someone not agreeing and then becoming a “sabotager.”

The Levels of Consensus

Level I - I can say an unqualified “yes” to the decision. I am satisfied that the decision is an expression of the wisdom of the group.

Level II - I find the decision perfectly acceptable.

Level III - I can live with the decision; I’m not especially enthusiastic about it.

Level IV - I do not fully agree with the decision and need to register my view about it. However, I do not choose to block the decision. I am willing to support the decision because I trust the wisdom of the group.

Level V - I do not agree with the decision and feel the need to stand in the way of this decision being accepted.

Level VI - I feel that we have no clear sense of unity in the group. We need to do more work before consensus can be reached.

- 2. Voting** – each team member gets one vote and the choice with the most votes wins
 - Voting is an easy, familiar, and popular way to make decisions.
 - It is okay to take a vote for relatively unimportant decisions, but remember this method of decision-making can leave the “losers” feeling left out.
 - Voting is a much faster way to make a decision, but pushing for consensus often makes implementation much faster.
 - Explore important issues by polling the team. Go around once and have each team member just state how they vote. Then go around again where people briefly give one or two reasons for their vote.

Delegating Decisions

In some cases, the team may let one or more team members make a particular decision. This works well when the decision requires particular expertise or when time is short and a deadline is approaching. “Jane and Mary will be responsible for obtaining input from the entire team, but then they can make the final call on which exhibitors to use.”

Discuss team members and roles

A Team Needs All Kinds of People

All role characteristics can shift; all roles contribute to the greater good of the team.



Leader

- Leads, guides, directs
- Sees the big picture
- Tracks goals and accomplishments



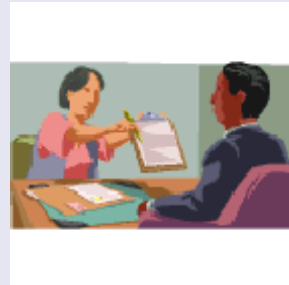
Facilitator

- Focus on how team gets work done
- Provides training
- Resolves conflicts



Creator

- Idea person
- Creates options
- Finds solutions



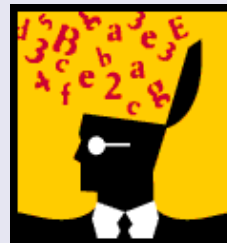
Manager

- Clear communicator
- Assigns tasks
- Knows resources



Organizer

- Maintains order
- Likes details
- Good with multiple projects and tasks



Innovator

- Idea person
- Creative qualities
- Sees possibilities others miss



Evaluator

- Analyzes
- Reviews
- Asks questions



Finisher

- Enjoys detail
- Likes to carry out project to completion

How Can One Person Make a Positive Difference on a Team?

1. **Do It Right the First Time** - learn the job; do the job right the first time.
2. **Listen to Your Patients/Customers/Management and Aim to Meet Their Expectations**
3. **Treat Your Co-Workers and Other Departments as Customers**
4. **Confront Poor Quality When You See It** - when you notice quality problems but say and do nothing, you're part of the problem. When you speak up or act, you're part of the solution.
5. **Stretch; Don't Settle** - know that when you stop actively improving your work, quality doesn't stay the same; it slips. In your words and personal actions, show ever-higher standards for yourself and those you influence. Some people do just enough to get by on the job - but that "getting by" attitude threatens quality and those who make a difference.
6. **Seize Opportunities to Get Involved** - speak up, make suggestions, join teams, become part of the solution.
7. **Look for Solutions** - don't point the finger, blame, or gripe. Act to make things better.
8. **Appreciate Quality When You See It** - reflections of quality are all around you. Stop, take notice, recognize and congratulate the people and teams responsible for quality service and solutions.
9. **Pursue Continuous Improvement in Yourself** - learn, read, and expand your skills so that you can be ever more effective in making quality happen.
10. **Become a Quality Advocate** - dare to go public with your commitment to quality. Talk it up. Express optimism. Be a positive and inspiring influence to improve quality.

Adapted by NCP - Leebov, Wendy, Ed.D., The Eienstein Consulting Group. *The Quality Quest - A Briefing for Health Care Professionals*. Chicago: American Hospital Publishing, Inc., 1991.

Conduct second meeting

Provide “prevention” overview (Appendix A for PowerPoint Presentation)
Discuss phases of team development. (Phases of Team Development appear below.)

Phases of Team Development

Teams go through fairly predictable phases or stages. Each phase has its own set of feelings and its own behaviors. The phases are: forming, storming, norming, and performing.

Forming

Feelings

- Excitement, anticipation, and optimism
- Pride in being chosen for the team
- Initial, tentative attachment to the team
- Suspicion, fear, and anxiety about the job ahead

Behaviors

- Attempts to define the task
- Attempts to decide how task will be accomplished
- Attempts to determine acceptable group behavior and how to deal with group problems
- Decisions on what information needs to be gathered
- Lofty, abstract discussion of concepts and issues
- Impatience with lofty, abstract discussions
- Discussion of symptoms or problems not relevant to task
- Difficulty in identifying relevant problems
- Complaints about the organization and barriers to task

Because there are so many distractions at the beginning, the team accomplishes little, if anything, that concerns its project goals. This is perfectly normal.

(Continued on next page)

Storming

Feelings

- Resistance to task/project
- Resistance to quality improvement approach
- Sharp fluctuations in attitude about the team
- Sharp fluctuations in attitude about team's chance of success

Behaviors

- Arguing among members even when they agree on the real issue
- Defensiveness and competition; factions and "choosing sides"
- Questioning the wisdom of those who were selected for the team
- Questioning appointment of other members of the team
- Establishing unrealistic goals
- Concerns about excessive work
- A perceived "pecking order"
- Disunity, increased tension, and jealousy

These many pressures mean team members have little energy to spend on progressing toward the team's goals. But they are beginning to understand each other.

Norming

Feelings

- A new ability to express criticism constructively
- Acceptance of membership in the team
- Relief that it seems everything is going to work out

Behaviors

- An attempt to achieve harmony by avoiding conflict
- More friendliness, confiding in each other
- Sharing personal concerns and problems
- Discussion of the team's dynamics
- A sense of team cohesion, a common spirit and goals
- Establishing and maintaining team ground rules/boundaries

(Continued on next page)

Performing

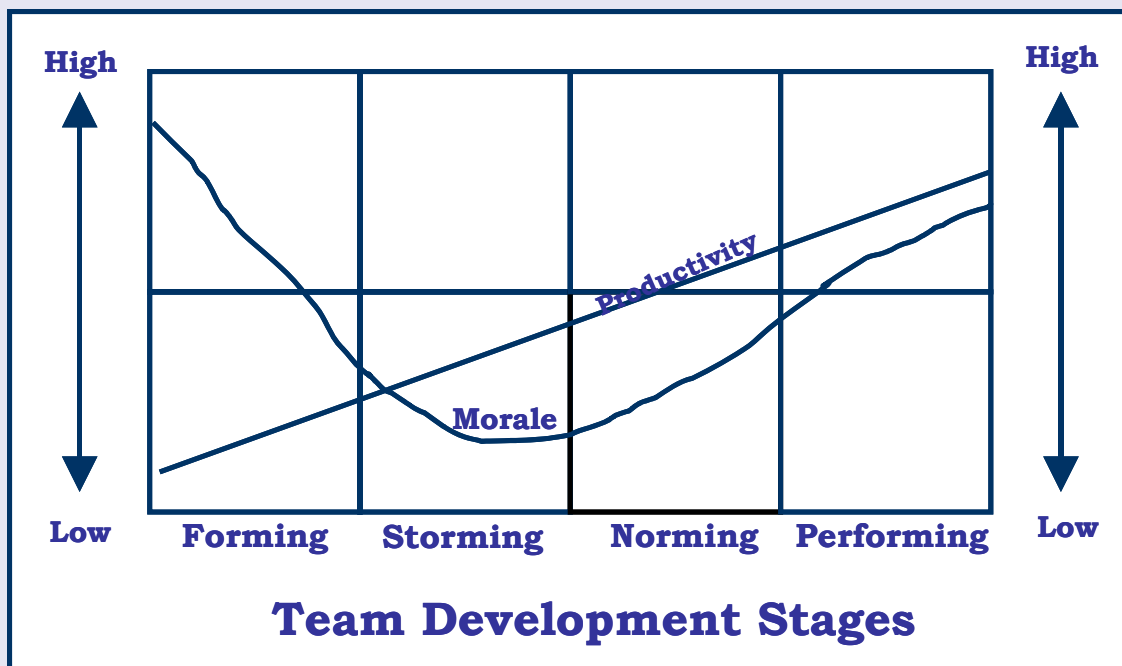
Feelings

- Members have insights into personal and group processes
- Members have better understanding of each other's strengths and weaknesses
- Satisfaction with the team's progress

Behaviors

- Constructive self-change
- Ability to prevent or work through group problems
- Close attachment to the team

As team members become more comfortable with each other and better understand the project and focus on the process, they become a more effective unit. At this point, significant progress is made and you start to get a lot of work done.



Keep Your Team on Target

How to keep your team motivated and productive

- Accomplish something.
- Conduct effective meetings.
- Involve and consult the “right players” when making major decisions to avoid “spinning wheels.”
- Reward members who do what they promise.
- Revisit group rules when conflicts arise.
- Request input and provide feedback from patients, staff, and management.
- Review team mission and progress toward goals at regular intervals.
- Retain and/or change membership based on team effectiveness.
- Make a concerted effort to involve ALL team members, so that your projects are a true group effort rather than a one-person show.
- Frequently publicly acknowledge members’ contributions both within and outside of the meetings.
- Find some way for team members who appear obstructionistic or negative to make a contribution - give them something you can reward them for.

Establish a communication system

- Decide if e-mail is the best system between meetings.
- Discuss importance of keeping brief and accurate team minutes.
- Discuss periodic team updates to management via presentations or reporting.
- Encourage flexibility and call extra meetings when necessary and cancel meetings where there is no reason to meet.

Promote creativity among team members

Many times, an individual or the team becomes “stuck”. Encourage creativity by allowing time for brainstorming and exploring new approaches. Actually prompt participants to use creative thinking and solutions by suggesting that “thinking out of the box” will be required here.” A list of creativity tips follows.

Creativity Tips

1. **CAPTURE IDEAS WHENEVER AND WHEREVER.** Many of the best ideas are “free” and often come when a person is relaxed and not working on a problem. Record ideas immediately.
2. **MODEL OPENNESS AND ACCEPTANCE OF IDEAS.** Be aware of verbal and nonverbal behavior. Much of how and what is communicated about ideas is expressed in the verbal and nonverbal responses to the ideas of others.
3. **REDEFINE A PROBLEM IN MANY WAYS.** Ask “why?” Many times the team sets out to solve the wrong problem. Challenge the team’s assumptions.
4. **GO OUTSIDE OF THE PROBLEM AREA.** Look for connections for solving problems from other areas. Ask, “What ideas can the team get for solving this problem from a completely different world?”
5. **DEVELOP CREATIVITY HABITS.** When working on a challenge or an opportunity ask the team: “How else can the team do this?” “What if?”
6. **SEPARATE IMAGINATIVE THINKING FROM JUDGMENTAL THINKING.** When generating ideas, don’t criticize ideas or the ideas of others. After generating a number of ideas, then evaluate them, but don’t try to generate and evaluate at the same time.
7. **EVALUATE IDEAS BY CONSIDERING THE PLUSES OR STRENGTHS OF THE IDEA FIRST; THEN LIST THE POTENTIALS IN THE IDEA: THEN LIST THE CONCERNS (PPC).** Once concerns have been determined about an idea, phrase the concerns as a question or problem statement. This will allow for consideration of ways to overcome the concern instead of disregarding the entire idea.
8. **WHEN WORKING TO SOLVE A PROBLEM, SET A QUOTA OF AT LEAST THIRTY TO THIRTY-FIVE IDEAS AND STRIVE TO REACH THAT QUOTA.** To get new ideas, it is important to stretch beyond the obvious ways for solving a problem. The more ways of accomplishing the goal, the greater are the chances of doing it.
9. **WE ARE ALL CREATIVE, BUT IT IS IMPORTANT TO REALIZE THAT CREATIVITY REQUIRES PRACTICE AND DEVELOPMENT LIKE ANY OTHER SKILL.**
10. **LOOK AT PROBLEMS AS OPPORTUNITIES.** Every “problem” we encounter has something to teach us.

Source: [Why Didn't I Think of That?](#) By Roger L. Firestien

Initiate and Maintain a Prevention Team

Begin to develop a prevention program plan (see Chapter 3).
Decide about minute taking format. (An sample minute taking format appears below.)

Sample Team Minutes

Issue/Topic	Discussion/ Conclusion	Recommendations/ Actions	Responsible Person	Target Date	Effectiveness Of Action



Examples From the Field:

Manchester, NH:

The prevention team as it is called now was “re-born” after a lapse in activities. The team meets every other week, has done bulletin boards, and plans on a regular basis to address monthly topics via boards, sessions with staff or patients. The team sponsors a spring activity for domestic violence - a jeopardy game that was held during lunch well received by staff and patients. Elevators, commonly used areas by patients and staff, and large bulletin boards in the building lobby and primary care are used to post announcements.



Washington, DC:

The interdisciplinary Washington DC VAMC Prevention Team (Preventive Medicine Committee) was formed in January 1998 to set up a medical center plan to implement the VHA Health Promotion and Disease Prevention Program (HPDPP). This group is composed of interdisciplinary clinical and administrative staff at all levels. Many frontline staff from all Primary Care Teams and inpatient units serve on the committee. The team is very involved in the formulation of policy, documentation systems, reminder development, clinic processes, educational resources, EPRP review and all activities related to the program.

Discussion Questions

1. List a few examples of how a Prevention Coordinator might fulfill the role:

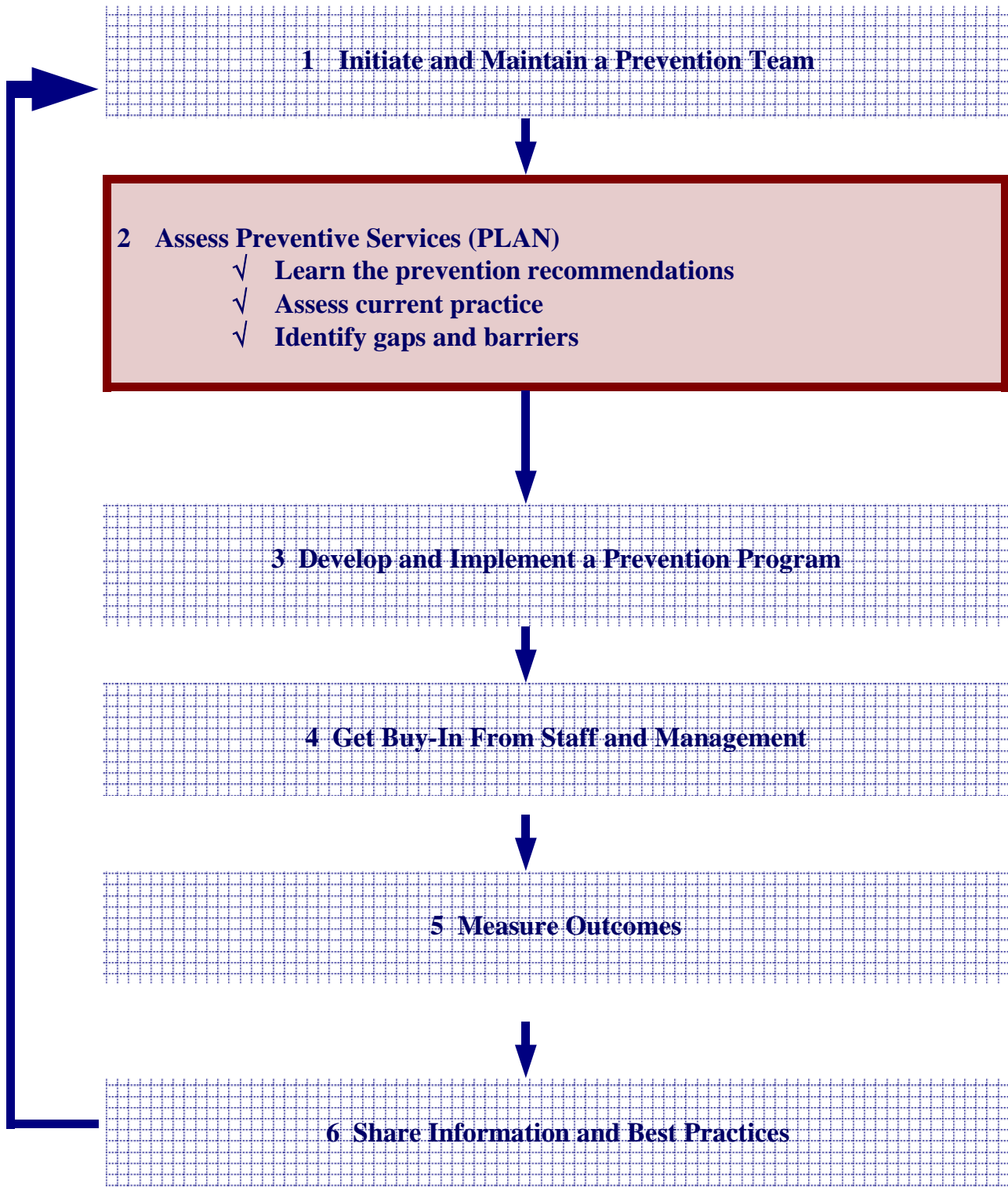
2. How would you form a prevention team at your medical center? Describe and list the steps you would take:

3. How does a PC find time for the role?

2

Assess Preventive Services





2

Assess Preventive Services

POINTS TO CONSIDER:

- *Focus on high-priority prevention recommendations.*
- *Use data to assess performance.*
- *Consider system, provider and patient barriers.*
- *Problem solve solutions.*

Once the Prevention Coordinator and Prevention Team have been established, the next step is to assess your facility's current system for providing health promotion activities and delivering clinical preventive services. Looking at the range of health promotion and disease prevention activities and services provided will give you a good sense of what's happening in your medical center in the realm of prevention. There are several steps in this process and tools that will help you assess your current practices and program in a systematic way.

Learn the Prevention Recommendations

The first step in the assessment process is to review the list of current performance measures for preventive services from the Office of Quality and Performance .

Appendix C lists the performance measures for FY 2004. (Updated lists of performance measures can be found at <http://vaww.oqp.med.va.gov>.) The Office of Quality and Performance also develops clinical practice guidelines for most of the performance measures. These guidelines provide detailed information about prevention and treatment for the clinical topics covered by the performance measures. Many facilities have developed clinical reminders to prompt health care providers about delivering these services. Additional preventive services for screening, counseling, immunizations, and chemoprevention recommended by the US Preventive Services Task Force and the VA National Center for Health Promotion and Disease Prevention are also listed in Appendix C.

The US Preventive Services Task Force (USPSTF) is an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services. The Task Force grades its recommendations according to one of five classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms).

A. The USPSTF strongly recommends that clinicians provide [the service] to eligible patients. *The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.*

B. The USPSTF recommends that clinicians provide [this service] to eligible patients. *The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.*

C. The USPSTF makes no recommendation for or against routine provision of [the service]. *The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.*

D. The USPSTF recommends against routinely providing [the service] to asymptomatic patients. *The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.*

I. The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. *Evidence that the [service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.*

The USPSTF grades the quality of the overall evidence for a service on a 3-point scale (good, fair, poor):

Good: Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair: Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.

Poor: Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

Assess Preventive Services

USPSTF, the prevention program will ensure that the services having greatest impact on veterans' health will be provided at high levels throughout the facility.

Assess Current Practice

To analyze how well your facility is doing in providing recommended preventive care, there are several sources of data that may be helpful. The Quality and Administrative members of the Prevention Team will be especially helpful in tracking down this information. Preventive services that are part of the Performance Measure set are monitored closely and reported on a regular basis, through the External Peer Review Program (EPRP) process. For average risk patients, performance measure compliance results are available for influenza and pneumococcal immunizations; screening for breast, cervical, and colorectal cancers, and hepatitis C risk factors; screening and control of hypertension; and screening/counseling for depression, tobacco use, and problem drinking. Performance measure results are available for all the recommended preventive services for patients with chronic diseases.

For aggregated national or VISN-level reports on clinical practice guideline/performance measure compliance:

- Visit <http://vaww.oqp.med.va.gov>.
- For most recent data, access the Network Performance Report, EPRP data, and select quarterly or yearly data reports. (Information can be viewed from a national, VISN, or facility perspective.)
- For current FY data, access the Data Consolidated Initiative, Executive Briefing Book. Most performance measure compliance can be viewed under the Quality heading.
- Under the Performance Measure heading is the Technical Manual, which gives specific information about how data for each performance measure are collected and includes established goals for the FY.
- Other data which can be assessed from this site include:
 - External Peer Review Program (EPRP)
 - Survey of Healthcare Experience (SHEP), inpatient and outpatient satisfaction results.
- This website also has a section on successful VA implementation practices with a point of contact for each example.

Assess Preventive Services

Determining how well your facility is doing with recommended preventive care not tracked by EPRP reports may be more difficult. If you wish to track performance of screening appropriate patients for type 2 diabetes, for example, consider doing electronic chart reviews of a sample of patients seen in primary care during a designated month. For help with diagnosis and other codes needed to do these reviews, contact the Automated Data Processing Applications Coordinator (ADPAC) or the Information Resource Management Service (IRMS) office in your medical center.

You may also be interested in looking at other reports that are routinely generated for your facility, such as the workload report, which tracks number of patient visits, number of new patients seen (“uniques”), and wait times for appointments. These reports are available from the ADPAC or IRMS office.

For aggregated national or VISN-level reports on workload data:

- Visit <http://klfmenu.med.va.gov> or <http://vssc.med.va.gov>.
- Examples of information that can be accessed from this VISN Support Service Center (VSSC) site include:
 - cumulative no-show rates
 - wait times for next appointments
 - workload numbers (# of patients treated, visits, uniques, etc.)
 - patient satisfaction results
- This website also has a listing of best practices submitted from different facilities.

Identify Gaps and Barriers

You have now reviewed the preventive services recommended for average risk patients and those with certain chronic diseases. You have reviewed your facility’s data on performance measure compliance, workload, and possibly other preventive service delivery. How do your services measure up? Where are the gaps in what’s being provided? Are there **system**, **provider**, or **patient** barriers to preventive services?

Some questions to ask:

- Are there **system**-related gaps or barriers? These might include insufficient computer support, space, data access, or limited resources or time to address preventive care.
- Are there **provider**-related gaps or barriers? Some examples are lack of familiarity with prevention recommendations and performance measures, insufficient skills in providing behavioral change counseling, or reluctance to consider changes in clinical practices needed to more efficiently provide preventive care.

- Are there **patient**-related gaps or barriers? These could be problems with access to health care, transportation problems, lack of family support for making behavioral changes, or misunderstanding about the importance of preventive care.

Grouping the gaps and barriers into one of these three headings – system, provider, patient – may help you to determine how to begin to solve problems. Working through the questions on this worksheet may help you to identify where you need to start the process of improving your facility’s delivery of health promotion activities and preventive care services.

Worksheet For Assessing Preventive Services Delivery

Staff Readiness:

What are the values, attitudes, and beliefs of our staff about prevention?

What are the values, attitudes and beliefs of our patients about prevention?

Are staff competent to provide preventive services?

Preventive Services:

What kinds of preventive services do we aspire to provide to all of our patients, based on the needs of the population we serve?

What is the difference between what we aspire to provide and what we currently provide?

What preventive care do we currently provide our patients?

Do we provide preventive services for which each patient is eligible?

What services are we documenting?

Existing Services:

What policies and procedures do we have in place for providing preventive services?

What preventive services delivery systems have worked? Why?

What preventive services delivery systems have not worked? Why?

What can we do differently?

Environmental Factors:

How does our current physical environment support or inhibit our delivery of preventive services?

How does our current patient flow support or inhibit our delivery of preventive services?

Consider using these questions during a Prevention Team meeting to encourage discussion about your facility's current health promotion/disease prevention practice.

Discussion Points About Preventive Services Delivery		
	<i>Agree</i>	<i>Disagree</i>
1. Prevention is an important aspect of care provided in our practice.	<input type="checkbox"/>	<input type="checkbox"/>
2. Prevention should be more strongly emphasized in our practice.	<input type="checkbox"/>	<input type="checkbox"/>
3. Someone at our facility has the vision, leadership, and authority to make prevention happen here.	<input type="checkbox"/>	<input type="checkbox"/>
4. We have adequate time to do one-on-one patient education or patient counseling.	<input type="checkbox"/>	<input type="checkbox"/>
5. Nurses at our facility consider patient education as one of their main tasks.	<input type="checkbox"/>	<input type="checkbox"/>
6. Physicians at our facility regard patient education as one of their main tasks.	<input type="checkbox"/>	<input type="checkbox"/>
7. We are willing to allocate resources (time, training, personnel, and space) to implement a comprehensive program to deliver clinical preventive services.	<input type="checkbox"/>	<input type="checkbox"/>
8. Internal communication is strong among staff and physicians in our practice.	<input type="checkbox"/>	<input type="checkbox"/>
9. A sense of teamwork exists among staff members and physicians at our facility.	<input type="checkbox"/>	<input type="checkbox"/>
10. Our facility has already implemented specific programs for prevention (e.g., cancer prevention programs, smoking cessation, and diabetes education).	<input type="checkbox"/>	<input type="checkbox"/>
11. We have effective referral mechanisms for patients to receive behavior change counseling.	<input type="checkbox"/>	<input type="checkbox"/>
12. We follow up on patients referred to other services (e.g., record test results on charts).	<input type="checkbox"/>	<input type="checkbox"/>
13. We can allow adequate planning time to incorporate prevention into our practice.	<input type="checkbox"/>	<input type="checkbox"/>
14. We have a quality assurance system in place to assess and improve service delivery (e.g., CQI, TQM).	<input type="checkbox"/>	<input type="checkbox"/>
15. We have a system in place to report the percentage of eligible patients who are receiving needed screening tests (e.g., Pap smears and immunizations).	<input type="checkbox"/>	<input type="checkbox"/>



Examples from the Field:

Hines, IL:

The dietitians at the Hines VA Medical Center “assessed” the employee population and determined a need to make available a weight loss prevention activity. The prevention activity was modeled after the weight loss content promoted on the Today Show, which had teams from different cities across the country competing with each other to lose weight and body fat. In order to compete for prizes, contestants had to sign up with a group of three individuals and give themselves a team name. All participants had their weight, body fat and abdominal girth measured by the dietitians and dietetic interns. Each team was assigned a dietitian coach who was available as a mentor to guide them in their weight loss attempts.

Three hundred employees participated in the contest at the onset. One hundred and eight-seven participants returned for post measures (62%). There was a grand total of 989 pounds lost, 193% of body fat lost, and 266 inches lost at the conclusion of the contest. Awards were given to the winning team.



Discussion Questions

1. Which preventive services does your medical center provide well? Which ones are more difficult to do?

2. Does your medical center set target goals for preventive services that are not in the performance measure set?

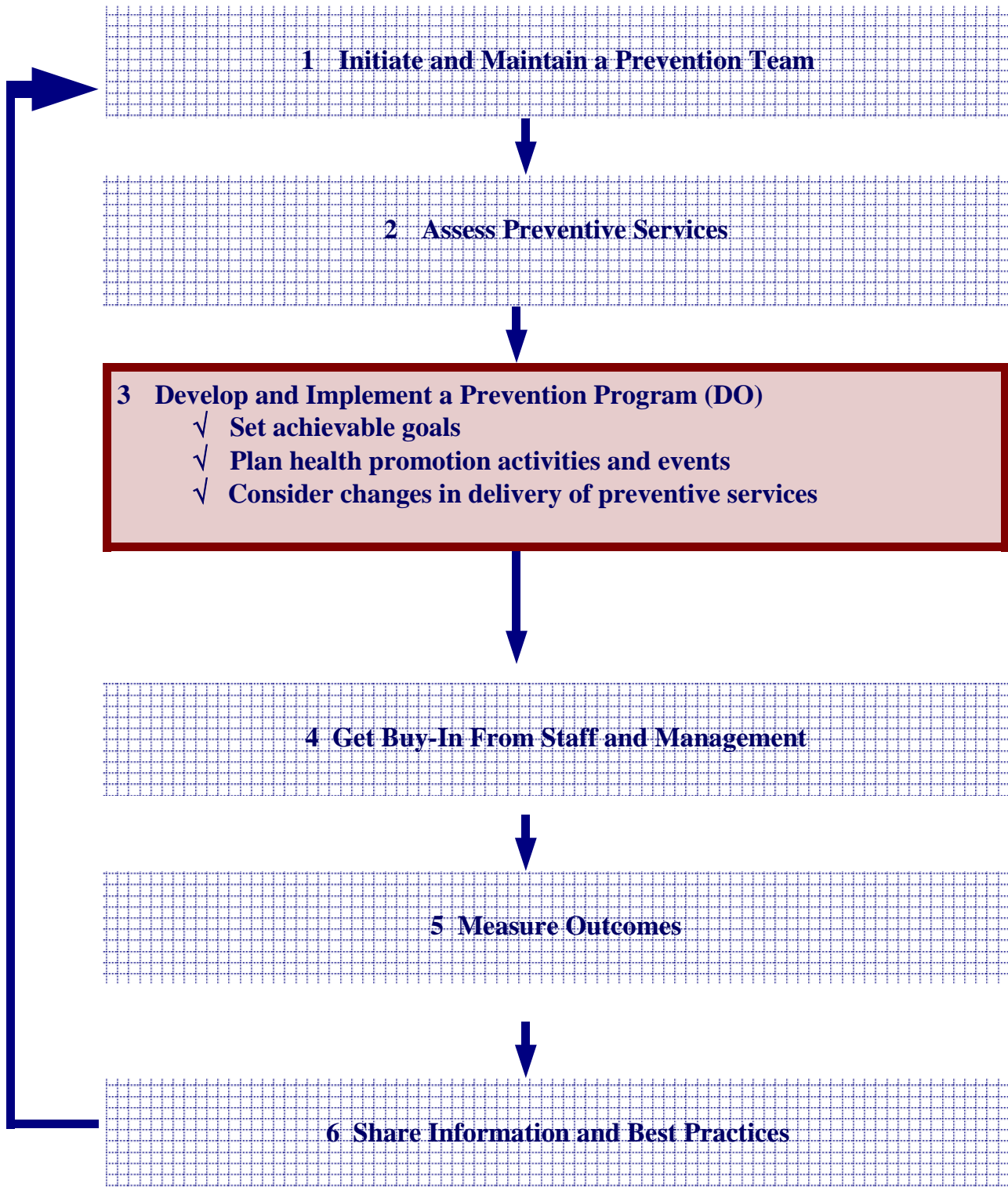
3. How are results of compliance and workload reports disseminated to providers and staff in your facility?

4. What are the steps you would take to overcome the gaps and barriers you've identified in providing health promotion activities and preventive care services?

3

Develop and Implement a Prevention Program





3

Develop and Implement a Prevention Program

Set Achievable Goals

Now that you have established a Prevention Team and assessed your current level of performance of preventive services and readiness to change, you will need an action plan to guide your prevention program's activities throughout the coming year or more. Although each facility has unique needs and the process may vary from one setting to

POINTS TO CONSIDER:

- *Follow your "hunches."*
- *Review patient education materials for content and reading level.*
- *Be creative.*
- *Think about patient flow in the clinic in considering system-level changes.*

another, the steps to developing and implementing an action plan for your prevention program in any setting should include the following:

- Set goals and timelines for 1 year and 3 years
- Determine what needs to be done by whom and when
- Plan health promotion activities and events
- Consider changes in delivery of preventive services, if needed, using a variety of delivery models
- Use patient health education materials

Set goals and timelines for 1 year and 3 years

An action plan is the guiding document for the work of the Prevention Team and the Prevention Coordinator. It specifies what preventive care issues will be addressed, which team members and other appropriate people/groups will address them, and a timeline for getting the actions accomplished. The goals and timeframes should be both short-term (1 year) and long-term (3 years). The goals should be reasonable and feasible (not too lofty). Use the information about current prevention practice learned in the assessment step to set the goals and to determine the specific actions to be accomplished. Congratulate yourselves on areas of current high performance and target those areas that need some attention.

Determine what needs to be done by whom and when

Consider starting with just one prevention issue first. It could be a fairly simple issue, such as promoting a monthly national observance, so the Prevention Team can experience a sense of accomplishment, before trying to take on a bigger, more complicated issue, such as increasing rates of colorectal cancer screening. Alternately, the Team may want to begin by addressing the area with the greatest need for improvement. See the Worksheet for questions to consider in developing a specific action plan and the sample report forms for writing down your decisions and plans.

Program Planning Worksheet

What issue will we address? (first, identify your target population and the preventive service - example: influenza immunizations for patients in the spinal cord clinic)

What needs to be in place to start the project (procedures, materials, staff roles, etc.)?

Who will be responsible for leading the project?

What IT support is needed?

When would the project start?

What information should be collected to evaluate the results? Who will do this and how will it be done?

What staff training will need to take place first? Who will do it and when/how?

What information/materials will be needed?

Design an annual prevention program action plan

Plan prevention activities on an annual basis. Do this every October or November at your team meeting. Review the following documents for ideas of areas to target:

- Schedule of monthly prevention topics the NCP will be developing and disseminating.
- National Health Observances website for additional ideas: www.health.gov/NHIC/pubs (this document is published annually).
- Past year's prevention topics from NCP.

Select prevention topics:

- Based on patient request (refer to Patient Satisfaction Data).
- Staff interest (may want to survey primary care staff)
- Prevention Team brainstorming and prioritizing

Decide frequency of activity (may want to start off quarterly and then increase)

Minimal Core Prevention Program Elements

1. Establish a Prevention Team and meet on a regular basis.
2. Review preventive services, which are included within the national performance measures.
3. Decide on 1-2 clinical preventive services that need improvement (look at your medical center's performance on the prevention measures).
4. Participate in one annual national preventive initiative.
5. Participate in a VISN-wide activity either improvement of a clinical preventive service or a health promotion activity (coordinate with VISN Preventive Medicine Leader).
6. Select other health promotion activities like 1-2 monthly prevention topics; coordinate a simple activity; or participate in a prevention booth at the medical center health fair.
7. Provide a staff education prevention activity.
8. Nominate either a Clinical (Hands On) Prevention Champion, Administrative (Behind the scenes) Prevention Champion or a Prevention Team Award annually.
9. Share at least one prevention program success story.

Complete an annual prevention program action plan. Your plan might look like the following sample plan.

Sample Annual Prevention Program Plan Fiscal Year

Activity	Steps	Responsible Person(s)	Target Date
<p>Select 1 or 2 Preventive Services Needing Improvement</p> <p>Colorectal Cancer Screening</p>	<p>1)</p> <p>2)</p> <p>3)</p>	<p>Lead: Connie RN</p> <p>Support: Primary Care Team—Blue Team 1</p>	<p>Monthly Ongoing</p>
<p>Select 1 or 2 Preventive Services Needing Improvement</p> <p>Alcohol Abuse Screening</p>	<p>1)</p> <p>2)</p> <p>3)</p>	<p>Lead: Dr. Richard</p> <p>Support: Mental Health Red Team</p>	<p>Monthly Ongoing</p> <p>Quarterly Reports</p>
<p>Participate in one Health Promotion Initiatives (Check One):</p> <p><input type="checkbox"/> Public Health Week</p> <p><input type="checkbox"/> Women’s Health Week</p> <p><input type="checkbox"/> Weight Management/ Physical Activity</p> <p><input checked="" type="checkbox"/> Veterans’ Day</p>	<p>1)</p> <p>2)</p> <p>3)</p> <p>4)</p>	<p>Lead: Susi—PC</p> <p>Support: Rosemary, Linda, Tim (Team Members)</p>	<p>November</p>

**Sample Annual Prevention Program Plan (cont'd)
Fiscal Year**

Activity	Steps	Responsible Person(s)	Target Date
Participate in 1 or 2 Health Promotion Monthly Prevention Topics Weight Management	1) 2) 3)	Lead: Mary RN Support: 3 Team Members	January
Participate in 1 or 2 Health Promotion Monthly Prevention Topics Heart Disease	1) 2) 3)	Lead: Steve PA Support: 3 Team Members	February
Plan Health Promotion Simple Activity or Participate in Health Fair by having a booth	1) 2) 3)	Lead: Kristy, Wellness Coordinator Support: 3 Team Members	September
Participate in a Health Promotion VISN-Wide Activity or Improvement Improve Mammography Screening Rate	1) 2) 3)	Lead: Pam—VISN Preventive Medicine Leader Support: All PC's and their teams from the VAMC's	3rd Quarter April, May, June
Plan to recommend and reward staff Nominate One Prevention Champion this year	1) 2) 3)	Lead: PC Coordinator	April
Participate in Staff Education and Recognition Primary Care Doctor will present Hypertension Inservice	1) 2) 3)	Lead: Dr. Linda Dr. Steve	July
Other Plan your yearly prevention program	1) 2) 3)	Lead: Eileen PC Support: Prevention Team	September

Plan Health Promotion Activities and Events

One of the best ways to highlight prevention messages is through health promotion activities and events, such as health fairs, campaigns, or other attention-getting events. Although organizing these activities requires some effort, they are fun to do and often attract a wide variety of patients, as well as employees. Having health promoting messages throughout the medical facility is a good way to remind everyone of the importance of taking care of one's health. Here are ideas for organizing and implementing several different types of activities, from a simple activity to one that is more complex.

Ideas to Organize and Implement a Simple Prevention Event/Activity

It's great to allow for flexibility in your medical center's prevention program. Spur of the moment and spontaneous prevention activities spark enthusiasm and are very effective in promoting prevention.

Staff members may read an article or attend seminars/meetings, which may generate a great prevention idea. Allow staff to e-mail or attend the next prevention meeting to present the idea. Always encourage participation. Help support the idea by allowing the staff member to coordinate an activity and provide assistance as needed.

Some examples include:

- **“Walk a little more today” – promote physical activity to patients and staff** (Display posters at medical center entrances and have a table with literature on physical activity)
- **Start a yoga class for patients or staff**
(Solicit help of an administrative staff person who can lead a yoga class or coordinate a class by rotating videotapes – announce in patient and staff newsletters, post flyers, etc.)
- **Encourage patient and staff participation in the “Great American Smoke Out”**
(Follow national media ideas)
- **Buckle Up – Seat Belt Safety Awareness**
(Post safety tips in patient areas, on patient TV channels, ask Police/Security section to provide information in the patient waiting room)
- **Staff “take the stairs” day**
(Post flyers, ask physical therapy staff member to greet staff on their way into work and share benefits of increased physical activity)
- **Share a nutrition “tip of the day” – for 10 days straight**
(Announce a nutrition health tip via patient TV channel, waiting room for pharmacy pick up area, etc.)
- **Skin Protection –The importance of sunscreen**
(Ask nurses to distribute patient information and answer patient questions at the medical center entrance)

Steps to Organize and Implement a Prevention Activity Based on a Monthly Prevention Topic

This will take a little more work than the “simple event/activity”.

1. Pre-Event Planning:

- Decide location of event such as lobby, in front of registration area, in the canteen, etc.
- Decide date(s) and times for event
- Decide if table/booth/exhibit can be free-standing or needs a staff member available to promote activity and answer questions patients may have
- Arrange for staff coverage if applicable
- Remember the logistics:
 - Reserve space: lobby/conference room/class room, etc.
 - Reserve space as far in advance as possible - consistency in location helps enhance participation
 - Ensure that A/V items are in place – TV/VCR/flipcharts.
 - Have handouts available
 - Advertise the Prevention Activity
 - Send e-mails to staff to communicate with patients (2-4 weeks in advance)
 - Publish planned prevention activity in facility newsletter
 - Post flyers in patient areas
 - Announce future topics at each activity

2. Prevention Activity:

- Provide handouts
- Answer questions
- When possible, provide prevention related items for free (water bottles; key chains with prevention message; refrigerator magnet with signs and symptoms of heart attack; healthy food, like apples or pretzels). Use available resources according to local policy and budgetary guidelines. Voluntary Service may be able to fund or supply food/drinks for events for veterans.
- Enjoy the patients, visitors, and staff who visit the activity
- Invite participant feedback. Post a sheet for patients to record comments, suggestions regarding future topics

3. Communicate outcome of Prevention Activity:

- Write a brief summary of the activity, count approximate number of participants and obtain pictures of patient participation
- Keep management informed of all activities
- Share your activity by submitting summary/pictures/article to:
 - Local medical center/CBOC newsletter
 - NCP HealthPOWER Newsletter
 - Post on local website/VISN website/NCP website
 - Add prevention activity to Annual Prevention Report (Chapter 5)

4. Evaluate effectiveness of prevention activity

- Number of participants via attendance log
- Ask for informal feedback from participants
- Decide if activity was beneficial enough to continue

Steps to Participating in a Health Fair

1. The Prevention Coordinator or designee is the most likely person to lead this initiative with the assistance and support of prevention team members.
2. Brainstorm which preventive services you would like to offer to. Examples include:
 - Weight Management – measurement of height and weight to determine BMI
 - Hypertension screening
 - Depression information
 - Stop Smoking booth
 - Skin cancer prevention education
 - Influenza vaccinations (during Oct-Feb)
 - Cholesterol screening
 - Fitness advice
 - Alcohol abuse resources
 - HIV information
 - Dental health information
 - Colorectal cancer information
 - Drug addiction resources
 - Nutrition counseling
 - Vision information
 - General safety information
3. Pre-Event Planning (Start 1-3 months in advance):
 - Decide if table/booth/exhibit can be free-standing or needs a staff member available to promote activity and answer patients questions
 - Arrange for staff coverage if indicated
 - Remember the logistics:
 - Reserve space early
 - Ensure that A/V items are in place – TV/VCR/flipcharts.
 - Have handouts available
 - Advertise the Health Fair
4. Day of Health Fair
 - Staff booths
 - Provide handouts
 - Answer questions

(Continued on next page)

- When possible, provide prevention related items for free (water bottles; key chains with prevention message; refrigerator magnet with signs and symptoms of heart attack; healthy food, like apples or pretzels). Use available resources according to local policy and budgetary guidelines. Voluntary Service may be able to fund or supply food/drinks for events for veterans.
 - Enjoy the patients, visitors, and staff who visit the prevention exhibit.
 - Invite participant feedback. Post a sheet for patients to record comments, suggestions regarding future topics.
5. Communicate Health Fair Prevention Exhibit success:
- Have a “Health Fair debriefing” to identify strengths/successes and areas for improvement, and review participant evaluations
 - Write a brief summary of the activity, count approximate number of participants and obtain pictures of patient participation
 - Keep management informed of prevention activity health fair success/improvements
 - Share your activity by submitting summary/pictures/article to:
 - Local medical center/CBOC newsletter
 - NCP HealthPOWER Newsletter
 - Post on local website/VISN website/NCP website

Consider Changes in Delivery of Preventive Services, if Needed, Using a Variety of Delivery Models for Preventive Services

If the team identifies a need to change how preventive services are being delivered, consider a range of approaches, or delivery models, for addressing the selected prevention issues, based on what seems most appropriate (e.g., mass campaigns for influenza immunizations, group clinics for patients with diabetes). The same solution likely doesn't fit all problems. Action plans for some prevention topics may center on changes in clinic structure or organization, such as expanding the role of nurses for counseling patients about difficult behavior changes.

One delivery model that has been found to be effective for preventive services is group orientation clinics, where patients are asked about preventive care as part of the process of learning about services at the VA medical center. This allows an opportunity to determine which preventive services patients have had recently and which ones need to be completed. For preventive services with standing orders, nurses can complete those immediately. For ones requiring referrals, that process can be started before the patient has his/her first appointment with the primary care provider.

Some facilities have expanded the role of nurses to allow them to take a larger part in providing preventive services, especially counseling. A growing number of screening, counseling, and chemoprevention services require more detailed education and sharing of the decision making process than busy providers have time to do. Engaging other members of the health care team can help to spread the workload around, thus enabling patients to receive high quality care without overburdening the primary providers.

Another model for delivering preventive services that has been used successfully in many facilities is group clinics, typically for patients with particular diseases, such as diabetes or hepatitis C. During these group visits, a wide range of prevention and treatment issues can be addressed.

In thinking through how and where to consider changes in organization to improve preventive service delivery, it may be helpful to map out how a patient moves through the primary care clinic area. Thinking through the patient flow may give the Prevention Team ideas about ways to efficiently provide appropriate preventive care. Refer to the Clinical Flow Worksheet for questions to consider.

Clinical Flow Worksheet

Patient Enters the Clinic for an Appointment

- How and when does your clinic identify which screening activities are up-to-date and which preventive services are indicated for your patients?
- Which staff members greet patients?
- Who guides patients through the clinical setting?
- Where do patients go and with whom do they interact?
- Whom do patients see before seeing the clinician? What information is collected or discussed at this time?

Patient Sees the Clinician

- How does the clinician use the patient appointment to reinforce, educate, and counsel the patient on preventive care and positive health behaviors?
- How is the patient's preventive care monitored over time?
- What services are documented? How and where are services documented?

Patient Exits the Clinic

- How does the staff obtain patients' feedback on their experiences in the setting?
- How does the staff demonstrate their interest in the patients' progress toward healthier lifestyles?
- How can the staff reinforce patients' positive behavior changes?
- What kind of monitoring system is in place to follow up with off-site screenings?
- What kind of reminder system is in place to follow up with needed screenings or counseling?

There are many ways to efficiently and effectively ensure that patients receive health promotion and disease prevention education and procedures. The Prevention Coordinator, working with the prevention team, can determine which strategies and activities work best for which issues and needs of the patients in their facilities. An important section of the action plan is to identify measurable outcomes, so the team will be able to determine how well its plan is working, and to get buy-in from staff and administrative leaders. Those steps are covered in the next 2 chapters.

Disseminate patient prevention health education materials

Having high quality, well written patient education materials about prevention readily accessible in clinic areas helps providers and clinical staff to reinforce prevention counseling messages to patients. Patient education materials need to be written in words that patients can understand (not using jargon) and at a reading level low enough to fit most people (usually about 6th grade level). Good sources of prevention materials are the Patient Health Education Committee, the VA medical center library, and NCP materials posted on its website (www.vaprevention.com).



Examples From the Field:

Washington, DC:

The prevention team is very involved in the formulation of policy, documentation systems, reminder development, clinic processes, educational resources, EPRP review, and all activities related to the program. Staff education is continuous whether it occurs in the yearly VISN 5 conference, in meetings, or in emails. At this facility, there is a spirit of ownership of the medical center staff of the HPDPP. The program is founded on very strong support from the medical center leaders and excellent performances are recognized and rewarded. A combination of good leadership, supportive management, staff involvement, staff education, good communication, strong organizational structure, and staff recognition are key to keep a team started and going.



New Jersey Health Care System:

This facility "Walk" was organized by the PC (Prevention Coordinator) with help from Voluntary, Employee Health, and Guest Relations Departments. Everyone from all sites (9 CBOCs, East Orange and Lyons campuses) was invited. There were 30 participants at the Lyons Campus led by the Associate Director and Prevention Coordinator. East Orange campus had 28 participants led by the Chief of Guest Relations and at the CBOCs approximately 20 individuals participated collectively.

Those participating included veterans, volunteers and employees from various departments. All of the walks lasted about 30 minutes and the length of the walks varied from facility to facility. All were given educational material at the start of the walk and at the end of the walk bottled water was distributed to the participants.



Poplar Bluff, MO:

Monday, November 10, 2003, the John J. Pershing VAMC hosted a program entitled, Veterans On the MOVE! - Making America Stronger!" This program included veterans/patients, VSOs, volunteers, staff and significant others related to the veterans being treated at this facility. The activity began with a formal program, including a welcome by the Medical Center Director who is an active supporter of healthy life styles and exercise. The medical center preventive health coordinator presented briefly regarding the benefits of preventive health activities, and the positive outcomes that have been linked to walking. Handouts on exercise, with an emphasis on walking were made available for all. Then the entire group was asked to participate in the kick-off walk, which was scheduled for a quarter of a mile, on the walking path surrounding the medical center. Over 50 individuals participated in the walk, with participants ranging from 4 years of age to 85 years of age. Certificates of accomplishment were provided to all who walked, signed by the Director of the VA National Center for Health Promotion and Disease Prevention. Special recognition was given to the oldest and youngest participants.

Continued on next page

The MOVE Program has been set up with an emphasis on continuing the activity on a regular basis. Employees have set up competitive walking teams, to identify who has walked the furthest, with the most positive life style changes within the next year. Patients have been invited to join these teams, thereby having a support group to work with, as well as the safe walking environment of the medical center.



VA Central Iowa Healthcare System:

Theme: In 1918, on the 11th hours of the 11th day in the 11th month, the world rejoiced and celebrated. After four years of bitter war, the Allied powers signed a cease-fire agreement (an armistice) with Germany at Rethondes, France on November 11, 1918, bringing World War I to a close. The “war to end all wars” was over. November 11, originally known as Armistice Day was renamed Veterans Day in 1954 to honor veterans of all US wars. VA Central Iowa Healthcare System used the number 11 as a fitting remembrance of the sacrifice of veterans and promotion of the Veterans on the MOVE” initiative, which was intended to encourage exercise and weight reduction.

Activities: Five events were planned for veterans and staff at each campus (Des Moines and Knoxville). Starting time of events were 11 minutes past the hour between 10:11 a.m. and 2: 11 p.m. Each event lasted for 11 minutes or involved the number 11. The events were:

- 11 minute walk. At 11:11 a.m. the Chief of Primary Care received applause after providing 11 beneficial tips for exercise and weight reduction in Des Moines. Winds of up to 50 miles per hour challenged the 22 walkers who circled the medical center. The Associate Director for Patient Care/ Nursing Services inspired walkers in Knoxville and modeled the exercise benefits of walking, including demonstrating use of her pedometer. As an exercise instructor in the community, she genuinely and enthusiastically endorsed the many benefits of some type of regular physical activity.
- 11 minutes of a “marathon of motion.” Exercise in 11 minute increments keep a treadmill and exercise bike going continuously between 10:11 a.m. and 3:00 p.m.
- 11 minutes of stress management techniques provided by a psychologist and a nurse included exercises to alleviate stress.
- 11 nutritional tips and suggestions of healthful food products were provided at the VA Canteen along with a special healthy meal that sold out.
- 11 minutes of yoga at the Des Moines campus and 11 minutes of bowling in Knoxville. At Knoxville’s bowling venue, Ted Sharp brought his “300” ring and news story as well as another high average bowling ring. Ted offered bowling tips to veterans and staff. Des Moines participates. A yoga instructor encouraged stretching muscles regularly.

Discussion Questions

1. Identify key steps in developing a prevention program.

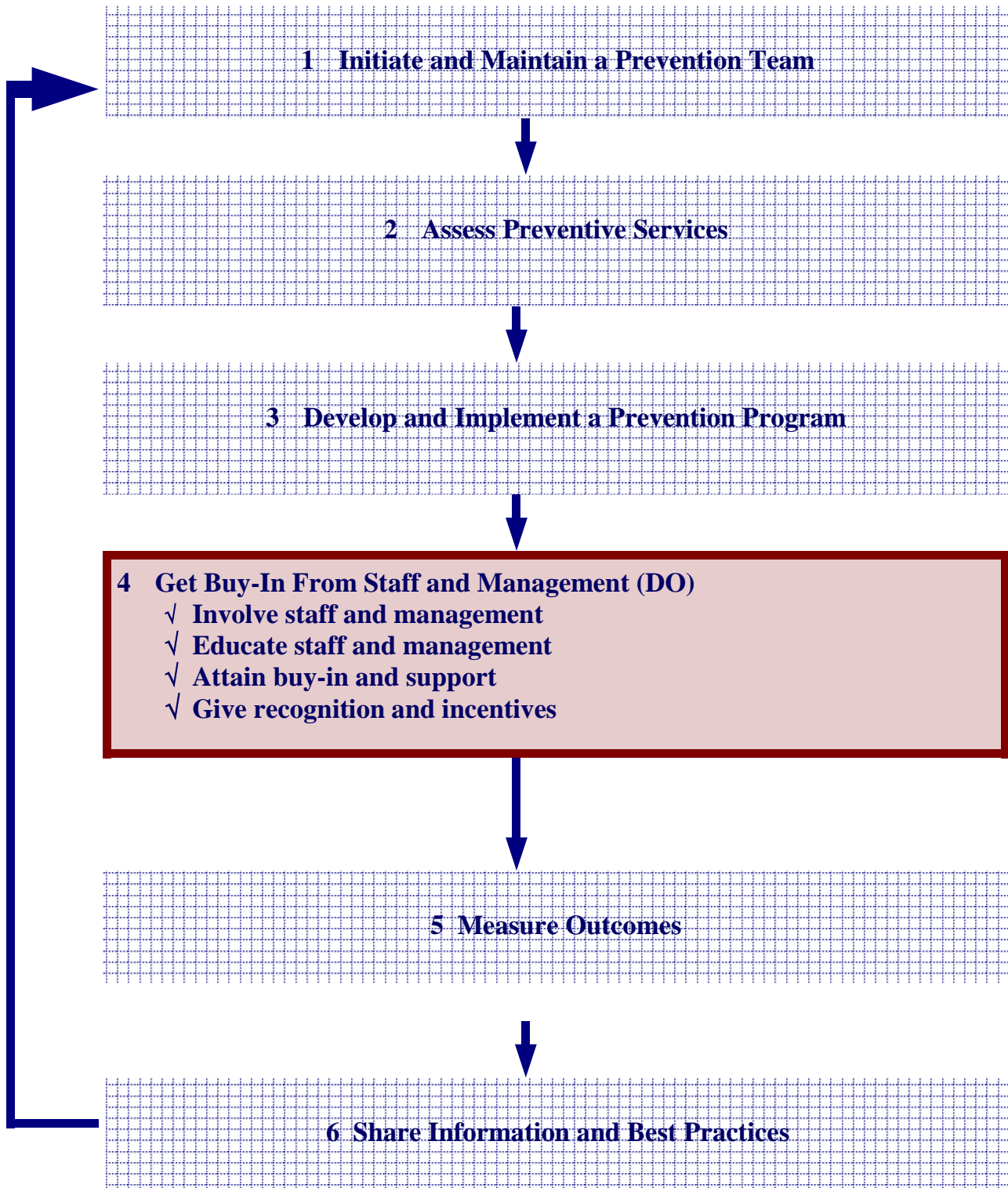
2. What steps would you take in planning facility activities related to a national observance?

3. How would you explore different delivery models if you decide to change how your facility delivers preventive services?

4

Get Buy-In from Staff and Management





4

Get Buy-In From Staff and Management

Involve Staff and Management

POINTS TO CONSIDER:

- *Know your facts.*
- *Seek opportunities to engage others in your mission.*
- *Be responsive to issues.*
- *Never give up!*
- *Persistence pays off.*

Now that you and your Prevention Team have been meeting regularly, have assessed the delivery of preventive services and have a good start on developing an action plan, it is time to seek buy-in from management and staff. Before an organization-wide systems change can occur, the entire staff should agree:

- Prevention is important
- Prevention aligns with the clinical setting's values

Incorporate staff values and beliefs:

Staff values and attitudes about prevention, how staff view their current practice, and goals for the delivery of preventive care are critical components which impact system-wide change. Use information from the assessment of staff for readiness to change (Chapter 2).

- Solicit, acknowledge and consider input.
- Understand the values, attitudes, and beliefs of the staff to determine support and buy-in of the staff.
- Acknowledge the value of staff members who openly resist change. Often those who resist change see barriers to change that need to be addressed. If the opinions of all staff members are considered important, and if all staff members are enlisted to solve problems, then barriers to implementing *Put Prevention Into VA Practice* can be overcome. Those who initially resist may become champions of change and innovators.

Embrace new ideas:

The PCDA (Plan-Do-Check-Act) model and the scientific approach in general thrive on new ideas – ideas about how to make things work better and run smoother. Without new ideas and change, there is no improvement in an organization.

Idea “killers” include sentiments like:

- Management will never go for that!
- If it ain't broke, don't fix it!
- The policy says.....
- That will only work in private industry, remember you work for the Government!

Creative managers/leaders love to hear expressions like these:

- What do you think about this new idea?
- What are the options?
- I'd really like your help on expanding this idea to see if it will work.
- Let's give it a try.
- I've got a crazy and wild idea.
- I don't know much about that: can you tell me more?
- Who else has some ideas about this?
- What are some other ways to accomplish this goal?

Educate Staff and Management

An important way to get buy-in from staff and management for the prevention program is through educational activities on prevention topics. Learning new or updated information on prevention issues helps staff and management to understand the key concepts and controversies and to appreciate the significance of prevention issues for patient care. There are a number of ways to provide educational opportunities:

- Provide an in-service for clinic staff in primary care or subspecialty clinics.
- Organize a “Lunch and Learn” session or a 15 minute “coffee break” inservice.
- Ask local “experts” from the facility or affiliated medical school to speak at a departmental or staff meeting.
- Discuss educational opportunities with the Assistant Chief of Staff for Education.
- Contact the local health department for speakers on public health issues.
- Contact a local community college for speakers on general topics related to health care (such as “Spanish for Health Care Providers and Staff”).
- Look for on-line continuing education modules on prevention topics (the NCP has several posted on its webpage).
- Attend national prevention conferences and report back to others about what was learned.
- Seek out other individual educational opportunities.

Use the following educational approach as an example.

Guidelines for Organizing a Lunch & Learn

1. Have an objective in mind. Response is best when the topic and objective address a specific need, such as new processes or equipment, change in practice, etc.
2. Choose a time that is best for the targeted audience.
In some settings, the hour before clinics begin is the best time – or during lunch break - or the end of the day. Trials of different times might be needed to ensure the best time.
3. Remember the logistics:
 - a. Reserve a conference/class room appropriate for the group size.
 - b. If possible, reserve the space for a year in advance. (Consistency in location helps enhance attendance.)
 - c. Ensure that A/V items are in place – TV/VCR/flipcharts.
 - d. Offer to copy handouts.
4. When contacting or arranging speakers, inform them about the number of people to expect and their backgrounds (MDs, PAs, RNs, NPs, etc.).
5. Advertise the presentation. Send out e-mail notices, post flyers, announce future topics at each session, keep management informed of all presentations.
6. Vary teaching methods. Methods may include lecture, case study formats, panel presentations, videos, teleconferences.
7. Vary topics. Consider medical models, behavioral topics, legal issues and concerns.
8. Provide parallel information. Tie in speaker content with Clinical Practice Guidelines. Have pocket guides for distribution when appropriate. Use handouts whenever possible.
9. Thank the speaker and the audience.
10. When possible, provide food. Use available resources according to local policy and budgetary guidelines.
11. Provide CE credit to all participants who sign the roster. Have all names logged into TEMPO.
12. When possible, provide CMEs, CEUS for credit.
13. Invite participant feedback. Post a sheet for attendees to record comments, suggestions re future topics, alternate suggestions for times for in-services.

Attain Buy-In and Support

A single person can make a difference and a team can do phenomenal things! Talk with staff and management, involve them in the problem and ask them to be part of the solution. Communicate issues and ask for support and buy-in. Persistence does and can pay off.

An Example of “Buy In – From the Bottom Up”:

Staff buy-in can be achieved in a variety of ways. Sometimes, staff responds to a challenge that is presented to them. Carol Robinson, RN, MSN, was one of the Primary Care staff members at DVAMC who was presented with a challenge and rose to the occasion. Not only is their response an example of buy-in from the bottom up, but they also followed most of the steps described in this manual with the creation of a Nurse Managed Risk Reduction Clinic, reflecting a comprehensive cardiovascular risk reduction approach..

The Chief of Ambulatory Care Services (ACS) asked for nursing input to fix a problem: patients with Coronary Disease had higher LDLs than recommended by National Cholesterol Education Panel guidelines. The nurses explored ways to better manage lipid without increasing patient visits to Primary Care providers by doing literature searches and networking with multiple VA facilities. (*Assess Prevention Services*)

The nurses developed a proposal for a clinic structure that was approved by the Chief of ACS. (*Develop and implement a plan*) Initial designated team members included the following: (*Initiate and Maintain a Team*)

- Part-time physician (developed protocols for nurses to modify cholesterol medications)
- Part-time dietitian (focused on dietary components)
- Physician’s assistant (assisted with assessment and writing of prescriptions for medication changes)
- Two part-time nurses (developed patient education materials)

Four months into the process, patients were enrolled in the clinic. Consults came from the Primary Care staff. Initially, patients required counseling but few medication changes. Soon after the Risk Reduction Clinic began, a Lipid Clinic was started. To ensure good coordination between the clinics, one nurse coordinated both. If lipid management was required, the dietitian and nurse saw the patient and the physician assistant reviewed medication modifications. If the consult was more complex, the dietitian and nurse provided lifestyle counseling and the physician saw the patient.

Since the clinic's creation, staffing has increased to include: Endocrine fellow, Primary care resident, 1.5 RNs, 1 LPN, 1 dietitian, clerical staff. The Clinic contacts increased from approximately 650 nurse visits in 1997 to almost 1600 in 2003, growing 20-40% each year. (Measure Outcomes) Other outcomes include:

- Positive patient satisfaction survey results (patients express appreciation of the close follow-up and trust established with staff)
- Patient outcomes with eighty (80) percent of the hard-to-manage patients reaching LDL goals and an additional twelve (12) percent close to goal
- Ninety-two (92) percent of patients report positive dietary changes
- Eight-five (85) percent of patients are exercising more
- Fifty-six (56) percent of tobacco users quit and remained off tobacco for at least a year.
- Staff involved express satisfaction with their ability to provide a needed service to high-risk cardiovascular patients while expanding their professional expertise and pioneering expanded roles for VA nurses.

This is truly a prevention example of obtaining “Buy In – From the Bottom Up” and *Sharing Information and Best Practices*.

In VISN 4, the Network Director's presence in the field of health promotion and disease prevention is felt throughout the network via use of Roundtable Discussions. Each quarter, the Network Director invites caregivers to meet personally with him for an organized discussion of health promotion and disease prevention topics. Recently, topics covered have included:

- nutrition and prevention of diabetes,
- prevention of communicable diseases in general and sharps injuries to employees in particular,
- smoking cessation,
- prostate cancer screening.

For each of these topics, providers at various levels within the network, topic experts, and administrative staff are invited to have an in-depth discussion of the particular issue. The experts provide a presentation on the state of the art and recommended practices for health promotion and disease prevention related to that particular topic.

The Roundtables have proved particularly effective in raising provider awareness, which has resulted in changes in practices within the network. Most importantly, the discussions provide a briefing for the Network Director on the importance of the

specific topics and implications on allocation of resources for additional action designed towards health promotion and disease prevention.

The Roundtables also serve the additional purpose of bringing providers in contact with the Network Director and provide them an opportunity to voice their opinions as well as experiences. The Network Director's conviction for improving quality of care for veterans, his personal involvement, interest, and dedication to health promotion and disease prevention is readily apparent to the participants in the Roundtable Discussions; thereby, altering the culture, practices and expectations within the network.

In brief, the Network Director is an outstanding champion of health promotion and disease prevention through his personal example and practices, one to one meetings with veterans, support of education in health promotion and disease prevention, and most of all by holding regular Roundtable Discussions on important topics related to health promotion and disease prevention.

In the process of attaining buy in, you may need to use some of your best negotiation skills. Here are some tips on the art of negotiation.

THE ART OF NEGOTIATION

TIPS:

1. Know yourself:

Take personal inventory: am I going too fast; do I want to win no matter what? Either of these stances may lead to an adversarial role and limit your options.

2. Do your homework:

Know who you are negotiating with; determine if this is a win/win situation or win/lose; does the person want to negotiate, dread it, or is in a neutral position?

3. Practice double and triple think:

In addition to knowing what you want, anticipate what the other party wants (double think), and what they think you want (triple think).

4. Build trust

Negotiation involves a high level of communication, which won't happen without trust. Without trust, manipulation and suspicion color communications. Be trustworthy; honor commitments; be truthful and respect confidences.

5. Develop external listening

Turn off your inner voice so that you can listen externally only in order not to miss nonverbals, facial expressions, etc.

6. Move beyond positions

Initially state your position. After trust is established, identify true interests. Learn the other party's interests by asking questions.

7. Own your power

Don't assume the other person has more power, due to position, etc. Balance power by really assessing the other person's power and your own. Power breaks down to 2 main categories: internal (can't be taken away from you; includes personal power, level of self-esteem, and self-confidence) and external (fluctuates with situation, such as demotion or loss of expertise due to new technology). Negotiations are never dead because power dynamics change. Be patient.

8. Know your BATNA

BATNA stands for Best Alternative to a Negotiated Agreement (taken from Harvard Negotiation Project research). Before negotiations start, know your options. What are your choices, the pros and cons of each choice and consider the BATNA of the other person.

9. Know what a win is

Think about best and worst case scenarios. Settlement range is the area between the two (a Win). Don't agree to anything below your bottom line, because you may fail to honor that commitment.

10. Enjoy the process

Negotiation is a process with predictable steps. Skill can be developed in facilitation of each step.

(From Skills, Techniques and Strategies for Effective Negotiation: Tips from Barbara Braham: <http://www.bbraham.com/html/negotiation.html>)

Give Recognition and Incentives

Reward good team participation. Small and big recognition goes a long way. Ideas include:

- Handwritten thank you note
- Recognition and praise by the Medical Center Director and/or Chief of Staff and/or Service Chief at a team meeting or at a Special Recognition Employee Meeting
- Certification of Appreciation
- Certificate of Appreciation with a cash award
- Team “time off” award for contributing team members
- T-shirt, coffee mug, desk calendar or other symbol that serves as a team award
- Published article mentioning all team members
- Pictures and a summary of team contributions highlighted in the local/VISN/National newsletters
- A nice, simple thank you at frequent intervals
- Letter of appreciation highlighting individual contributions to team member’s supervisor/Service Chief
- Nominate a Prevention Champion—a colleague, prevention role model or a team

Peter R. Scholtes and other contributors: *The Team Handbook*, Joiner

Brian L. Joiner: *Fourth Generation Management - The New Business Consciousness*

Joyce Wycoff, with Tim Richardson: *Transforming Thinking - Tools and Techniques That Open the Door to Powerful New Thinking for Every Member of Your Organization*



Examples From the Field:

Washington DC:

Top Down— In Fall 2003, the Chief of Staff formed a Performance Measures Work Group. This group has members that come from leadership and staff positions. A major part of their work is to provide top-level management support to the implementation of the Health Promotion and Disease Prevention program, monitoring performance, identifying processes for improvement, and supporting staff to effect improvement activities.

Bottom Up—Staff valued prevention at the start of the program in 1998. It was very important that all staff were educated and understood not only what the prevention program is all about but also to be able to envision what our medical center will become - a center that is more ambulatory care with a focus in prevention and less in the disease treatment mode. All kinds of educational activities were used from full workshops to individual instructions for all staff. Each staff member is required to complete training prior to providing preventive services. Mentoring is also used. Once a year, the medical center Primary Care clinics function on a skeleton crew, so that all clinical staff attend a one-day update on prevention. Staff are consulted for any new initiative from the design of a reminder template to the timing of the introduction of a new initiative. An example of from the “bottom up buy-in” is the use of clinical reminders. At first, the staff found completion of reminders tedious but eventually participated in the design of local reminders. Staff are involved in design of all reminders.



VA New York Harbor Health Care System:

A “Veterans on the MOVE” walk to encourage veterans and employees to increase their activity levels took place on November 10th at all three campuses of VA New York Harbor Healthcare System (VANYHHS). Each participant was given a booklet containing exercise, nutrition tips, and forms they could use to record their daily activity levels and monitor their progress.

More than 70 people ranging in age from 16-82 years old participated in the walk at our VANYHHS campuses located in three New York City boroughs: the background for the walks included the lovely grounds of our campus at St. Albans in Queens, the banks of the East River one block away from our Manhattan campus, and the popular walking paths adjacent to the emerald green Brooklyn golf course within view of the Verrazano-Narrows Bridge across the street from our Brooklyn campus. Our VANYHSS director and other administrators joined in this first “Veterans on the MOVE” walk and encouraged others to walk as well. Enthusiastic designated employees led the walks and also brought up the rear to keep stragglers together.

Discussion Questions

1. How supportive is your medical center's management toward prevention?

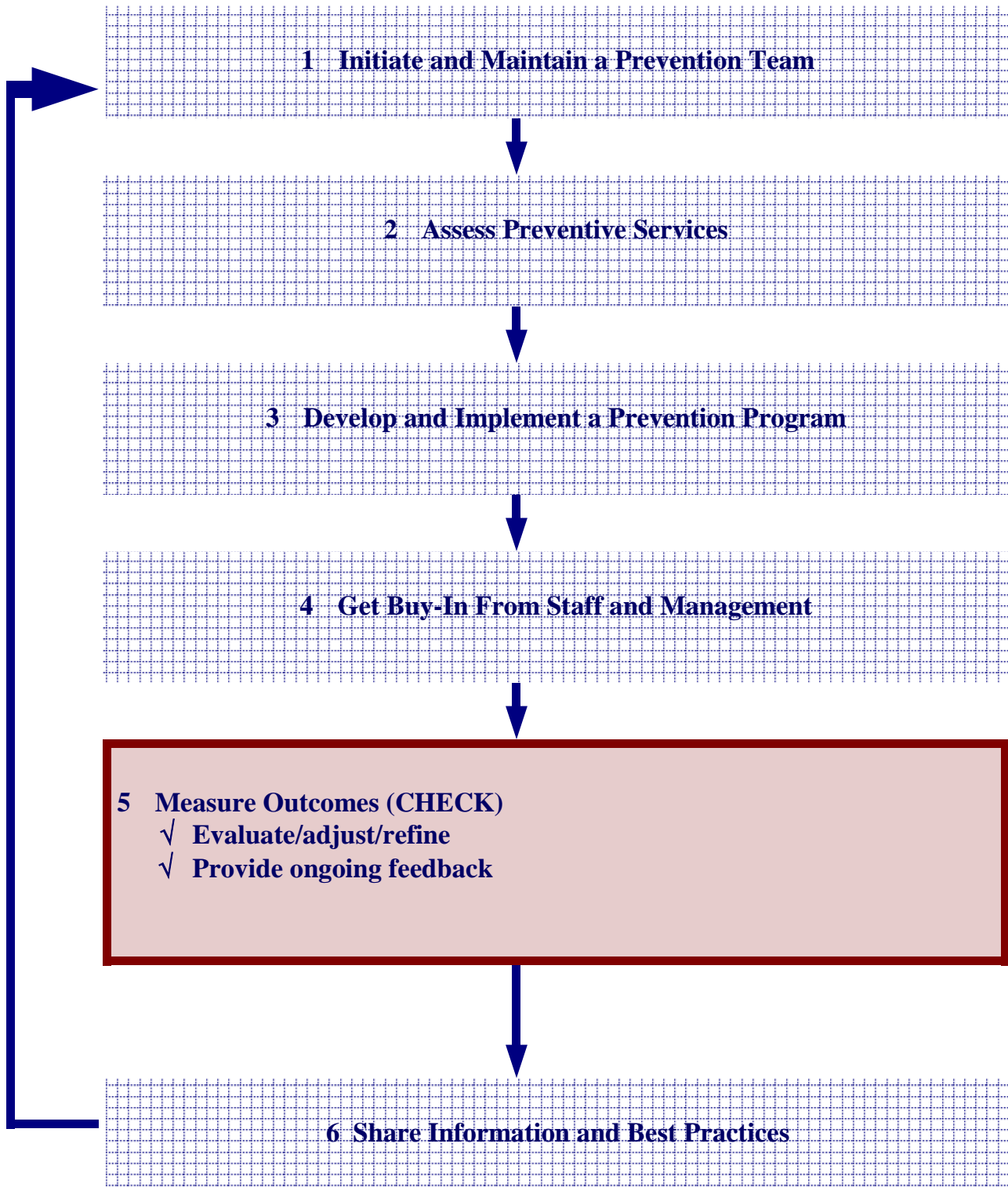
2. How open is your medical center to accepting change or supporting new ideas?

3. Share examples of a successful change that happened because of:

- a. Buy-in from the "bottom up"?**
- b. Buy-in from the "top down"?**

Measure Outcomes





5

Measure Outcomes

POINTS TO CONSIDER:

- *Evaluate continuously.*
- *Communicate and ask staff for their input.*
- *Use data whenever possible to assess progress towards goals.*
- *Record accomplishments.*
- *Identify areas where improvements are needed*

Evaluate/Adjust/Refine

Evaluating your medical center's prevention program is one of the key factors to ensure there is a successful Prevention Program in place. Evaluation is a continuous process and is a critical step in a quality improvement (QI) model. Your medical center's quality improvement model may be Plan-Do-Check-Act, Plan-Do-Study-Act, or perhaps your medical center has adopted another model. Whatever model you are using, evaluation or assessment (i.e. Check, Study) is one of the important steps in the process.

While evaluation and assessment is an ongoing process, a formal review of your program should be conducted annually. To begin the process you will need to identify those individuals who will be in charge of conducting the review, and those individuals who will assist in the review. It is also important to consider the goals that were

established and to assess your progress in meeting these goals and objectives. These goals will include the National Performance Measures with established fully successful and exceptional targets, and may also include goals that have been established locally for your medical center's prevention program. Whenever possible data that can be collected from patients, staff and the system, should be used to evaluate your

accomplishments and assist in identifying and prioritizing areas for improvement. Your quality management department is a good resource to assist you with the national performance goals and to guide you to the official data that is posted in the Office of Quality and Performance's (OQP) Executive Briefing Book (EBB). Other key pieces of information to consider in your evaluation are such things as local patient and staff questionnaires or surveys; results of medical record reviews; and information shared during staff meetings or at more informal gathering, such as lunches.

Program evaluation includes a review of a number of factors. For ease of understanding, these factors can be grouped into three categories: structure, process and outcomes. A good place to begin evaluating your program is to look at the structure. This review can be accomplished by answering a few key questions. Do we have a plan for our Prevention Program? Have we established goals and objectives to achieve? Do we have a committee to coordinate our activities? Do we have the right areas represented on our committee? Do we have the right team members?

Next, consider the processes that are in place for the delivery of preventive services to your clients. These processes of care delivery are directly linked to the success of your prevention program and to the outcomes you will be able to achieve. Once again, a good approach to conduct an evaluation is to ask yourself and your team members some key questions. Is there a systematic process in place to deliver preventive services? Has the staff received appropriate training? Are patient education services in place to enhance the patient/client partnership? Are clinical reminders being utilized to provide guidance in prevention to the practitioners? What things are working well and what processes are not effective? What changes would enhance our activities for the upcoming year?

In addition to evaluating the processes in place for the delivery of preventive services, it is important to evaluate how you approach your performance improvement activities. Communication is one the critical elements for performance improvement. Each staff member needs to have a basic understanding of the goals and objectives and the established targets. In addition, data needs to be frequently shared on current level of performance and the improvements that have been made. Key questions to address include the following: Do we have a process in place to analyze our data on a monthly basis? Do we share the results of our performance with the staff routinely? Are the results published where staff can see them? Do we review the established targets and determine how close we are to the measurable goal? Do we determine areas where we are under-performing and develop a plan for improvement? Do we publicize and celebrate our achievements? These are all important questions that will impact the outcomes and successes your prevention program is able to achieve.

The final piece to evaluate is outcomes. In the context of this discussion we will *consider successful outcomes as those in which we reach our measurable goals.*

consider successful outcomes as those in which we reach our measurable goals. The implementation of clinical practice guidelines that includes the provision of preventive services are measured and evaluated through the national performance measurement system. The majority of the data is being collected through the External Peer Review Program (EPRP), with an on-site individual abstracting data from the medical record at each medical center. Thus, one of the easiest ways to evaluate outcomes in the context of this discussion is through a review of the results of your EPRP, by conducting a comparison of performance to the fully successful and exceptional goals that have been established. This review could result in a simple list of the measures where the exceptional goals were met, where the fully successful goals were achieved and where the medical center was under-performing. Many of the measures in the clinical interventions realm are now focused on health care outcomes, rather than looking only at the process of care. For example, rather than just ensuring that a patient's blood pressure was checked, the focus is on ensuring the blood pressure is under control. Nonetheless, there is a clear linkage between the process and the outcomes of care.

Ways to Evaluate Performance

Staff:

- Have regular staff meetings to assess need for education, to introduce new ideas, and present regular reports
- Review national employee satisfaction surveys results
- Elicit employee feedback and suggestion through local questionnaires, if appropriate
- Schedule informal opportunities to share and communicate, such as staff lunches

System:

- Conduct chart reviews to assess delivery and documentation of services; compare to baseline reviews; share findings with staff
- Review/analyze monthly EPRP reports on performance
- Review/analyze monthly patient satisfaction survey results (Survey of Healthcare Experiences of Patients: SHEP)

Patient:

- Elicit patient feedback by creating a suggestion box, conducting focus groups, having clerks get feedback from patients, conducting customer satisfaction surveys/calls

Provide Ongoing Feedback

Time, you will need to evaluate your performance on an ongoing basis to determine whether the prevention goals are being met. The more often you evaluate your progress towards your goals, the more opportunities you will have to identify areas where you are excelling, focus on areas that require addition emphasis due to under-performance, and make the appropriate mid-course corrections. For example, if you only review progress towards your goals every six months, in a year's period of time you may only make appropriate changes twice. On the other hand, when you do a monthly review of your progress towards the established goals, there will be 12 opportunities to make changes to enhance your performance. This also provides the opportunity to share news of your achievements more frequently, thus motivating staff and recognizing those individuals who are instrumental in meeting your goals.

Providing feedback to staff through the review and analysis of information is a critical factor in making improvements. It is extremely important that the staff have easy access to such information. Assess to data can be facilitated by posting the results of your prevention measures (i.e. cancer screening, diabetic foot exam, hypertension control, immunizations administered, etc.) and showing the progress towards the established goals. This can be done by displaying monthly performance information on a chart or poster placed in a common staff area, such as a conference room or lunch/break room, etc. Studies have demonstrated that when staff see the results of their performance, can see what the goal is and how close they are, they will frequently make the needed changes.

It is particularly important to acknowledge areas of excellence to motivate staff to maintain and improve the delivery of preventive services. To evaluate effectively, it is necessary to set times for ongoing evaluation and to keep lines of communication open. Positive feedback can be given verbally, via e-mail messages, in staff meetings and conferences, and/or through formal channels, such as awards for special contributions and/or written feedback for proficiency input.

Specific deficiencies may be hard to pinpoint. Use your quality representative team member to problem-solve difficult issues. There are many quality tools that the quality representative can assist you with, such as flow charts, run charts, Pareto charts and cause and effect diagrams.

When an opportunity for improvement appears, on an individual basis, feedback may be presented in a one-to-one session in which there is an opportunity for discussion about the specific deficiency and suggested actions for improvement.

Use evaluation tool on the next page as a sample.

PREVENTION PROGRAM EVALUATION

Sample Questions to Ask

1. How will we review our progress?
2. How often do we need to review progress?
3. Who is responsible for the review?
4. How will we measure success?
5. Are we functioning in line with our purpose/vision?
6. Are we providing the services we said we want to provide?
7. Do we need to reevaluate our goals and/or the services we offer?
8. What is not working well? Why?
9. What can be done differently?
10. Are we documenting the services we provide?
11. What data are available so we can evaluate our performance?
12. Do we need to obtain additional information for a complete evaluation?
13. Do we need to conduct chart reviews to evaluate the quality of preventive services, or is our EPRP data sufficient?
14. If so, who should conduct the reviews?
15. Who will analyze and present data?
16. How are staff members performing their functions?
17. Are staff members working together as a team?
18. Are staff members contributing suggestions?
19. How do staff members feel about their work?
20. Do staff members feel supported and heard?
21. How will we measure the need for staff training?
22. Who will arrange for staff training?
23. Who will conduct staff training?
24. What will we do if we need technical support?
25. How are patients responding to our program and to changes made?
26. Do we get specific feedback from the national, monthly patient satisfaction survey?
27. Are we delivering our services in a timely manner?
28. Are we collaborating with other specialty services to ensure continuity of care and appropriate follow-up to our preventive screening efforts?



Examples From the Field:

West Haven, CT:

This facility gave all providers a list of their patients with HbA1c's over 8 with instructions to adjust treatment if possible, refer to the group, and/or send them to the patient education classes. The goal is to have each patient come to 4 group visits for three months.

Ten people were scheduled in a group. They found that a cohort is not necessary; mixing the new members with older session members was more interesting and helpful to the vets.

Graphing of the BS's demonstrated to them that consistency in their diet, activity and medication impacted their success, and helped them to understand why medication adjustments were made cautiously.



CBOC affiliated with Fresno, CA:

“Nurse Managed Clinics and How to Increase Colorectal Cancer Screening Rates”

The team was faced with low colorectal performance measure scores. Current services were assessed and an improvement plan was implemented. Staffing was adjusted with a goal of 1 LVN per provider. Job responsibilities were defined for each team member. System changes were implemented to include moving nursing and administrative clerks to Medical Services. Great improvements were made to a greater than 95% compliance by implementing the following interventions:

- Card processes initiated during clinical reminders and intakes
- Completion of test and education by nursing staff
- Noted in Log Book for follow-up
- Encouraged thru Provider
- Date of return on exit sheet
- Verification of results in two weeks
- Contact patient for reminder, results, and thank you's



Washington DC:

Achievement of fully satisfactory scores for colon cancer screening had been elusive for this medical center since this preventive measure was required. In 2001, a local clinical reminder was developed to assist providers in ordering the screen on time. After an order was entered, the patient picked up the fecal occult blood test (FOBT cards) from the Laboratory staff who provided instructions on specimen collection. The patient was requested to turn in the cards in person at the lab within 14 days.

Beginning 2002 the processes listed below were gradually put in place to improve performance. (All processes were discussed and approved by the Preventive Medicine Committee members, Primary Care staff, and top management.) As a result of these actions, performance based on EPRP data started to trend up from a cumulative score of 58% (below satisfactory) for FY 2003 to a cumulative score of 74% (fully satisfactory) as of February 2004.

1. Reminder letters are mailed monthly from the ACOS/Ambulatory Care to veterans who have appointments in Primary Care Clinic and are due for colorectal cancer screening the following month. A patient education brochure is enclosed with the letter.
2. Primary Care Staff RNs instruct, order FOBT lab test, provide the FOBT cards, and document the encounter using a colon cancer screening clinical reminder. The patient is given verbal and written instruction. The patient receives a brown bag containing the FOBT cards, written instructions (with pictures), and a stamped biohazard return envelope.
3. The Primary Care Provider countersigns the electronic order and reinforces the importance of colon cancer screening to the patient.
4. Patients are interviewed for outside colon cancer screening procedures rendered by private physicians or other VAMCs, which are documented using clinical reminder templates.
5. FOBT specimens from the patient are mailed to a Maryland Community Based Clinic address to insure safety of the specimens from irradiation of Washington, DC mail. Trained drivers do a daily delivery of specimens from the CBOC directly to the Lab.
6. Lab personnel complete FOBT tests on specimens received immediately. If an incomplete set of FOBT cards are received or if 1-2 cards are outdated, the Lab mails another set to the patient to complete the test.
7. Frontline staff participate actively during EPRP reviews. They review their own patient records during EPRP surveys and attend exit reviews. Staff is given feedback on performance scores after each EPRP review. All are active in the Preventive Medicine Committee.
8. Monthly team performance is monitored using clinical reminder due reports. Performance scores by team and by clinic are presented to staff monthly.
9. Staff education is a must. Questions and ideas from the staff are always addressed. All staff are active in the Preventive Medicine Committee where problems and solutions are discussed.

Discussion Questions

1. How is performance (at the individual provider and/or program level) evaluated in your clinical area?

2. How would you access that information?

3. Who are facility resources who might help you retrieve data or provide access to electronic information?

6

Share Information and Best Practices



1 Initiate and Maintain a Prevention Team



2 Assess Preventive Services



3 Develop and Implement a Prevention Program



4 Get Buy-In From Staff and Management



5 Measure Outcomes



6 Share Information and Best Practices (ACT)

- ✓ Share with others in your facility
- ✓ Share with others in your VISN
- ✓ Share with others across the nation



6

Share Information and Best Practices

POINTS TO CONSIDER:

- *Sharing facilitates improvement.*
- *Sharing generates enthusiasm.*
- *Sharing your best practices enhances your credibility.*

Once you and your Prevention Team have achieved success with assessing the delivery of preventive services in your facility, developing and implementing an action plan, getting buy-in from staff and management, and measuring outcomes of your program, you're ready to let others know about what you've done. Sharing your experiences with other staff and management in your facility, with other prevention coordinators in your VISN, and with VA providers across the country is important. Not only is it a great way to spread the word about your activities, it's also a good opportunity to get feedback and learn new ideas from others.

Share with others in your facility

Look for opportunities to spread the word about your prevention program and its plans, activities, and initiatives. Consider these ideas:

- Write an article for the medical center newsletter
- Send a brief summary to all providers and staff in key areas
- Give a short presentation at a staff meeting
- Set up a meeting with your supervisor
- Nominate a team or colleague for a Prevention Champion Award. Here is a copy of the Prevention Champion Nomination Form. You can also submit a nomination via the website at <http://vaww.nchdpd.med.va.gov/nominatechamp.asp>

Prevention Champion Nomination Form

*The VA National Center for Health Promotion and Disease Prevention is pleased to announce the quarterly **National Prevention Champion Award**, which will be presented to one VA employee per quarter in recognition of meritorious and distinguished accomplishments in the field of Prevention and Health Promotion in the Veterans Health Administration*

Name of Nominee: _____

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

Immediate Supervisor: _____
Printed Name Signature Work Phone #

Please write a brief description (limit narrative to 1-2 pages and address achievements within the past 12 months) regarding your nomination (on reverse side/blank sheet). Justification factors you may consider:

- ♣ Someone who has made significant contributions in the field of health promotion and disease prevention (clinical, education, research)
- ♣ Someone who has done an excellent job in a function or on a project related to prevention/health promotion
- ♣ Someone who has taken initiative, shown innovativeness, persistence, has an impact and/or made a difference in prevention/health promotion to veterans served
- ♣ Someone you feel worthy of such an award, maybe a leader, a helper, a shaker and a mover who makes the impossible happen
- ♣ Team awards will be considered

The winners will receive:

****A Special Award**Recognition in the HealthPOWER! Prevention News and the Magazine of Ambulatory and Primary Care**Recognition at the Annual Prevention Conference**Recognition on the NCP Website showcasing accomplishments**An opportunity to visit the National Center in Durham, NC.**

1st Quarter

Submission deadline: November 15
Award announcement: December 15

2nd Quarter

Submission deadline: January 30
Award announcement: March 15

3rd Quarter

Submission deadline: March 30
Award Announcement: May 15

4th Quarter

Submission deadline: July 30
Award announcement: August 15

You may submit nomination forms via:

Website: www.vaprevention.com

E-mail: susi.lewis@med.va.gov

Fax: 919-383-7598

Mail: NCP

Attn: Susi Lewis
3000 Croasdaile Drive
Durham, NC 27705

Questions? Please call 919-383-7874

Ext. 233 (Connie) or Ext. 234 (Susi)

Sharing with others in your VISN

Getting to know and working with the other Prevention Coordinators in your VISN is a good way to get support and ideas for your prevention program. Some ways to keep in touch with them are to:

- Set up periodic conference calls
- Organize periodic meetings with your VISN Preventive Medicine Leader
- Post an article on the VISN web page

Sharing with others across the nation

VHA is a large virtual community and there are many ways to connect with Prevention Coordinators across the country and others interested in prevention. Some of these ways are:

- Dial into the monthly NCP Prevention Coordinators' conference call
- Use the Prevention Coordinators listserv (VHA Preventive Med Program Coordinators in Outlook)
- Write an article for the NCP's quarterly newsletter, *HealthPOWER!* Prevention News
- Present a poster at the NCP's annual training conference
- Nominate a Prevention Champion

The NCP has developed an annual report for facilities and VISNs regarding preventive care. The summaries/reports that follow will provide an opportunity for each facility to share information and best practices from their prevention programs. The NCP will compile the results of the survey into a report, which will be available on the Center's website (www.vaprevention.com or www.health4vets.com).

VISN ANNUAL PREVENTION SUMMARY (print or type)
(Please attach each of your medical center’s individual reports to this summary)
Submit to NCP by October 30th
FY _____

VISN: _____ VISN Preventive Medicine Leader: _____

<p>1. Strategic Prevention Plan: Describe the VISN Prevention Strategic Plan for the past year as well as the VISN’s overall strategic plan encompassing the next year (include description of patient demographics; barriers; strengths, etc).</p>	<p>Refer to National Strategic Plan objective 9a. You may attach your plan to this report.</p>		
<p>2. Evaluate VISN wide performance in prevention:</p>			
<p>a. Provide a list of program successes. <i>Example: At VAMC X Alcohol screening using Audit C improved from 82% to 96%</i></p>			
<p>b. Describe the effectiveness of VISN Prevention Program. <i>Example: 7 of the 8 medical centers now have prevention teams in place; Improvement VISN wide noted with influenza immunization rates which increased from 78% to 84%; Goal to improve Colorectal Screening Rates VISN wide just established; etc.</i></p>			
<p>c. Attach summary of VISN/ Facility performance measure report card.</p>			
<p>d. Attach VISN prevention performance measures report if different than c.</p>			
<p>3. Prevention Training a. Did the VISN PM leader attend the annual conference?</p>	<p>Yes____ No____ If no, did someone else attend? Yes____ No____ Specify (name):</p>		
<p>b. Please list the Prevention Coordinators/medical center in your VISN who attended.</p>	<table border="0"> <tr> <td>Prevention Coordinator</td> <td>Station</td> </tr> </table>	Prevention Coordinator	Station
Prevention Coordinator	Station		

Share Information and Best Practices

c. Please list strategies used to encourage PCs to attend.	
d. Do you as the VISN Preventive Medicine Leader offer/facilitate prevention education to your Prevention Coordinators? (Example- conference calls; provide educational opportunities; etc.)	Yes_____ No_____ If yes, please provide details:
e. Do you hold monthly or quarterly VISN prevention calls?	Yes_____ No_____ If yes, please comment on the value/benefits: If no, please indicate reason calls do not take place:
4. Turnover Rate: How many PCs changed in your VISN in the past FY?	# of PC changes/total # of PCs in VISN: Comments:
5. Reward & Recognition Did you submit a VISN Prevention Champion nomination or a Prevention Team Award nomination during the past year?	Yes_____ No_____ If yes specify who/what team was nominated:
6. Other information you would like reflected on the annual prevention report to Congress.	
7. Please attach individual Medical Center reports to this summary report.	Thank you! Any questions? Call NCP at 919-383-7874 ext 234
8. Please provide feedback on the ease and use of this report as well as other details that could better reflect prevention performance and how it might be improved.	

VISN Preventive Medicine Program Leader: _____

VISN Director: _____

Date annual report submitted to NCP: _____

MEDICAL CENTER ANNUAL PREVENTION REPORT (print or type)
FY _____

Medical Center: _____ **Station Number:** _____

Prevention Coordinator: _____

Employee Wellness Coordinator: _____

#	Question	Answers/Comments
1.	Prevention Team Does your Medical Center have a Prevention Team?	Yes_____ No_____
2.	Was the Prevention Team established in this FY?	Yes_____ No_____
		If No, skip to question 4 Specify month/date:
3.	When was the first meeting?	List first meeting date – month/year:
4.	Who leads the Team?	Name/Title
5.	Check the following disciplines who participate on the Team: Specify others not listed:	<input type="checkbox"/> Physician <input type="checkbox"/> RN <input type="checkbox"/> Clinical Nurse Specialist <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Psychologist <input type="checkbox"/> Dietician <input type="checkbox"/> Patient Health Educator <input type="checkbox"/> Wellness Coordinator <input type="checkbox"/> Quality Manager <input type="checkbox"/> Leadership Rep <input type="checkbox"/> Clinical Applications Coordinator
6.	Preventive Services What are your top 3 prevention priorities for the current FY?	List:
7.	What changes have you implemented for your top 3 priority areas?	Specify:

8.	List your Prevention Team's top 3 accomplishments (include data if available)	List:
9.	How did you communicate your successes and plans for improvement within your facility/VISN/nationally?	Specify:
10.	What national performance measures are targeted for improvement next year?	List:
11.	In addition to the national performance measures (as above), which other prevention services are targeted for improvement next year, if any?	Specify:
12.	List your participation in national initiatives, monthly prevention topics, health fairs, community outreach events, simple health promotion events, etc.):	Check: <ul style="list-style-type: none"> <input type="checkbox"/> Public Health Week <input type="checkbox"/> Women's Week <input type="checkbox"/> Veterans on the Move Day <input type="checkbox"/> Health Fair <input type="checkbox"/> Monthly Prevention Topic <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____
13.	Health Promotion What other promotional efforts to encourage healthy living did your medical facility participate in?	List:
14.	Staff Education: Did the Prevention Coordinator attend the NCP annual training conference?	Yes _____ No _____

Share Information and Best Practices

15.	Staff Education Did someone else attend the NCP annual training conference?	Yes_____ No_____ If yes, specify name/title:
16.	What prevention training occurred within the facility, or VISN during the past year?	Specify:
17.	Reward & Recognition Did you submit a Prevention Champion nomination or a Prevention Team Award nomination during the past year?	Yes_____ No_____ If yes specify who/what team was nominated:
18.	Other Other Information you would like to share with NCP?	Specify:
19.	Preventive Strategic Plan Please attach the action plan/strategic plan that guides your prevention program to this annual report.	Thank you! Any questions? Call NCP at 919-383-7874 ext 234
21.	Please provide feedback on the ease and use of this report and how it might be improved.	

Prevention Coordinator: _____ **Date:** _____

Medical Center Director: _____ **Date:** _____

VISN Preventive Medicine Program Leader: _____

Date annual report submitted to VISN Preventive Medicine Program Leader: _____

Whatever form of communications you use, remember to do it well. Here are a few tips about writing e-mail messages.

Use Good E-Mail Etiquette

Email is a form of communication many of us use daily. It's become ubiquitous in our work and at home. Even though we're very familiar and comfortable with it, there are some simple things we should keep in mind when using email:

- **DON'T WRITE MESSAGES IN ALL CAPS.** To the recipient, it seems like shouting. If you want to emphasize a word or phrase, use **bold** or *italics* or a **different color**.
- If you're one of several recipients of a message, think carefully about whether to reply just to the sender or reply to all. If you're just saying "thanks," send your reply only to the sender. No need to clutter everyone's mailboxes. If you're providing information that the others need to know, then reply to all. Sometimes it is helpful for all recipients to know that you have responded to a question that has been posed, so they will know that it has been answered.
- If you're sending an email message to a large group of people, put their email addresses in the "BCC [blind carbon copy]" box. That way the recipients won't have to scroll down through the long list of email addresses to get to your message.
- Remember that email is forever! What you write may be filed electronically or printed out in hard copy and kept or forwarded without your knowledge. So be careful in what you say and how you say it. Although email is very convenient, it is limited in that it doesn't convey body language or tone of voice. It's easy for someone to misinterpret what you're saying, unless you choose your words carefully.
- If you have a strong negative emotional response to an email, don't reply back right away. Give it some time – say, overnight – before you respond. By then, you'll likely be in control of your emotions and you'll be able to reply in a more thoughtful, constructive way.
- Be mindful of correct spelling, grammar, punctuation, and so on. Use the spell check feature on Outlook. Using email to contact your colleagues at work is likely part of your job; be professional. Double-check the email before you send it.
- Don't forward an email to other people if the message contains sensitive or personal information unless you have permission of the original sender.



Examples From the Field:

VISN 20:

The VISN 20 Women Veterans Health Committee, a standing VISN Committee, developed a cadre of e-mail messages that individual facilities could distribute to employees (and patients) throughout the week. Every facility chose to distribute one message daily via VISTA e-mail to all employees. VISN office staff also received daily messages. This collection of e-mail messages addressed common health issues in health. Example: cardiac disease, osteoporosis, violence. These messages are available for review upon request. Also, these messages will be updated for use in upcoming years. Employees gave favorable feedback about these messages.

For future Women’s Health Awareness Weeks, the VISN 20 Women Veterans Health Committee plans to develop more VISN-wide activities. The relatively short timeframe for this year’s Week precluded such coordination.



Battle Creek, MI:

To disseminate patient prevention health education materials, the PHE Coordinator places all handout materials developed by the NCP on the Patient Education Information Page (part of VA’s web page). She then sends out an “all employee” email bringing staff’s attention to the new materials posted on the web page.



Manila, PI:

The VA Outpatient Clinic, Manila, celebrated National Women’s Health Week with a special symposium covering women’s health issues and preventive health measures. The veterans participated in a fun quiz on Women’s Health Issues that was compiled from the www.4women.gov website. Feedback was very positive from the veterans with many comments like “*thank you*” and “*please do this again next year.*”



Bay Pines, FL:

In recognition of National Public Health Week, April 7-13, 2003, the Clinical Nutrition Section of N&FS helped to promote awareness of how exercise and nutrition helps veterans and all stakeholders at Bay Pines to achieve and maintain a healthy weight. Daily messages were posted on the marquis and in postmaster. Approximately 2,500 employees were made aware of National Public Health Week’s message to achieve and maintain a healthy weight with diet and exercise, through both local and VA wide postmaster messages.

Literature displays at several CBOCs and in the outpatient area at Bay Pines were arranged. A Registered Dietitian was present at the display area during peak hours on April 8 and 9, providing weight checks and nutritional counseling. Approximately 600 pages of nutrition information were distributed to veterans who attended the literature display.

Posted messages on the marquis reached an estimated 10,000 veterans and 2,500 employees entering through the main gate.



Columbia, SC:

In observance of the “Great Veterans Weigh In” and National Public Health Week activities, staff were extremely observant of health concerns such as weight loss and healthy dietary intake. Primary care providers were given instructions on monitoring clinical practice guidelines that insure constant measuring of weight monitors. In addition to educating providers, veterans followed in primary care clinics were educated on healthy dietary intake.

“Healthtouch” educational kiosks have been placed in waiting areas to assure that veterans, family members, and staff have preventive health information at their fingertips.

Information materials from the VA National Center for Health Promotion and Disease Prevention bulletin have been circulated to administrative and clinical staff for use in the spirit of National Public Health Week.



National Center for Health Promotion and Disease Prevention:

During the monthly prevention call in February 2004, the following best practices were shared:

VISN 12 shared how they have improved their breast and cervical cancer screening rates.

Memphis VAMC shared a best practice “a postcard intervention” to increase influenza immunizations, colon cancer screening, mammography and pap smear performance measures.

Dr. Noffsinger’s article “Understanding Today’s Group Visit Models” was also shared.



National Center for Health Promotion and Disease Prevention:

In FY 2003, the Prevention Champion Award was established: To view past winners, check <http://vaww.nchpdp.med.va.gov/champ.asp>

Discussion Questions

1. List ways you can share prevention successes in your facility.

2. Discuss ways to share and disseminate best prevention practices.

3. Who/what are information resources in your facility, your VISN, and nationally?

Appendix A Resources



VA Prevention Workforce Development Model

The VA Prevention Workforce Development Model is a model designed to guide the development and practice of the VA prevention workforce, the clinical and administrative staff who provide, either directly or indirectly, preventive care services to the veteran patient population. The model addresses three areas of prevention practice—content, domain, and scope—and the personal mastery characteristics needed to carry out that practice.

The content of prevention practices covers three types of preventive services: screening, counseling, and immunizations/chemoprevention. These cover all the preventive services routinely provided to patients (e.g., screening for cancer, counseling about tobacco use cessation, annual influenza immunizations, use of medications for high blood pressure to lower risk of heart attacks and stroke).

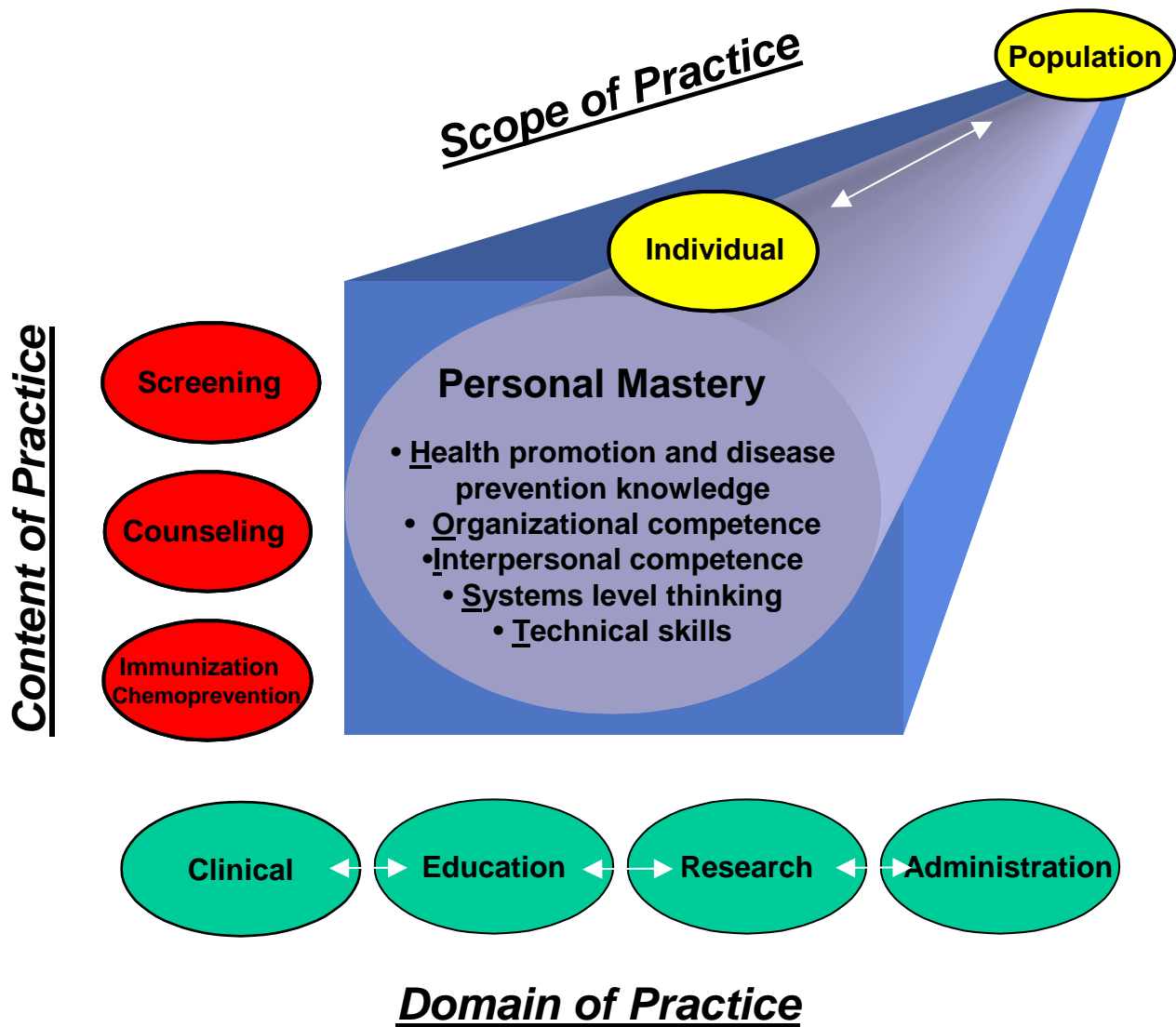
The domain of prevention practice includes clinical, education, research, and administrative activities. All these practice settings are necessary to plan and implement comprehensive, coordinated prevention programs in VA medical centers and facilities.

The scope of prevention practice ranges from individual patient care—what most VA prevention workforce members do on a daily basis—to the care of larger groups of patients, that is, the care of patient at the population level. Patient populations may be defined in many different ways, such as all patients with diabetes or all patients seen in mental health or entire medical center populations. Thinking about patients as members of populations helps to plan and deliver preventive services more efficiently and effectively.

The personal mastery areas include the knowledge, skills and competencies that members of the VA prevention workforce need to provide preventive care in a high quality way. The VA Prevention Workforce must have:

- basic core of knowledge about health promotion and disease prevention strategies and concepts.
- interpersonal competence to work with many different types of patients and staff on prevention issues.
- organizational competence to be able to influence others to effect individual and organizational change.
- ability to think in terms of systems of care in order to plan innovative ways to deliver preventive care and make changes in the process of care within the system.
- technical skills necessary to accomplish the requisite tasks in their area of practice.

VA PREVENTION WORKFORCE DEVELOPMENT MODEL



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VA National Center for
Health Promotion and Disease Prevention

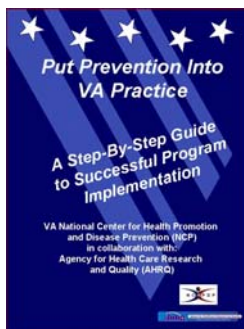
Building the VA Prevention Workforce

“Put Prevention Into VA Practice”

A Step-By-Step Guide to
Successful Program Implementation

All things prevention

Acknowledgements



1. Field Reviewers
2. Agency for Health Care Research and Quality (AHRQ)
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 - Steven Yevich, MD, MPH
 - Susi Lewis, MA, RN

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Examples

- Coordinate health promotion activities
- Communicate prevention recommendations
- Share
 - Successes
 - Failures
 - Best practices
- Learn and become a prevention expert
- Network with other PCs and VISN Leaders
- Inform NCP about how we can help you

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Prevention Coordinator Role

Words that describe a PC:

Leader, Innovator, Doer, Counselor, Cheerleader, Organizer, Maverick, Facilitator, Finisher, Juggler, Mediator, Evaluator, Creator, Salesperson, Consoler, Champion, Risk-Taker, and Crusader!!

NCP appreciates what you do and your contributions to the health and well-being of our veterans.

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Prevention Coordinator Role

Progress always involves risk; you can't steal second base and keep your feet on first.



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Recommended Preventive Services

Source of Recommendations:

- NCP/USPSTF
- VHA Performance Measures
- Clinical Practice Guidelines
- Clinical Reminders

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These Recommendations Should Form the Basis of Your Prevention Program

1. Center health promotion activities and events around the prevention recommendations
2. Offer prevention services, especially those with “A” or “B” level ratings:
 - “A” – strongly recommended based on good evidence that the service improves important health outcomes and that benefits substantially outweigh risks.
 - “B” – recommended based on at least fair evidence that the service improves important health outcomes and the benefits outweigh harms.

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Assess Current Prevention Program

- Determine:
 - What works?
 - What doesn’t work?
- Identify gaps and barriers:
 - System (85%)
 - Education (10%)
 - Provider (5%)
 - Patient (??)

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Chapter 5 – Measure Outcomes

Continuously evaluate your prevention program

- Evaluate areas of excellence
- Evaluate areas of deficiency

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Ways to Evaluate Performance

- Regular forums to review findings, ask for feedback, assess educational needs, etc.
- Chart reviews and other QI measures
- Patient feedback via suggestion box, focus groups, surveys, etc.
- Monthly/yearly EPRP data

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***We cannot direct the wind...
But we can adjust our sails.***

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Communicate Prevention Program Results



- Keep an ongoing log with specifics
- Submit an annual review of team accomplishments
- Share program aspects with staff and management

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Chapter 6 – Share Information and Best Practices

- Once your prevention team has achieved success in:
 - Assessing the delivery of preventive services
 - Developing and implementing an action plan
 - Getting buy-in from staff & management
 - Measuring outcomes of your program.....

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Let Others Know About Your Accomplishments



Share with others

- Facility
- VISN
- Nation

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Share With Others in Your VISN and Across the Nation

VISN

- Set up periodic conference calls
- Organize periodic meetings with your VISN Preventive Medicine Leader
- Post an article on the VISN web page

Nation

- Dial in for monthly Prevention Calls
- Publish in NCP HealthPOWER!
- Share ideas on outlook e-mail group for PC's
- Post successes/failures on vaprovention.com

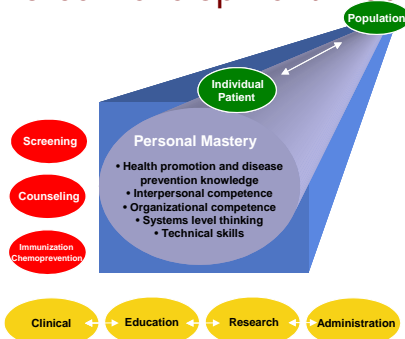
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Appendices

- Resources
- Sample PC Position Description
- VHA Prevention Recommendations
- PC and VISN Med Leaders Contact List

All things prevention

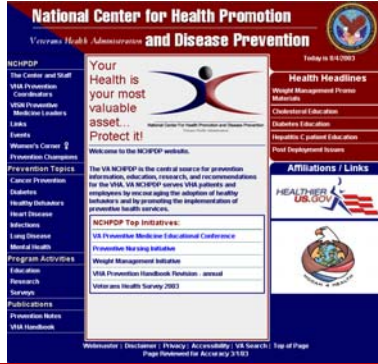
VA Prevention Workforce Development Model



Domain of Practice

All things prevention

How to Access Prevention Coordinators & VISN Preventive Med Leaders vaprevention.com health4vets.com



Summary

Prevention is Important!

Be a prevention leader and influence others.

One person can make a difference, a team can make a bigger difference and an organization that is **“for prevention”** is unstoppable!!



Your Input is Valuable



- Please share your ideas about the “Put Prevention Into VA Practice Manual”
- Tell us how to improve it
- Tell us what makes little or no sense!
- E-mail, call, or fax the NCP 919-383-7874 ext. 234 or fax 919-383-7598

All things prevention

Ideas About Behavioral Change Principles

Almost all of prevention boils down to personal behavior, and to be maximally effective, prevention projects must incorporate known principles and strategies for behavior change. Some of these principles and strategies are listed below.

- **Enhanced awareness increases behavior.** With staff and patients alike, actually repeatedly prompting the desired behavior puts it in the front of those persons' minds. This can be accomplished by:
 - Frequently repeated verbal messages
 - Prominently displayed attention-getting posters
 - Prominently displayed attractive brochures, cards, or newsletters
 - Reminders of various sorts for staff or patients
 - Postcards sent to patients
 - A written “behavioral prescription” given to patients regarding healthy behaviors
 - Prominently played attention-getting video clips or videotapes

- **Contingent positive reinforcement increases behavior.** Everyone responds to contingent rewards with more of the behavior being rewarded. This is a powerful force, and can easily be incorporated into prevention programs. Some ways to do this are:
 - Build in some form of reward for accomplishments in every prevention program.
 - Reward people frequently—once is not enough!
 - Verbal and other forms of recognition for accomplishments in front of peers, supervisors, and medical center leaders is an effective strategy, for both staff and patients.
 - Awarding t-shirts, special “coins,” buttons, other special trinkets, and certificates motivates patients and staff to work for them. Ask interested organizations to donate these items.
 - For patients, opportunities to “tell one’s story” about their behavior changes is often rewarding.
 - Patients often feel rewarded by having opportunities to do “peer counseling” about weight control, smoking cessation, physical activity, etc.

- **Behavior must often be “shaped.”** Changes in a behavior must often occur in stages. Prompting and reinforcing each stage leads to progress and refinement of the desired goal. This applies to individuals or institutions alike.
 - Break overall end-stage prevention goals into parts that are achievable this year, with additional elements added each year until the goal is reached.
 - Patients may need to work on small changes in health behavior at first, with other changes added as tolerance and motivation allow.
 - Each step needs to be rewarded in some way.
- **Having a goal motivates behavior.** People will strive to reach a goal, as long as that goal is something they value (will feel rewarded upon reaching), and is achievable.
 - Assure that goals are valued by the target person or group.
 - Break large goals into small relatively easily achievable units.
 - Arrange positive reinforcement for achievement of each step.
- **Competition is a powerful motivator.** Winning is a goal most people strive for because it often reaps tangible rewards, or at least recognition and heightened self-esteem.
 - Arrange for competitions among staff or groups of patients to see which group can lose the most weight, do the most walking, get the highest percentage of flu shots, and so on.
 - Assure some special recognition or other prize for the winners.
- **A change in behavior must reap some benefit.** People must see some significant benefit to changing one or more of their health behaviors.
 - Teach providers to discuss the benefits of improved health behaviors with their patients.
 - Benefits should be personalized to each patient’s medical situation.
- **Providing practical “how to” instructions encourages behavior change.** People are more likely to do something new (e.g., lose weight, stop smoking, change eating habits, begin exercising) if they know how to do it, so that the goal seems achievable.
 - When encouraging patients to adopt healthy lifestyle behaviors, be sure they are given specific and easily understandable instructions on how to do it. These instructions need to be written, and backed up by discussion and opportunities for questions and answers.
 - Easily understood information handouts that address specific barriers are particularly helpful to patients.

- **Social support encourages behavior change.** Studies show that people do better with almost everything if they have adequate support from others.
 - Arrange for prevention activities to be done in groups, especially in small groups. Group clinics work well for this purpose.
 - Set up systems for individual patients engaged in health behavior change to get frequent staff follow up. Telephone contact works well for this purpose.
 - Set up a “buddy system” or peer counseling/coaching system for patients attempting to change their health behaviors.

- **“Readiness to change” interventions promote progress toward actual behavior changes.** People may be at different stages in their progression toward making a change, and depending on the stage they are in, they may be assisted with moving from one stage to the next by a specific type of intervention.
 - In the “precontemplation” stage a person is not considering making a change. Nonjudgmental provision of information relevant to that person’s individual situation is most helpful at this stage.
 - In the “contemplation” stage a person is considering whether to make a change. Additional nonjudgmental information and assistance with examining the pros and cons regarding the change is most helpful here.
 - In the “preparation” stage a person is getting ready to make a change. Assisting with planning and “how-to” instructions and reinforcement for the decision are all helpful in this stage.
 - In the “action” stage a person has already made the desired change. Support and reinforcement for the new behavior is critical here.
 - In the “maintenance” stage a person has maintained the change for more than six months. Support, reinforcement, and relapse prevention strategies would be helpful during this period.

- **Modeling healthy behavior encourages imitation.** Staff who personally model healthy behavior naturally encourage patients and other staff to do likewise.
 - A specific person or group of people can be pointed out as positive examples. They can be asked to describe to others how they came to engage in their healthy behaviors, as an example.
 - An overall environment in which staff serve as healthy behavior role models will influence those around them without specifically trying to do so.

- **A health-promoting environment exerts a positive influence.** Just being in a place where good health behavior is promoted obviously encourages people to “be one of the crowd.”
 - Staff can serve as healthy role models.
 - Healthy behavior talk should be obvious in the setting.
 - Attractive posters and brochures with images suggestive of healthy behaviors, health promotion information, videos, and so on should be prominently displayed.
 - Mark walking trails to encourage walking and physical activity.
 - Try to arrange for a place where patients and staff can exercise.
 - Insist on healthy food being available in the canteen, with nutritional content displayed.

- **Personal accountability and feedback boosts performance.** Having to report one’s progress to others is a powerful motivator. Ongoing feedback allows people to make appropriate adjustments to meet the standards.
 - Set up a system for providers and/or other staff to get personal feedback on their prevention activities, and for that performance to be reviewed by their supervisor or by management. The feedback system must be generally non-punitive in nature.
 - Make sure patients have a system to monitor and be accountable for their health behaviors, especially those they are engaged in changing. Feedback to them on their progress is critical for maintaining their motivation.

Appendix B

Sample Prevention Coordinator Position Description



Prevention Coordinator Sample Position Description

Introduction

The Prevention Coordinator will lead the prevention campaign in the medical center by communicating prevention recommendations, coordinating prevention initiatives and activities, assisting staff with meeting/exceeding prevention performance measures, collaborating with the Employee Wellness Coordinator, and completing the annual prevention report. (Taken from Prevention Directive.)

Major Duties

The Prevention Coordinator:

1. Serves as liaison for the local Prevention program with the facility, the network office, NCP and VHA Headquarters.
2. Reviews the provision of comprehensive health promotion and disease prevention services.
3. Collaborates with state and community agencies to develop and implement programs of health promotion and disease prevention.
4. Develops and engages in a local Preventive Medicine program that implements national and local policies.
5. Promotes relationships among and between patients, staff, and community that fosters open communication, information sharing, and education relative to preventive medicine issues and services.
6. Provides clinical guidance and information on preventive service recommendations.
7. Provides health promotion and disease prevention education to patients, clinical and administrative staff informally and/or formally.
8. Keeps abreast of professional and scientific literature to maintain knowledge base in prevention.
9. Participates in health promotion and disease prevention research initiatives and activities.
10. Establishes a resource library of pertinent clinical and administrative publications reflecting current preventive medicine strategies, goals, and objectives.
11. Coordinates public relations and advertising efforts.

Factors

1. Knowledge

- a. Comprehensive knowledge of the VA's Prevention program
- b. Knowledge of concepts and behavioral health promotion strategies and practices.
- c. Significant knowledge of pathophysiology of common preventable diseases.
- d. Knowledge of program development, program implementation, and program administration strategies and practices.
- e. Knowledge of cost-effectiveness as it relates to preventive medicine strategies.
- f. Knowledge of barriers encountered by the provider and patient when seeking to implement disease prevention strategies.

2. Skills

- a. Extremely strong skills in communicating in both written and verbal modalities
- b. Significant skills in organizing, planning, directing, and in leading team efforts.
- c. Skills in group and team communication.
- d. Ability to stay informed of current trends and developments in prevention practices.
- e. Advanced skill in utilizing computer-based resources for collection of information, word processing, graphics, electronic mail and Internet.
- f. Strong interpersonal skills sufficient to develop and maintain effective and productive relationships with professional colleagues, leaders of major national health and related agencies, as well as NCP staff members.

Appendix C

VHA Prevention Recommendations



**PREVENTIVE SERVICES INCLUDED WITHIN
NATIONAL PERFORMANCE MEASURES FY 04**

Measure	Test/Service	Eligible Patients	Frequency
CANCER MEASURE			
9a. Breast	Mammogram	Women ages 52-69 seen in Eleven Clinics	Every 2 years
9b. Cervical	Pap test	Women < age 65 with cervix seen in Eleven Clinics	Every 3 years
9c. Colorectal	Fecal occult blood test/ flexible sigmoidoscopy/ colonoscopy	Men and women ages 52 and older seen in Eleven Clinics	FOBT – annual; Sigmoidoscopy – 5 years; Colonoscopy – 10 years
HYPERTENSION MEASURE			
10b1. BP \leq 140/90	BP	Patients with dx. of hypertension seen in Eleven Clinics	Most recent
10b2. BP > 160/90 or not recorded (lower is better)	BP	Patients with dx. of hypertension seen in Eleven Clinics	Most recent
ISCHEMIC HEART DISEASE			
Patients with acute myocardial infarction (AMI)			
10c7. LDL-C <100 mg/dl	Full lipid panel	Patients with AMI 60 days - 5 years ago	Past 2 years
10c8. LDL-C \geq 120 on lipid-lowering medication	LDL-C	Patients with AMI 60 days - 5 years ago	Past 2 years
ENDOCRINOLOGY MEASURE			
Patients with diabetes			
11a. BP \leq 140/90	BP	Patients with dx. of diabetes seen in Eleven Clinics	Most recent
11b. BP \geq 160/90 or not done (lower is better)	BP	Patients with dx. of diabetes seen in Eleven Clinics	Most recent
11c. Foot sensory exam with monofilament	Monofilament testing	Patients with dx. of diabetes seen in Eleven Clinics	Past 1 year
11d. HbA1C >9 or not done	HbA1C	Patients with dx. of diabetes seen in Eleven Clinics	Past 1 year
11e. LDL-C <120 mg/dl	Full lipid panel	Patients with dx. of diabetes seen in Eleven Clinics	Past 2 years

11f. Retinal exam, timely by control	Dilated retinal exam by ophthalmologist or optometrist or dilated photo or retinal digital image	Patients with dx. of diabetes seen in Eleven Clinics	Past 1 year if on insulin or HbA1C ≥ 8 or no HbA1C in past 12 months; Past 2 years if 2 of 3: not on insulin, HbA1C < 8 , normal eye exam in past 24 months
INFECTIOUS MEASURE			
Community Acquired Pneumonia (CAP)			
12a2. Influenza immunization prior to admission	Influenza immunization	Patients admitted for CAP who have been seen in VHA in previous 24 months and are $>$ age 49 or have chronic disease indications	Past influenza season
12a3. Pneumococcal immunization prior to admission	Pneumococcal immunization	Patients admitted for CAP who have been seen in VHA in previous 24 months and who meet other indication criteria (age, residence, chronic diseases)	Once ever
Hepatitis C			
12b1. Hepatitis C Screening or Tested	Query of hep C risk factors or hep C testing or hep C diagnosis	Patients in either Eleven Clinics or Mental Health (MH) Diagnosis cohort	Ever
12b2. Hepatitis C Tested or Diagnosed	Hep C testing or hep C diagnosis	Patients in either Eleven Clinics or MH Diagnosis cohort	Ever
IMMUNIZATIONS MEASURE			
12c1. Influenza – Eleven Clinics	Influenza immunization	Patients in Eleven Clinics and age $>$ 49 or have chronic disease indications	Past influenza season
12c2. Influenza – Spinal Cord Injury & Disease (SCI&D)	Influenza immunization	Patients in SCI&D cohort and age $>$ 49 or have chronic disease indications	Past influenza season
12c3. Pneumococcal – Eleven Clinics	Pneumococcal immunization	Patients in Eleven Clinics and who meet other indication criteria (age, residence, chronic diseases)	Once ever

Appendix C

12c4. Pneumococcal – Spinal Cord Injury & Disease	Pneumococcal immunization	Patients in SCI&D cohort and who meet other indication criteria (age, residence, chronic diseases)	Once ever
MENTAL HEALTH MEASURE			
Substance Use Disorder			
13b1. Screened for at risk alcohol usage	AUDIT or AUDIT-C	Patients in Eleven Clinics and MH cohorts	Every 1 year
TOBACCO CESSATION MEASURE			
14a. Tobacco counseled at least 3 times – Eleven Clinics	Counseling to cease tobacco use	Patients using tobacco seen in Eleven Clinics	Up to 3 times in past year, if 3 visits (min. 1)
14b. Tobacco counseled at least 3 times – MH	Counseling to cease tobacco use	Patients using tobacco seen in MH	Up to 3 times in past year, if 3 visits (min. 2)
14c. Tobacco counseled at least 3 times – SCI&D	Counseling to cease tobacco use	Patients using tobacco seen in SCI&D	Up to 3 times in past year, if 3 visits (min. 1)
14d. AMI –counseled while inpatient	Counseling to cease tobacco use	Patients using tobacco admitted with AMI	Once during admission
14e. CAP-4 counseled while inpatient – Pneumonia	Counseling to cease tobacco use	Patients using tobacco admitted with CAP	Once during admission
14f. HR-4 counseled while inpatient – Heart Failure	Counseling to cease tobacco use	Patients using tobacco admitted with heart failure	Once during admission
14g. Tobacco Use in the past 12 months: Eleven Clinics	Tobacco use	Patients seen in Eleven Clinics	Past 12 months
14h. Tobacco Use in the past 12 months: MH	Tobacco use	Patients seen in MH	Past 12 months
14i. Tobacco Use in the past 12 months: SCI&D	Tobacco use	Patients seen in SCI&D	Past 12 months

*Third United States Preventive Services Task Force Recommendations:
A's and B's
2001- April 2004*

Recommendations for All Adults

- Screening for Alcohol Misuse
B recommendation for screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.
<http://www.ahrq.gov/clinic/uspstf/uspsdrin.htm>
- Aspirin for Primary Prevention for Cardiovascular Events
A recommendation that clinicians discuss aspirin chemoprevention with adults who are at increased risk for coronary heart disease (CHD). Discussions with patients should address both the potential benefits and harms of aspirin therapy.
<http://www.ahrq.gov/clinic/uspstf/uspsasmi.htm>
- Screening for High Blood Pressure
A recommendation that clinicians screen adults aged 18 and older for high blood pressure.
<http://www.ahrq.gov/clinic/uspstf/uspshype.htm>
- Screening for Colorectal Cancer
A recommendation that clinicians screen men and women 50 years of age or older for colorectal cancer.
<http://www.ahrq.gov/clinic/uspstf/uspscolo.htm>
- Screening for Depression
B recommendation for screening adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and followup.
<http://www.ahrq.gov/clinic/uspstf/uspsdepr.htm>
- Screening for Type 2 Diabetes
B recommendation for screening for type 2 diabetes in adults with hypertension or hyperlipidemia.
<http://www.ahrq.gov/clinic/uspstf/uspsdiab.htm>

- Counseling for Healthy Diet

B recommendation for intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.

<http://www.ahrq.gov/clinic/uspstf/uspstfdiet.htm>

- Screening for Lipid Disorders

A recommendation that clinicians routinely screen men aged 35 years and older and women aged 45 years and older for lipid disorders and treat abnormal lipids in people who are at increased risk of coronary heart disease.

B recommendation that clinicians routinely screen younger adults (men aged 20 to 35 and women aged 20 to 45) for lipid disorders if they have other risk factors for coronary heart disease.

B recommendation that screening for lipid disorders include measurement of total cholesterol (TC) and high-density lipoprotein cholesterol (HDL-C).

<http://www.ahrq.gov/clinic/uspstf/uspstfchol.htm>

- Screening for Obesity

B recommendation that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.

<http://www.ahrq.gov/clinic/uspstf/uspstfsobes.htm>

- Counseling for Tobacco Use

A recommendation that clinicians screen all adults for tobacco use and provide tobacco cessation interventions for those who use tobacco products.

A recommendation that clinicians screen all pregnant women for tobacco use and provide augmented pregnancy-tailored counseling to those who smoke.

<http://www.ahrq.gov/clinic/uspstf/uspstfbac.htm>

Recommendations for Women Only

- Screening for Asymptomatic Bacteriuria in Pregnant Women
A recommendation that all pregnant women be screened for asymptomatic bacteriuria using urine culture at 12-16 weeks' gestation. <http://www.ahrq.gov/clinic/uspstf/uspstfbact.htm>
- Screening for Breast Cancer
B recommendation for screening mammography, with or without clinical breast examination (CBE), every 1-2 years for women aged 40 and older. <http://www.ahrq.gov/clinic/uspstf/uspstfbrca.htm>
- Breast Cancer Chemoprevention
B recommendation that clinicians discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention. <http://www.ahrq.gov/clinic/uspstf/uspstfbrpv.htm>
- Screening for Cervical Cancer
A recommendation for screening for cervical cancer in women who have been sexually active and have a cervix. <http://www.ahrq.gov/clinic/uspstf/uspstfcerv.htm>
- Screening for Chlamydial Infection
A recommendation that clinicians routinely screen all sexually active women aged 25 years and younger, and other asymptomatic women at increased risk for infection, for chlamydial infection.
B recommendation that clinicians routinely screen all asymptomatic pregnant women aged 25 years and younger and others at increased risk for infection for chlamydial infection. <http://www.ahrq.gov/clinic/uspstf/uspstfchlm.htm>
- Screening for Hepatitis B Virus Infection in Pregnant Women
A recommendation for screening for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit. <http://www.ahrq.gov/clinic/uspstf/uspstfhepb.htm>
- Screening for Osteoporosis
B recommendation 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.
<http://www.ahrq.gov/clinic/uspstf/uspstf/uspstf.htm>

- Screening for Rh (D) incompatibility
 - A** recommendation for Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.
 - B** recommendation for repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.
<http://www.ahrq.gov/clinic/uspstf/uspstf/uspstf.htm>

Strength of Recommendations:

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations according to one of five classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms).

A: The USPSTF strongly recommends that clinicians provide [the service] to eligible patients. *The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.*

B: The USPSTF recommends that clinicians provide [this service] to eligible patients. *The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.*

Quality of Evidence:

The USPSTF grades the quality of the overall evidence for a service on a 3-point scale (good, fair, poor):

Good: Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair: Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.

Appendix D

Prevention Coordinators

VISN Preventive Med Leaders



VISN Preventive Medicine Leaders

VISN Preventive Medicine Leaders are the designated VA advocate for health promotion and disease prevention initiatives, programs, and activities at the local, state and national level. Each VISN has a representative who communicates prevention activities to the facilities within the network.

For an updated list of VISN Preventive Medicine Leaders, visit NCP's website: <http://vaww.nchpdp.med.va.gov/VISNpreventiveMedLeaders.asp>

Prevention Coordinators (PCs)

Prevention Coordinator (PCs) are the designated VA advocate for health promotion and disease prevention initiatives, programs, and activities at the local facility level. Most of our facilities have a PC.

For an updated list of PCs, visit NCP's website at <http://vaww.nchdp.med.va.gov/programcoordinators.asp>



May 2004