HEALTH PROMOTION AND DISEASE PREVENTION CORE PROGRAM REQUIREMENTS

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive designates the National Center for Health Promotion and Disease Prevention (NCP), Office of Patient Care Services, as the VHA office responsible for guidance and coordination of health promotion and disease prevention (HPDP) services for Veterans within VHA. This VHA directive provides core program implementation and reporting requirements for a comprehensive, evidence-based, population-level interdisciplinary HPDP program at each Department of Veterans Affairs (VA) facility and VA health care system (HCS).

2. SUMMARY OF MAJOR CHANGES: This updated directive includes the following changes:

a. Changes the name of the VHA Preventive Care Program to HPDP Program.

b. Specifies the minimal core requirements of these HPDP programs in greater detail.

c. Designates the Healthe*e*Living Assessment (HLA) as the online health risk assessment for VHA.

3. RELATED ISSUES: VHA Directive 1120; VHA Directive 1120.01; VHA Handbook 1120.04; VHA Handbook 1120.05; and VHA Handbook 1101.10.

4. RESPONSIBLE OFFICE: The National Center for Health Promotion and Disease Prevention (10P4N), Office of Patient Care Services (10P4), is responsible for the contents of this VHA directive. Questions may be referred to the Chief Consultant for Preventive Medicine at 919-383-7874, or by Fax to 919-383-7598.

5. RESCISSION: VHA Handbook 1120.02, Health Promotion and Disease Prevention Core Program Requirements, dated July 5, 2012, is rescinded.

6. RECERTIFICATION: This directive is scheduled for recertification on or before the last working day of February 2023. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

Carolyn M. Clancy, M.D.
Executive in Charge

DISTRIBUTION: Emailed to the VHA Publications Distribution List on February 7, 2018.

CONTENTS

CORE PROGRAM REQUIREMENTS FOR HEALTH PROMOTION AND DISEASE PREVENTION (HPDP)

HEALTH PROMOTION AND DISEASE PREVENTION CORE PROGRAM REQUIREMENTS

1. PURPOSE

This Veterans Health Administration (VHA) directive designates policy concerning Health Promotion and Disease Prevention (HPDP) programs at each Department of Veterans Affairs (VA) facility and Health Care System (HCS). **AUTHORITY:** Title 38 United States Code (U.S.C.) 7318.

2. BACKGROUND

a. The VHA National Center for Health Promotion and Disease Prevention (NCP), located in Durham, NC, was established in 1995 as a field-based unit of VHA Central Office within the Office of Patient Care Services (PCS) to implement the Veterans Health Care Act of 1992. Public Law 102-585, 511,106 Stat. 4943, 4955-57 (codified at 38 U.S.C. 7318) mandates NCP to:

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

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

b. HPDP programs are aligned with VHA's Mission to "honor America's Veterans by providing exceptional health care that improves their health and well-being", as well as with VHA's Vision, which emphasizes prevention and population health. HPDP programs also support VHA's efforts to transform from an episodic disease-focused model of care to a patient-driven Whole Health Model that encourages continuous Veteran engagement and promotes Veteran wellness, self-care, and self-management of chronic conditions.

c. Many diseases that cause disability and death among Veterans can be prevented, mitigated, or delayed. HPDP services can lead to longer and healthier lives, reduce hospitalizations, preserve functionality, and enhance patient satisfaction and quality of life. Effective preventive services are available for the leading causes of death and morbidity. Screening tests, immunizations, preventive medications, and counseling to support health behavior change are the major strategies employed. The main behavioral factors contributing to preventable disease are tobacco use, physical inactivity, poor diet, unhealthy alcohol use, and overweight or obesity. Key interventions to reduce health risks include system-level, provider-level, and patient-level strategies that assist patients in changing risky behaviors and adopting healthier ones. VHA is committed to raising the awareness of healthy behaviors and encouraging and supporting Veterans in their efforts to adopt healthy lifestyles.

d. VHA's 2013 – 2018 Strategic Plan calls for VHA to provide personalized, proactive, patient-driven health care for Veterans. This plan, along with VHA's 2014 Blueprint for Excellence, supports VHA's vision, which emphasizes prevention and

population health. Led by NCP, VHA's preventive care programming is designed to ensure that Veterans receive comprehensive health education, appropriate clinical preventive services, support for self-care that includes health behavior change, and support for self-management of chronic conditions such as overweight and obesity. Self-care and self-management support offers Veterans the knowledge, skills and confidence they need to successfully prevent illness, and promote their health and well-being, and to manage their existing health conditions.

e. The HPDP Program is closely integrated with primary care/Patient Aligned Care Teams (PACT) and supports facility HPDP infrastructure and staff. This support requires training and mentoring staff in patient-centered health behavior coaching strategies, and providing tools to assist PACT and other clinical staff in assessing and addressing Veterans' HPDP needs and interests. ***NOTE:*** *See VHA Handbook 1101.10, Patient Aligned Care Team (PACT) Handbook, dated February 5, 2014, or subsequent policy.*

3. DEFINITIONS

a. **Clinician Coaching.** Clinician coaching is the process of assisting clinicians to apply Veteran-centered communication skills (e.g., health education, health coaching, health behavior change counseling, shared decision-making and self-management support skills) in their clinical interactions. Clinician coaching supports and extends facility-based Patient Education: TEACH for Success (TEACH) and Motivational Interviewing (MI) skill training for PACT staff by providing opportunities for reflection, skill practice and feedback to support the skill development and application in clinical practice. Clinician coaching in TEACH and MI skills supports the integration of HPDP into care. TEACH and MI facilitators receive extensive training from NCP in clinician coaching skills and methods.

b. **Clinical Preventive Service.** A Clinical Preventive Service (CPS) is a service delivered in the clinical setting for the primary prevention of disease, or for the early detection of disease in persons with no symptoms of the target condition, with the goal of preventing or minimizing future morbidity and mortality. CPS examples include: screening for infectious diseases; cancers; heart and vascular diseases; injury and violence; mental health conditions and substance abuse; metabolic, nutritional, endocrine, musculoskeletal, obstetric, and gynecological conditions; neurological disease; and vision.

c. **CPS Guidance Statement.** A CPS guidance statement is a statement that defines VHA recommendations regarding the delivery of an individual clinical preventive service to Veterans. The CPS guidance statement describes the clinical preventive service, the target population, and other factors influencing the use or non-use of the clinical preventive service.

d. **Gateway to Healthy Living.** The Gateway to Healthy Living program is a group intervention designed by NCP to serve as an entry point for Veterans who want information, motivational support, and collaborative goal setting to help with self-

management for healthy living. The program helps Veterans who are considering any health behavior change (e.g., increasing physical activity, eating wisely, stopping tobacco use, limiting alcohol use, and managing stress) to identify their reasons for making a change, develop SMART goals (Specific, Measurable, Action-oriented, Realistic, Time-based), and connects them to existing clinical programs or self-management tools.

e. **Health Behavior Change.** Health behavior change is the process of considering, initiating, achieving, and maintaining change in health behavior(s), e.g., tobacco use, risky alcohol use, unhealthy diet, weight management, and physical inactivity.

f. **Health Coaching.** Health coaching is an evidence-based method for working with patients to enhance their well-being and achieve their health-related goals. Health coaching is a patient-centered, highly-collaborative method that applies principles and methods derived from health education, health promotion, and health behavior change research. Health coaching includes: assessment of patients' educational needs, concerns, values, preferences, and past experiences; information sharing; goal setting; action planning; skill building; problem solving; and arranging a follow-up plan.

g. **Health Education.** Health education is an important component of health promotion and disease prevention. Health education is a process that includes any combination of education, information, and other strategies to help Veterans optimize their health and quality of life. Health education programs and services assist Veterans to adopt healthy behaviors, partner with their health care teams, make informed decisions about their health, manage their acute and chronic conditions, and use problem-solving and coping skills. The Veterans Health Education and Information program is responsible for VHA health education policy, education, and programming. ***NOTE:*** *See VHA Handbook 1120.04, Veterans Health Education and Information Program Requirements, dated September 24, 2015, or subsequent policy.*

h. **Health Promotion and Disease Prevention.** Health promotion and disease prevention (HPDP) refers to environmental, educational, motivational, and clinical activities designed to encourage improvement in health behaviors and conditions of living that are conducive to improving the health and well-being of populations and individuals. Disease prevention refers to health-related interventions or services that aim to prevent or minimize future morbidity and mortality by delaying or averting the onset of severity of disease, or detecting already existing disease at an early stage when it can be more successfully treated. Health promotion and disease prevention are closely linked and services address both aims. HPDP services include, but are not limited to: clinical preventive services (screenings, immunizations, health behavior counseling, and preventive medications); related health education; self-management support; and health coaching.

i. **Healthe*Living* Assessment.** TheHealtheLiving Assessment (HLA) is an interactive online tool that can help Veterans better understand their health habits and overall health. It provides personalized advice on ways to improve one's health and

well-being. The HLA can be accessed through the My HealtheVet Web site at the following link: https://www.myhealth.va.gov/.

j. **Healthy Living Messages.** A set of nine evidence-based messages that promote whole health and well-being. See Appendix A.

k. **Healthy Living Team.** A term used to designate the group consisting of five facility-based core roles: Health Behavior Coordinator, Health Promotion Disease Prevention Program Manager, Influenza Campaign Coordinator, MOVE!® Coordinator, and Veterans Health Education Coordinator.

l. **MOVE!® Weight Management Program.** VHA's evidence-based, population-focused, clinical weight management programming. Guided by VHA Directive 1120.01, Core Requirements for MOVE! Weight Management Program for Veterans (MOVE!), dated June 5, 2017, or subsequent policy, is a comprehensive lifestyle intervention that includes caloric restriction, promotion of physical activity, and behavioral strategies targeting eating and physical activity. NCP-supported MOVE! options of care include: MOVE! Group Sessions, MOVE! Individual Sessions, MOVE! Telephone Lifestyle Coaching, Be Active and MOVE!, TeleMOVE!, and MOVE! Coach with Care.

m. **Motivational Interviewing.** Motivational Interviewing (MI) is an evidence-based clinical method that involves guiding patients to make healthy choices by eliciting and supporting their own motivation to change. MI is employed when patients are unsure or ambivalent about change or have difficulty following through with recommended health behaviors. When employing MI, clinicians embody a "spirit" or style that is highly collaborative, evocative, and supportive of patients' autonomy. NCP-developed MI training is designed to enhance clinicians' capacity to employ the spirit, principles, Veteran-centered communication skills, and techniques of MI during interactions with Veterans, and is specifically tailored to meet the needs of PACT clinicians.

n. **Patient-Aligned Care Team.** The patient-aligned care team (PACT) is an interdisciplinary team of health care professionals that provides comprehensive primary care in partnership with the patient. The PACT manages and coordinates comprehensive health care services consistent with agreed-upon goals of care. PACTs for special populations (e.g., Geri-PACT, Spinal Cord Injury PACT, Women Veterans Health PACT) are designated in the Primary Care Management Module (PCMM) by a specific indicator.

o. **Patient-Centered Care.** Patient-centered care is a fully engaged partnership of Veteran, family, and health care teams, established through continuous healing relationships and provided in optimal healing environments, to improve health outcomes and the Veteran's experience of care.

p. **Patient Education: TEACH for Success.** TEACH for Success (TEACH) is a VHA-developed and supported education program that provides VHA clinicians with training in evidence-based, Veteran-centered health education, and coaching skills that enable them to partner with Veterans to promote self-care, self-management of acute

and chronic conditions, health behavior change, and healthy living. TEACH participants learn about state-of-the-art Veteran-centered communication strategies that can be used in brief encounters with patients, and then practice the techniques using simulated patients and case scenarios. More information on this program can be found at http://vaww.prevention.va.gov/VHEI/TEACH_for_Success_web_update.pdf. ***NOTE:*** *This is an internal VA Web Site that is not available to the public.*

q. **Self-Care.** Self-care is what the Veteran does to optimize health and wellbeing. The World Health Organization (WHO) defines self-care as, "the ability of individuals, families and communities to promote health, prevent disease, and maintain health and to cope with illness and disability with or without the support of a health-care provider."

r. **Self-Management and Self-Management Support.** Self-management includes managing the medical aspects as well as the functions, roles and emotions associated with having an acute or chronic condition. To foster and enhance patient self-management, health care systems and health care teams provide self-management support, which includes: Guidance, education, collaborative goal setting, shared decision making, action planning, skill building, problem solving, and ongoing support. "Self-management support" and "supported self-management" are interchangeable. To illustrate the distinction between self-management and self-management support, weight management is what the patient does (self-management); weight management support (e.g., the MOVE! Weight Management Program) is what VHA staff provide (self-management support).

s. **Shared Decision Making.** The Informed Medical Decision Making Foundation defines shared decision making (SDM) as a collaborative process that allows patients and their providers to make health care decisions together, considering the best scientific evidence available, as well as the patient's values and preferences.

t. **Veteran-Centered Communication.** Veteran-centered Communication consists of four processes integral to developing healing, trusting clinician-Veteran relationships and to providing personalized, proactive Veteran-driven, whole health care: 1) eliciting, understanding and validating the Veteran's perspective; 2) understanding the Veteran within his or her psychological, social and environmental context; 3) reaching a shared understanding of the Veteran's health, health problems and treatment; and 4) helping Veterans participate in decision making, self-care and self-management of their conditions. For clinicians to employ effective Veteran-centered communication, they must develop and apply Veteran-centered communication skills, such as those featured in NCP-approved TEACH for Success and Motivational Interviewing training programs.

u. **VHA Central Office-Directed Self-Study Orientation Program.** This is a self-paced, self-study orientation program developed by NCP and designed to provide role-specific orientation for HPDP Program Managers, Health Behavior Coordinators (HBC), and Veterans Integrated Service Network (VISN) HPDP Program Leaders. The program includes instructions, role-specific orientation checklists, topic-specific learning modules, program evaluation, and an automated process to self-certify completion of the program.

v. **VHA Mandatory Training Subcommittee.** A subcommittee of the VHA National Leadership Council Workforce Committee whose charge is to determine mandatory training programs for employees.

w. **Whole Health Model.** The Whole Health model, developed by VHA Office of Patient-Centered Care and Cultural Transformation, will allow the VA to move from episodic disease-based care to a more continuous engagement with the Veteran throughout his/her life, emphasizing Veteran activation and engagement, complementary and integrative health (CIH), and innovative approaches to self-care and self-management. Whole Health combines state-of-the-art conventional medicine and preventive care with personalized health planning.

4. POLICY

It is VHA policy that HPDP staff and programs are available at each VA medical facility and community-based outpatient clinic (CBOC) and include core program implementation and reporting requirements.

5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

b. **Deputy Under Secretary for Health for Operations and Management.** The Deputy Under Secretary for Health for Operations and Management is responsible for:

(1) Communicating the contents of this directive to each of the Veterans Integrated Services Networks (VISN);

(2) Ensuring that each VISN Director has the sufficient resources to fulfill the terms of this directive in all VHA health facilities within that VISN; and

(3) Providing oversight of VISNs to assure compliance with this directive, relevant standards, and applicable regulations.

c. **Chief Consultant for Preventive Medicine.** The Chief Consultant for Preventive Medicine (Chief Consultant) or designee(s) is responsible for:

(1) Guidance and Technical Assistance. Guidance and technical assistance are provided to facility and HCS HPDP programs regarding strategies and programming that support the achievement of the overarching program goals about the Healthy Living messages described in paragraph 6.c. These functions occur through national and regional educational meetings, national conference calls, individual program consultation as requested, national training programs, Web resources, clinical tools, and other means. The Chief Consultant or designee maintains, evaluates, and routinely updates the HPDP Self-Study Orientation Program.

(2) Monitoring of Evidence-Based Guidelines. The Chief Consultant or designee monitors relevant published literature and clinical preventive services recommendations from the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices, Community Task Force on Preventive Services, and other national guidelines groups. As new evidence-based recommendations for HPDP services are published, NCP evaluates the need for new or revised policies, clinical tools, telehealth technologies, and processes that may be integrated into preventive care for Veterans across VHA. Telehealth modalities must meet VHA's national conditions of participation in telehealth services.

(3) Development of Guidance on Clinical Preventive Services. The Chief Consultant or designee coordinates the development, approval, updating, and dissemination of Clinical Preventive Services Guidance Statements and supports the implementation of guidance statements by VHA clinicians and administrators in VA medical facilities, as specified in VHA Handbook 1120.05, Coordination and Development of Clinical Preventive Services Guidance, dated July 29, 2015, or subsequent policy.

(4) Monitoring and Oversight. The Chief Consultant or designee monitors progress toward achievement of the HPDP program requirements as described in paragraph 6 using applicable national VA databases and VISN and facility reports. NCP may conduct on-site or virtual validation of self-reported information from facilities.

d. **VISN Director**. Each VISN Director is responsible for:

(1) Designating a VISN HPDP Program Leader and relaying information to NCP regarding:

(a) The name, job title, address, fax, phone number, and Email address of the VISN HPDP Program Leader; and

(b) Any changes in the VISN HPDP Program Leader assignment.

(2) Ensuring a comprehensive, evidence-based, population approach to HPDP is implemented at all VA facilities, outpatient clinics, and CBOCs in the VISN and that all minimum HPDP Program requirements are in place and sustained.

(3) Preparing, securing, and managing fiscal and staff resources needed to support HPDP programs and services.

(4) Ensuring that patients can access HPDP services across the VISN.

(5) Providing feedback and reports on HPDP programs, services, and products. See paragraph 7.

e. **VISN HPDP Program Leader.** Each VISN HPDP Program Leader is responsible for:

(1) Facilitating and supporting the activities of facility HPDP Programs within the VISN.

(2) Completing the VHA Program Office-directed HPDP Self-Study Orientation Program.

(3) Serving as the liaison for the VISN Director with NCP and other national program offices within Department of Veterans Affairs (VA) Central Office for HPDP-related issues and activities.

(4) Providing oversight, monitoring, and validation of facility HPDP programs and implementation of national HPDP recommendations, guidelines, and policies through regular contact with facility HPDP Program Managers and HBCs.

(5) Collaborating with HPDP Program Managers and HBCs to assess staff educational needs, working at the VISN level to ensure appropriate educational opportunities are offered.

(6) Contributing to the VISN strategic plan by evaluating facility HPDP Program data and programming. The Program Leader provides feedback to VISN leadership on HPDP gaps, barriers, and educational needs.

(7) Collaborating with VISN leaders for MOVE!, Veterans Health Education, Smoking Cessation, Women's Health, and Primary Care to develop VISN-level HPDP program goals and objectives.

(8) Sharing and recognizing successful HPDP programs and services.

(9) Promoting collaborative relationships with external stakeholders such as Veterans Service Organizations, community organizations, and government agencies around HPDP programs to improve the health of Veterans.

(10) Providing feedback and reports on HPDP programs, services, and products. See paragraph 7.

f. **VA Medical Facility Director.** Each VA medical facility Director is responsible for:

(1) Ensuring that the minimal core requirements listed in paragraph 6 are in place, active, and sustained at the facility and HCS.

(2) Designating the HPDP Program Manager and HBC and relaying information to the VISN and NCP regarding:

(a) The name, job title, address, fax, phone number, and e-mail address of these individuals;

(b) Any changes in these assignments.

NOTE: *It is strongly recommended that VA medical facilities and HCSs serving more than 25,000 unique patients annually dedicate a minimum of 1.0 FTEE without collateral assignments to both the HPDP Program Manager and HBC roles to meet the*

responsibilities specified in paragraphs 5.h. and 5.i., respectively. HCS Directors or large facilities may appoint more than one HPDP Program Manager and HBC to meet the needs of the system or facility.

(3) Ensuring that the organizational placement of the HPDP Program Manager and Health Behavior Coordinator positions facilitates collaboration with the clinical disciplines. Appropriate placements for these roles may include, but are not limited to, serving under the office of the Chief of Staff, Associate Director Patient Care Services, or the offices of Ambulatory or Primary Care, Mental Health, or Education.

(4) Ensuring that HPDP has the necessary resources (fiscal, space, equipment, personnel, and travel) to deliver appropriate HPDP services to Veterans.

(5) Ensuring HPDP and clinical staff have been trained in NCP-approved Veteran-centered communication skills, as specified in VHA Handbook 1101.10, and approved by the VHA Mandatory Training Subcommittee. See paragraph 6.f. for more detail.

(6) Establishing an interdisciplinary, facility-wide HPDP committee or subcommittee to plan, implement, and evaluate comprehensive, Veteran-centered HPDP services with the HPDP Program Manager and HBC as co-leaders or subcommittee leads. The HPDP committee or subcommittee should be aligned or integrated with related committees or subcommittees (e.g., Veterans Health Education, MOVE!, Tobacco Cessation, Whole Health, etc.).

(7) Designating a liaison from the Executive Leadership Team to ensure accountability, a reporting mechanism, and two-way communication between the Executive Leadership Team and the HPDP Program Committee or subcommittee.

(8) Ensuring that patients can access HPDP services at the main facility(ies) and all affiliated outpatient clinics and CBOCs where primary care is delivered.

(9) Ensuring that the facility HPDP Program Manager and HBC has sufficient time allocated for administrative, clinical, program development, and staff training responsibilities.

(10) Providing feedback and reports on HPDP programs to NCP. See paragraph 7.

g. **Facility Primary Care Service Chief.** Each Facility Primary Care Chief is responsible for:

(1) Ensuring requirements for PACT clinical staff training in NCP-approved Veteran-centered communication skills, as specified in VHA Handbook 1101.10, and approved by the VHA Mandatory Training Subcommittee are met, by:

(a) Allotting time for primary care/PACT staff to receive NCP-approved training in Veteran-centered communication;

(b) Ensuring that primary care/PACT clinical staff completes training;

(c) Supporting primary care/PACT staff participation in individual and group-based staff coaching and follow-up training activities to foster the development and maintenance of Veteran-centered communication skills;

(2) Ensuring that HPDP clinical services, including screening, immunizations, health behavior counseling, preventive medications, health education, self-management support, and health coaching are integrated into clinical care provided in all facility PACTs;

(3) Collaborating with HPDP Program staff to redesign and improve the quality of the delivery of HPDP-related services within primary care; and

(4) Collaborating with HPDP Program staff to ensure HPDP Program strategic plans and primary care strategic plans are aligned.

h. **Facility HPDP Program Manager.** The facility HPDP Program Manager must have sufficient time allocated for administrative, program development, and staff training responsibilities. Limited HPDP-related clinical responsibilities may be added as specified below. The HPDP Program Manager collaborates with members of the Healthy Living Team and other clinicians to integrate HPDP within facility programs and clinical care. Each VA facility HPDP Program Manager is responsible for:

(1) Completing the VHA Central Office-directed HPDP Program Manager Self-Study Orientation Program within 60 days of hire or appointment to the position.

(2) Planning, developing, implementing, monitoring, and evaluating the overall HPDP Program as specified in paragraph 6 at the facility(ies) and all CBOCs.

(3) Leading or co-leading the facility or HCS HPDP Program Committee or subcommittee.

(4) Ensuring that HPDP strategic plans are aligned and integrated with PACT and facility strategic plans.

(5) Advising facility and primary care leadership on clinical and administrative issues related to HPDP, including clinical preventive services.

(6) Advocating for policy and program development and resource allocation to support HPDP programs and services.

(7) Effectively managing resources allocated by the facility to the HPDP program.

(8) Providing leadership in the development or modification of delivery processes to support the successful implementation of evidence-based HPDP services into clinical care.

(9) Collaborating with facility staff to develop consistency between facility strategies (e.g., local policies and procedures, local protocols, clinical reminders, and standardized

templates) and VHA CPS guidance statements. Develops and implements a process to provide training of facility clinical staff in VHA CPS guidance statements,

(10) Serving, in collaboration with other clinical content experts, as a subject matter expert in HPDP and providing education on evidence-based HPDP products and services to PACT and other clinical staff. This includes, but is not limited to, VHA CPS guidance statements, recommended screenings and immunizations, Healthy Living messages, the HLA, etc.

(11) Collaborating with the Veterans Health Education Coordinator (VHEC) and the Health Behavior Coordinator (HBC) to support TEACH and Motivational Interviewing training programs to facility clinical staff. This includes supporting clinician coaching to clinical staff following TEACH and MI training to develop their skills.

(12) Leading the development and maintenance of a resource inventory of HPDP programs available to Veterans within the facility and local community.

(13) Coordinating and engaging teams to assess Veteran and programmatic needs, develop, implement, redesign, or improve the quality of the delivery of HPDP-related services.

(14) Serving as the communication liaison between VISN HPDP Program Leaders, NCP, and the facility HPDP Committee or subcommittee.

(15) Partnering with other program leaders (e.g., Patient Centered Care Coordinators) to support and strengthen Whole Health programming and services.

(16) Providing limited HPDP-related clinical services, such as facilitating Shared Medical Appointments or supporting MOVE!®, tobacco cessation, pain management, or similar programming, consistent with occupation-specific licensure requirements. Time devoted to clinical services is not expected to exceed 25 percent of total effort and must not infringe upon responsibilities specified in paragraph 5.h.(1)-(14).

i. **Facility Health Behavior Coordinator.** The facility Health Behavior Coordinator (HBC) must have sufficient time allocated for administrative, clinical, and staff training responsibilities. HBC work is intended to be embedded in the clinical setting. The role of the HBC is to collaborate with the Healthy Living Team and other clinicians to integrate evidence-based health behavior change, preventive care & self-management support interventions into care. The facility HBC is responsible for:

(1) Completing the VHA Central Office-directed HBC Self-Study Orientation Program within 60 days of hire or appointment to the position.

(2) Serving as co-leader of the facility or HCS HPDP Program committee or subcommittee and assisting in the development, implementation, and evaluation of HPDP programs and services.

(3) Collaborating with the Veterans Health Education Coordinator (VHEC) to deliver TEACH training programs to facility PACT and other clinical staff who provide health coaching and health behavior change counseling to Veterans. This includes offering clinician coaching to clinical staff following TEACH training to develop their skills.

(4) Collaborating with the MOVE! Coordinator to support program monitoring and improvements as needed. This includes providing TEACH and MI skills training and follow-up clinician coaching to MOVE! staff, serving as clinical consultant for weight management-related behavior change, and coaching MOVE! staff in group facilitation skills. HBCs provide direct consultation and care to complex MOVE! patients as needed.

(5) Leading, coordinating, and delivering NCP-supported MI training programs and providing ongoing follow-up skills training to PACT clinicians and other clinical staff, as needed. This includes offering clinician coaching to clinical staff following training to develop their skills. Coaching options include participating in team huddles, facilitating role-play type practice sessions, providing joint appointments with patients and clinicians, and encouraging case reviews and discussions, as needed. In addition to coaching staff in developing specific motivational communication skills, HBCs provide as-needed consultation to providers on health behavior patterns or change concerns, both informally in a curbside manner and more formally in presentations and discussions.

(6) Collaborating with PACT, Primary Care-Mental Health Integration, and other Mental Health staff to ensure effective coordination of behavioral and mental health interventions as well as to develop and integrate behavioral interventions (e.g., pain, sleep, stress, biofeedback) that help Veterans in their efforts to adopt healthy behaviors and reduce risky behaviors.

(7) Serving as a subject matter expert in health coaching, MI, patient self-management, and health behavior change; supporting the integration of health behavior change elements into clinical programming.

(8) Providing and developing content expertise on preventive health as it relates to the Healthy Living messages and goals as described in appendix A, including supporting smoking and tobacco use cessation clinical initiatives.

(9) Partner with other program leaders (e.g., Patient Centered Care Coordinators) to support and strengthen Whole Health programming and services.

(10) Providing limited HPDP-related clinical services, such as including performing specialty health psychology assessments (e.g., pre-bariatric surgery, pain management consultation etc.), consistent with occupation-specific licensure requirements. Time devoted to clinical services is not expected to exceed 25 percent of total effort and must not infringe upon responsibilities specified in paragraph 5.i.(1)-(9).

6. CORE HPDP PROGRAM REQUIREMENTS

a. **Health Promotion and Disease Prevention Program Manager.** Each VA facility or HCS must designate a HPDP Program Manager to facilitate coordination, communication, and consistent implementation of HPDP programming and the integration of HPDP services into clinical care. ***NOTE:*** *See paragraph 5.h. for HPDP Program Manager responsibilities.*

b. **Health Behavior Coordinator.** Each VA facility or HCS must designate a HBC to provide health behavior change training and consultation to clinical staff as well as limited direct clinical care to patients. ***NOTE:*** *See paragraph 5.i. for the HBC responsibilities.*

c. **HPDP Program Healthy Living Messages and Goals.** To facilitate delivery of HPDP services, nine key Healthy Living messages and associated goals have been developed for clinicians to share with Veterans and are in Appendix A. Facilities will use these messages as a foundation for health promotion.

d. **Interdisciplinary HPDP Governance and Organizational Structure.** An interdisciplinary, facility-wide HPDP committee or subcommittee must be established. The committee will provide strategic direction, planning, monitoring, and evaluation of HPDP programming and integration of HPDP services into clinical care. The placement of the committee or subcommittee within the organizational structure must facilitate integration with related committees (e.g., Veterans Health Education, MOVE!, Tobacco Cessation, Whole Health, etc.) as well as with relevant clinical disciplines. The HPDP committee or subcommittee must have representation from key facility stakeholders, including facility senior leadership. The HPDP Program is coordinated through the committee and specific functions are defined in a committee charter with the HPDP Program Manager serving as the chair or co-chair. A sample committee charter and more detail on committee responsibilities can be found at http://vaww.infoshare.va.gov/sites/prevention/HPDP_Facility_Programs/Shared%20Documents/Sample_Facility_HPDP_Program_Committee_Charter_template_2017.doc. ***NOTE:*** *This is an internal VA Web Site that is not available to the public.*

e. **HPDP Program Goals and Strategic Plans.** The overall goal of the HPDP program is to ensure evidence-based HPDP services are integrated into clinical care delivery throughout facilities and all affiliated community-based outpatient clinics (CBOCs), delivered in a variety of modalities tailored to Veterans needs and preferences. The HPDP committee or subcommittee must establish local program goals and strategic plans that aim to achieve the overall goal and address the other requirements listed in paragraph 6. HPDP Program strategic plans are to be developed every 1-2 years and aligned with PACT and facility strategic plans. Each HPDP program needs to ensure that Veterans are offered programs and resources that help them with core health behaviors associated with whole health and prevention of chronic disease. The HPDP program must develop a resource inventory that includes internal and community based HPDP-related services and ensure the inventory is available to

staff and Veterans. Internal programs and resources may include but are not limited to MOVE!, tobacco cessation, Gateway to Healthy Living, and the HLA.

f. **Staff Learning and Development.** Training in Veteran-centered communication, health education and health coaching skills such as those featured in NCP-approved TEACH for Success and Motivational Interviewing training programs is required to engage, support, and sustain PACT staff in providing quality HPDP services to Veterans. Healthy Living Team members are trained as facilitators who then train PACT and other facility staff. See paragraph 8, Training Requirements, for details.

g. **Outreach Activities.** The HPDP Program Manager and the HPDP Program Committee need to develop partnerships with community stakeholders and agencies to enhance, promote, and support healthy lifestyle behaviors among Veterans. They design, organize, or participate in at least one Veteran outreach event annually. The outreach event can be in collaboration with other facility outreach programs to include HPDP-related activities. Outreach events may include, but are not limited to, flu shot clinics at Veterans Service Organizations, farmers' markets, teaching kitchens, stand-downs for homeless Veterans, and physical activity programs at the local YMCA. More information on developing community partnerships is available at http://vaww.oce.med.va.gov/Default.aspx. ***NOTE:*** *This is an internal VA Web Site that is not available to the public.*

h. **Program Evaluation.** The program, including components found in preceding paragraphs 6.a. - 6.g., must be evaluated at least annually and improvements implemented as needed using VHA-approved improvement processes such as Lean, Six Sigma, or the Vision, Analysis, Team, Aim, Map, Measure, Change, Sustain (VATAMMCS) improvement framework.

7. REPORT(S)

Reports on the status of HPDP staffing, resources, and programming must be submitted to NCP and higher-level VHA offices, as requested through VHA-approved processes.

8. TRAINING REQUIREMENTS

Details of training programs can be found in the NCP Training Resources folder. ***NOTE:*** *This is an internal VA Web site that is not available to the public.* The training targets below are intended as minimum requirements, and can be exceeded, as other clinical staff will also benefit from this training.

a. The Registered Nurse Care Manager (or equivalent from Special Population PACTs) from each PACT that is listed in a facility's Primary Care Management Module must complete NCP-approved training in health education/health coaching (i.e., TEACH or an alternative program approved by NCP) and NCP-approved training in MI. Training in TEACH and MI must be completed within 12 months of assignment to a PACT. Training of additional PACT staff in MI is encouraged.

b. The Clinical Associate (or equivalent from Special Population PACTs) and Primary Care Provider from each PACT that is listed in a facility's Primary Care Management Module must complete NCP-approved training in health education/health coaching (i.e., TEACH or an alternative program approved by NCP) within 12 months of assignment to a PACT. NCP-approved MI training is also strongly recommended for PACT Clinical Associates and Providers.

c. Each facility must maintain the capacity to provide required TEACH and MI training by ensuring local TEACH and MI training facilitators (who have completed NCP-sponsored TEACH and MI facilitator training) and clinician coaches (who have completed NCP Clinician Coaching training) are available to provide both initial TEACH and MI training as well as follow-up clinician coaching.

d. After completing required TEACH and MI programs, additional training and clinician coaching of PACT staff is strongly encouraged to ensure clinician proficiency in TEACH and MI skills and support application of Veteran-centered communication skills in actual encounters with Veterans. Clinician coaching may be tailored to clinicians' learning needs and may be offered in individual and group formats using both face-to-face and non-face-to-face modalities (e.g., telephone coaching, review of case studies, review of audiotaped encounters). The clinician coaching process may include assessment, direct observation (in simulations or actual encounters with Veterans), goal-setting, practice, reflection, feedback, and repeated skill practice.

9. REFERENCES

a. Veterans Health Care Act of 1992, Pub. L. 102-585, sec. 511, 106 Stat. 4943, 4955-57 (codified at Title 38 U.S.C. 7318).

b. VHA Directive 1120, Responsibilities of the National Center for Health Promotion and Disease Prevention (NCP), dated July 30, 2015, or subsequent policy.

c. VHA Directive 1120.01, Core Requirements for MOVE!® Weight Management Program for Veterans (MOVE!), dated June 5, 2017, or subsequent policy.

d. VHA Handbook 1120.04, Veterans Health Education and Information Program Requirements, dated September 24, 2015, or subsequent policy.

e. VHA Handbook 1120.05, Coordination and Development of Clinical Preventive Services Guidance, dated July 29, 2015, or subsequent policy.

f. VHA Handbook 1101.10, Patient Aligned Care Team (PACT) Handbook, dated February 5, 2014, or subsequent policy.

g. Epstein RM, Street RL, Jr. Patient-Centered Communication in Cancer Care: Promoting Healing and Reducing Suffering. National Cancer Institute, NIH Publication No. 07-6225. Bethesda, MD, 2007.

h. Expanding Research, Education, Delivery and Integration of Complementary and Integrative Health Services into the Health Care Services Provided to Veterans, Draft Plan from the Office of Patient Centered Care and Cultural Transformation in response to the Comprehensive Addiction Recovery Act of 2016, P.L. 114-198, Section 932, January 9, 2017.

i. Home Telehealth Conditions of Participation: https://vaww.telehealth.va.gov/telehealth/ccht/cop/index.asp ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

j. Informed Medical Decision Making Foundation, Boston, MA.

k. National Center for Health Promotion and Disease Prevention Internet site at: https://www.prevention.va.gov/

l. VHA Blueprint for Excellence: https://www.va.gov/HEALTH/docs/VHA_Blueprint_for_Excellence.pdf, accessed December 16, 2016.

m. VHA National Center for Health Promotion and Disease Prevention Intranet Web site: http://vaww.prevention.va.gov/ ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

n. VHA Office of Community Engagement Internet site at: http://vaww.oce.med.va.gov/Default.aspx. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

o. VHA Office of Performance Measurement, Electronic Technical Manual: http://vaww.car.rtp.med.va.gov/programs/pm/pmETechMan.aspx. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

p. VHA Smoking and Tobacco Use Cessation Web site: http://vaww.publichealth.va.gov/smoking/index.asp. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

q. VHA Strategic Plan, 2013-2018, Office of the Assistant Deputy Under Secretary for Health for Policy and Planning, Department of Veterans Affairs, Washington, DC, 2012. https://www.va.gov/health/docs/VHA_STRATEGIC_PLAN_FY2013-2018.pdf, accessed December 16, 2016

r. World Health Organization, Implementation Tools: Package of Essential Noncommunicable (PEN) Disease Interventions for Primary Health Care in Low Resource Settings. World Health Organization, Geneva, 2013.

VHA HEALTHY LIVING MESSAGES AND GOALS

Veterans will be provided health promotion and disease prevention (HPDP) clinical interventions that are seamlessly integrated across the continuum of their health care and are delivered in a variety of modalities tailored to their needs and preferences. VHA clinicians and clinical support staff should incorporate these interventions into each Veteran's overall plan of care. To facilitate delivery of HPDP services, nine key Healthy Living messages and associated program goals for VHA have been developed for clinicians to share with Veterans:

1. **Message**: Be Involved in Your Health Care
   Goal: Increase patient engagement and involvement in health care

2. **Message:** Be Physically Active
   Goal: Increase physical activity and reduce physical inactivity

3. **Message:** Eat Wisely
   Goal: Increase consumption of vegetables, fruits, whole grains, low-fat dairy, and seafood in place of some meat and poultry; reduce consumption of sodium, saturated and trans-fatty acids, calories from solid fats and added sugars, and refined grains

4. **Message:** Strive for a Healthy Weight
   Goal: Prevent or reduce overweight and obesity through improved eating and physical activity

5. **Message:** Limit Alcohol
   Goal: Reduce risky alcohol use

6. **Message:** Be Tobacco Free
   Goal: Reduce tobacco use

7. **Message:** Get Recommended Screening Tests and Immunizations
   Goal: Increase appropriate use of recommended screening tests and immunizations

8. **Message:** Manage Stress
   Goal: Reduce associated symptoms of stress

9. **Message:** Be Safe
   Goal: Reduce falls, sexually transmitted infections, and self-harm