

**October 7, 2004**

**UNDER SECRETARY FOR HEALTH'S INFORMATION LETTER**  
**THE MANAGING OVERWEIGHT AND/OR OBESITY FOR VETERANS**  
**EVERYWHERE (MOVE!) PROGRAM**

1. This Under Secretary for Health's Information Letter encourages participation in the Department of Veterans Affairs (VA)-wide Weight Management and Physical Activity Initiative that addresses adverse health outcomes by attacking excess weight and sedentary life styles in veterans.
2. Research has clearly shown links between excess weight and lack of physical activity and numerous disease processes, including psychiatric pathologies. This lifestyle affects an individual's quality of life. The health care costs resultant from excess weight and physical inactivity are considerable (over \$100 billion annually). There is no similar single health risk that is so prevalent and is connected with so many diseases and a decreased quality of life, and which is preventable – even surpassing the adverse effects of smoking.
3. Since the United States (U.S.) Surgeon General's Call to Action in January 2002, the recognition of epidemic proportions of obesity and inactivity in the U.S. has stirred intense governmental and academic interest in research and programmatic derivation. VA is uniquely positioned to pioneer and field a nationwide weight management and/or physical activity program. No other government or civilian health care organization has the magnitude of responsibility, the number of medical centers, the inter- and intra-connectivity, the high standards of quality, or the central hierarchical organizational structure, as VA. No other organization or patient population holds the interest of Congress in the same way as VA and the veterans. VA can take the lead to define the blueprint for weight management for the Nation, while having a positive impact on reducing disease and associated costs, and increasing quality of life for the Nation's veterans.
4. In collaboration with VA Central Office and field staff, the VA National Center for Health Promotion and Disease Prevention (NCP) has developed a VA Weight Management and Physical Activity Initiative. Assessment and treatment procedures, clinical algorithms, and patient and provider information and instructional materials for Managing Overweight and/or Obesity for Veterans Everywhere (MOVE!) Program," can be found in Attachments B and C.  
***NOTE:** The development of this weight management and/or physical activity initiative pre-dates the Harvard-PrincetonCoopers (H-PwC) Evaluation of VA Cardiac Care Program study, and offers a proactive, systemic, and formalized primary prevention approach to reducing cardiac incidents in veterans by lowering risk factors of excess weight and sedentary life style.*

5. **Evidence-Based Recommendations.** Evidence supporting the efficacy of brief counseling or other interventions for dietary change, physical activity, or for weight control in general is limited, but rapidly growing. As with other areas involving behavior change, the existing evidence favors the efficacy of more intensive interventions. The MOVE! initiative is based upon the careful scientific evidence review published by the National Institutes of Health in 1998, and the Practical Guide subsequently published in 2000 (see subpars. 8b and 8c). Additional support comes from the recently released clinical guidelines for screening and interventions for obesity from the United States Preventive Services Task Force (USPSTF) (see subpars. 8d and 8e). These reports represent the best currently available scientific evidence regarding the overall evaluation and treatment of overweight and obesity. The majority of the recommendations in the MOVE! initiative are supported by evidence levels A and B (well-designed randomized controlled trials), with the remainder supported by level C evidence (uncontrolled or non-randomized trials, or observational studies). Based upon this, as well as the compelling need to address the obesity crisis in VA, patients need to be strongly encouraged and assisted with their decisions to lose excess weight and to engage in regular physical activity. If interventions for patients are planned, they need to include three key factors:

- a. Every patient needs to be periodically screened for overweight and inactivity.
- b. Every patient needs to receive counseling regarding healthy diet, physical activity, and behavior modification.
- c. Weight status and physical activity level need to be documented in the medical record for all patients, along with record of health sequelae of obesity and inactivity.

6. At present there is no central VA Directive addressing weight management and physical activity. Only one-third of VA medical centers have weight management and/or physical activity programs, and these are highly variable in quality, commitment, intensity, dimension, and approach. However, at present there are seventeen pilot projects underway which will assist NCP in refining the parameters of this initiative (see Att. F).

7. **Attachments.** The following attachments contain useful information:

- a. Attachment A provides a detailed review of the components of the MOVE! Program.
- b. Attachment B provides details of the five-level treatment model.
- c. Attachment C provides information on the medical implication of Overweight and Obesity in the veteran population.
- d. Attachment D provides an overview of the plan to implement the MOVE! Program and the current status of each action item.
- e. Attachment E provides the membership of the Weight Management Executive Council .
- f. Attachment F provides a list of the seventeen pilot programs.

8. **References.** *NOTE: Additional references may be found in Attachment B.*

- a. The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity. U.S. Department of Health and Human Services. Government Printing Office, 2001.
- b. The Practical Guide: Identification, Evaluation, and Treatment of Overweight and Obesity in Adults. National Institutes of Health (NIH), National Heart, Lung, and Blood Institute, North American Association for the Study of Obesity. NIH Publication Number 00-4084, 2000.
- c. Clinical guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. NIH, National Heart, Lung, and Blood Institute. NIH Publication No. 98-4083, 1998.
- d. USPSTF. "Screening and Interventions for Obesity in Adults: Recommendations and Rationale," Annals of Internal Medicine. 139:11, 930-932, 2003.
- e. McTigue, KM; Harris, R; Hemphill, B; et.al. "Screening and Interventions for Obesity in Adult: Summary of the Evidence for the U. S. Preventive Services Task Force," Annals of Internal Medicine. 139:11, 933-966, 2003.
- f. "Physical Activity and Health," A report of the Surgeon General. Department of Health and Human Services, Centers for Disease Control and Prevention and Health Promotion, Atlanta, GA, 1996.
- g. Healthy People 2010: Understanding and Improving Health. Washington, DC. U.S. Department of Health and Human Services, Government Printing Office, 2000.
- h. U.S. Preventive Services Task Force. Guide to Clinical Preventive Services. 2<sup>nd</sup> ed. Baltimore: Williams and Wilkins, 1996.
- i. Executive Order 13266, Activities to Promote Personal Fitness, June 20, 2002.
- j. VHA Handbook 1120.2.

9. Questions may be addressed to Richard Harvey, PhD, at 919-383-7874.

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Attachments

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ATTACHMENT A

**COMPONENTS OF THE MANAGING OVERWEIGHT AND/OR OBESITY FOR  
VETERANS EVERYWHERE (MOVE!) PROGRAM**

1. **Background.** The Department of Veterans Affairs (VA) National Center for Health Promotion and Disease Prevention (NCP) is developing a Veterans Health Administration (VHA) weight management and physical activity program entitled Managing Overweight and/or Obesity for Veterans Everywhere (MOVE!) for use system-wide. Current evidence-based techniques and materials will be utilized and adapted as necessary for seamless transition into primary care and other VHA settings. No experimental techniques or materials will be included; this program is to be consistent with current standards for evidence-based medical practices. It will provide a standardized format for provision of weight management, physical activity evaluation and treatment, and be packaged as a handbook for easy implementation; it will not require additional resources. The treatment components will be deliverable in modules and tailored for individual differences in medical status, age, ethnicity, and readiness to engage in weight management and physical activity behaviors. All procedures for patient encounters will be detailed in a handbook for clinicians, including actual scripts for encounters.

2. **Essential Components.** MOVE! contains the following essential components: counseling regarding nutrition, physical activity, and behavioral and/or psychosocial issues; long-term, ongoing evaluation and treatment of overweight and obesity in veterans; and medical record documentation of weight and physical activity status. This initiative includes:

- a. A standardized, partially computer-based, and individually tailored weight management and physical activity program for veterans, with increasing intensity of intervention, as needed.
- b. Evidence-based clinical practice guidelines for the evaluation and treatment of overweight and obesity.
- c. Performance measures related to weight management and physical activity identification and treatment.
- d. Multi-modality staff training with continuing education credits.
- e. A “tool kit” of materials, manuals, and instructions for health care providers and staff.
- f. Promotional and awareness enhancement materials and activities for patients, staff, and others.
- g. Involvement (to the legal extent possible) of VA employees in the program, with VA employees serving as role models for participating in weight management and physical activity.

h. Ongoing program evaluation and refinement, not only for pilot programs, but on a continuous basis during full implementation throughout VHA. Because this initiative is breaking new ground in that the scope will be larger, with potentially tighter control of service delivery, compared with any previous weight management studies, evaluation of even previously established “evidence” must be planned to validate the application to VHA.

i. Recommendations for a research agenda related to weight management and physical activity;

j. A VA Steering Committee to guide the overall strategic implementation of the initiative. Members of this committee would represent key VHA areas; for example: Patient Care Services (PCS), i.e., Primary and Ambulatory Care, Nutrition, Mental Health, TeleHealth, Physical Medicine and Rehabilitation, Employee Education Service (EES); Research and Development (R&D); Office of Quality and Performance (OQP); Ethics; Policy and Planning; Employee Health; Veterans Integrated Service Networks (VISNs); Voluntary Services; etc. ***NOTE:** This parallels the method used by industry in effectively implementing an initiative of this magnitude.*

k. An Executive Council, with governmental members and non-governmental consultants, as a neutral body comprised of nationally prominent experts in the area of weight management and physical activity to act as an impartial steering committee in regards to scientific propriety.

**3. Model.** A progressive or stepped care treatment model will be utilized, as clinically indicated, and as allowable within available resources. A credible weight management and physical activity program needs to include five treatment levels, mirroring weight management modalities available to the general population. These steps progressively increase in intensity and/or invasiveness; the more intensive levels may not all be available within each VA medical facility, but may be regionally situated. Systematic progression through each level is not necessary, but is determined by a patient’s weight history, medical condition, and psychological factors. These five treatment levels are as follows:

a. **Level One.** Level one is the initial clinical and computerized assessment; it includes tailored self-help, in the form of written materials, and scheduled staff follow-up contact as indicated.

b. **Level Two.** Level two consists of the components as described in Level one, plus: referral to specialized areas as needed; on site support groups (weekly multi-disciplinary group clinics or classes); and scheduled staff follow-up contact as indicated.

c. **Level Three.** Level three adds weight control pharmacological agents to either level one or level two treatment.

d. **Level Four.** Level four is a brief admission to an inpatient or residential weight control program in a medical center offering such treatment, and scheduled staff follow-up contact as indicated.

e. **Level Five.** Level five includes consideration for bariatric surgery, and scheduled staff follow-up contact as indicated.

*NOTE: The preceding levels are described with elaboration in Attachment B.*

4. **Referral.** Patients are to be referred to the appropriate sources for evaluation and/or treatment of co-morbid and/or complicating conditions such as poorly controlled or untreated diabetes, heart disease, clinically significant depression, blatant eating disorders, untreated orthopedic impairments, etc.

**ATTACHMENT B**

**THE MANAGING OVERWEIGHT AND/OR OBESITY FOR VETERANS  
EVERYWHERE (MOVE!) PROGRAM TREATMENT LEVELS**

The Managing Overweight and/or Obesity for Veterans Everywhere (MOVE!) Program model includes five treatment levels, mirroring weight management modalities available to the general population, to be utilized as clinically indicated, and as allowable by available resources.

**1. Level One Treatment**

a. At least annually, and upon other occasions as indicated, each patient must be assessed for Body Mass Index (BMI), and optional measurement of waist circumference. This will ordinarily occur during a primary care or other medical care visit. A BMI of 25 or more shall be identified as “overweight,” and a BMI of 30 or greater as “obese.” A waist circumference of 40 inches or more for males, and 35 inches or more for females, shall be considered “at risk” for obesity-related disease.

b. Patients identified during the initial clinical encounter as “overweight,” “obese,” or “at risk” must be advised to lose weight and be offered an opportunity to participate in the *MOVE!* weight management and physical activity program. The various program tracks and options will be described during this initial encounter.

c. Those individuals who are unwilling to enroll at that time will be counseled in accordance with the pre-cessation stage of readiness to change, with the goal of advancing the patient’s readiness to change. A handout addressing pre-cessation issues will be offered to such patients.

d. Patients who agree to proceed with enrollment in the MOVE! Program will then be asked to complete the computerized initial assessment questionnaire. The questionnaire assesses the following:

- (1) Types and amounts of food and alcohol intake;
- (2) Eating pattern and habits;
- (3) Physical activity type, intensity, and frequency;
- (4) Weight history;
- (5) Weight control history;
- (6) Familial weight data;
- (7) Readiness to change behavior;
- (8) Self efficacy;

- (9) Relevant self perceptions;
- (10) Major medical conditions;
- (11) Age;
- (12) Cultural and/or ethnic factors; and
- (13) Complicating factors, including mental health conditions, and other barriers.

e. The completed questionnaire is to be scored by computer. The results will provide an individually tailored report for the patient, including instructions and recommendations for beginning the MOVE! Program. The computer also produces a description of relevant factors regarding the patient for the staff; specific instructions and recommendations for assisting the patient; and specifies individually-tailored information and instructional handouts to be given to the patient. This report may then become a progress note in the Computerized Patient Record System (CPRS). Specific “alarm flags” are generated by certain responses to the questions; these result in a recommendation for referral of the patient to an indicated specialist for further evaluation or treatment of conditions that might impact upon weight management treatment (e.g., certain medical conditions, psychological disturbances, etc.).

f. The patient must be provided with a set of individually tailored information and instructional handouts. All materials will be prepared at a reading and/or comprehension level commensurate with that of the veteran population.

- (1) These materials address, at a minimum, the following topics:
  - (a) Nutrition and diet;
  - (b) Physical activity;
  - (c) Behavior modification strategies related to eating, satiety, physical activity;
  - (d) Motivational enhancement;
  - (e) Maintenance strategies; and
  - (f) Social and professional support.
- (2) Materials will be tailored with respect to individual differences in:
  - (a) Initial weight and BMI,
  - (b) Cultural and ethnic factors,

- (c) Age,
- (d) Stage of readiness to change behavior,
- (e) Co-morbid medical conditions and overall medical status, and
- (f) Other complicating factors.

**NOTE:** *Patients for whom walking is recommended may be given a pedometer.*

g. A plan for how to carry out the program must be formulated and discussed with the patient at the time the informational and instruction materials are issued. This plan must be patient-centered, so as to make the plan fit the patient, rather than making the patient fit the plan. The plan may include:

- (1) Specific materials for the patient;
- (2) Behavioral, dietary, and/or other goals, with specific time assignments;
- (3) Recommended classes and/or sessions;
- (4) Ancillary consults or appointments as needed; and
- (5) Follow-up dates, times, and methods of contact.

h. Follow-up contact must be conducted at frequent intervals on an ongoing basis. **NOTE:** *These intervals may be altered as clinically indicated.* Minimum recommended contact intervals are all of the following:

- (1) One week after initial contact.
- (2) Three weeks after initial contact.
- (3) Every 2 to 4 weeks thereafter until goals are achieved.
- (4) Every 3 to 6 months, as needed for maintenance.

i. **Type of Follow-up Contact.** A staff member must make telephone contact with the patient or make an alternative arrangement for follow-up contact. The content for follow-up encounters is provided in script form in the Provider's Weight Management and Physical Activity Treatment Manual and includes an individually tailored discussion of:

- (1) Progress, or lack thereof.
- (2) Interim assessment of stage of readiness to change behavior.

(3) Barriers and difficulties in carrying out recommended behavioral, dietary, and physical activity changes.

(4) Generation of possible remedies for barriers and difficulties.

(5) Praise and encouragement.

(6) Ongoing treatment plans, including receipt of additional materials.

## **2. Level Two Treatment**

a. **Brief Individual Attention.** Patients may require brief individual attention in the areas of nutrition, physical activity, psychosocial issues, or medical evaluation and treatment. Referral for any of these services is tantamount to a level two intervention.

b. **Intensive “On-site” Group Classes.** Intensive on-site group classes also constitute a level two intervention. Patients may move into level two because they:

(1) Failed to lose weight with less intensive interventions;

(2) Need closer support and supervision; or

(3) Are motivated to attend weekly group sessions at the beginning, or at any point during treatment.

c. **Small Groups of Participants Meet Weekly.** Small groups of participants meet weekly to learn and discuss additional strategies for weight control. Each session lasts 60 to 120 minutes, and features topical discussions; one on nutritional information, and another on a behavioral topic. A “progress review” is carried out for each patient in the group, and each patient is weighed. There is no recommended duration for such treatment. Each session is scripted and educational; materials and/or handouts for the session are available on a wide variety of topics such as:

(1) Types of vegetables, fruits, meats, starches, etc.;

(2) Food groups;

(3) Dietary balance;

(4) Detailed reading of food labels;

(5) Portion sizes;

(6) Coping with emotion-based eating;

(7) Stress control;

- (8) Overcoming prior attitudes about food, eating, and exercise;
- (9) Goal setting;
- (10) Motivational enhancement;
- (11) Types of physical activity; and
- (12) Proper exercise techniques.

### 3. Level Three Treatment

a. **Pharmacological Weight Control Agents.** The addition of pharmacological weight control agents to the treatment plan constitutes treatment at level three. Treatment with weight control medications may be conducted coincident with ongoing level one or level two treatment. While pharmacological augmentation of treatment is not a necessary step before moving to level four or level five, these agents may be appropriate for patients selected on the basis of:

- (1) Failure to successfully lose weight with less intensive treatment; or
- (2) A history of repeated failure to maintain weight loss in the past; or
- (3) Poor impulse control; and
- (4) A BMI of 27 or more with the presence of at least two major risk factors, or a BMI of 30 or more with or without risk factors.

b. **Available FDA-approved Drugs.** There are several FDA-approved drugs available for short-term and long-term weight management. A review of available pharmacologic interventions is currently being conducted by the VA National Center for Health Promotion and Disease Prevention (NCP). When the review is completed, it will be submitted to the VA Pharmacy Benefits Management (PBM) Strategic Healthcare group (SHG) and VA Medical Advisory Panel for National Formulary consideration for one or more agents. This helps avoid confusion among prescribers concerning which drugs are readily available through the VA formulary management process. As point of reference, at present, the following agents are FDA-approved for weight control:

- (1) Orlistat (Xenical<sup>®</sup>). This is a lipase inhibitor that prevents the absorption of up to 30 percent of consumed fat. It is a non-systemic drug, approved for long-term use.
- (2) Sibutramine (Meridia<sup>®</sup>). This is a norepinephrine, dopamine, and serotonin reuptake inhibitor that suppresses appetite, and is approved for long-term use.
- (3) Phentermine (Fastin<sup>®</sup>, Ioamin<sup>®</sup>). This is a sympathomimetic drug having noradrenergic action, and is approved for short-term use only.

#### 4. Level Four Treatment

a. **Inpatient or Residential Treatment.** Inpatient or residential treatment may be utilized, when available, as a level four treatment. Regional positioning of residential treatment facilities may be the most economical use of resources. Candidates for inpatient or residential treatment of obesity may be selected on the basis of:

- (1) Failure to achieve significant weight loss with less intensive treatment;
- (2) A BMI of 40 or greater; or
- (3) Inability to participate in less intensive treatment due to transportation or other constraints.

b. **Essential Components of Inpatient Care.** Inpatient or residential care may vary in duration as clinically necessary. Materials utilized for information and discussion in less intensive interventions may also be used during inpatient programs and will be covered in greater depth. In addition to careful assessment, essential components of inpatient care include:

- (1) Limited access to food, with supervised low calorie meals and food portions;
- (2) Intensive nutritional education;
- (3) Food planning and preparation classes;
- (4) An exercise prescription, with supervised physical activity;
- (5) Intensive physical activity education;
- (6) Intensive behavior modification, and education on behavioral strategies;
- (7) Group therapy, focusing upon cognitive and emotional re-education;
- (8) Pharmacotherapy, if indicated; and
- (9) Carefully planned follow up.

5. **Level Five Treatment.** Bariatric gastric bypass surgery (GBS), or other bariatric surgical procedures, is the level five treatment of last resort. Patients may be referred for a bariatric surgical procedure to medical centers where this service is available. Selection criteria for this treatment option must be derived from latest evidence, but at a minimum, must include:

- a. The failure to achieve significant weight loss utilizing treatment in level one through level four.

- b. A BMI of 40 or greater, or a BMI of 35 or greater with co-morbid conditions.
- c. Formal psychological evaluation showing the patient is: emotionally stable, able to control impulses, and able to maintain the frequent and long-term follow-up contact necessary for a successful outcome from the procedure.
- d. The ability to attend structured GBS group therapy, both pre-surgery and continual post-surgery; this therapy is to be proctored by multiple disciplines, to include: nutritional, behavioral, physical activity, medical, and GBS surgical components.

ATTACHMENT C

**BACKGROUND INFORMATION ON OVERWEIGHT AND OBESITY**

**1. Obesity and Inactivity are National Problems**

a. **Prevalence.** Escalating obesity prevalence and widespread physical inactivity in the United States (U.S.) population has been of increasing concern to clinicians, public health officials, and policy makers. However, obesity is treatable, and the resultant medical problems are preventable. While large amounts of weight loss are clearly difficult to achieve and sustain, current literature suggests that modest weight loss (5 to 10 percent of total body weight) can be both achieved and sustained, and is linked with improvements in health outcomes (see subpars. 6a and 6b). Recent national data show that 61 percent of adult Americans are overweight, while 26 percent are obese (see subpar. 6a). A Body Mass Index ((BMI), measured by kilogram of weight and meters in height (see subpar. 6b), of 25 to 29.9 is considered “overweight,” and BMI  $\geq 30$  is considered “obese” (see subpar. 6c). The prevalence of obesity has doubled over the last 4 decades (see subpar. 6a). National estimates suggest that 60 percent of U.S. adults are not regularly physically active, and 25 percent are not active at all (see subpar. 6d). The recent Surgeon General’s Call to Action to Prevent Overweight and Obesity suggests that obesity is as serious a problem as smoking, alcohol or poverty in terms of impact on morbidity (see subpar. 6a). The prevalence of diabetes has increased 61 percent since 1990, coincident with the increase in overweight and obesity (see subpar. 6e).

b. **Consequences of Obesity and Inactivity.** Obesity has been linked with increased risk of all-cause mortality; an estimated 300,000 deaths are associated with overweight and obesity each year in this country (see subpar. 6a). In addition, obesity is linked with a number of specific morbidities, including heart disease, cancer, cerebrovascular accidents, hypertension, dyslipidemia, sleep apnea, menstrual abnormalities, osteoarthritis, social stigma, and others (Table 1) (see subpar. 6c). Research in the Department of Veterans Affairs (VA) patient population showed worsened quality of life, including increased bodily pain, in obese patients (see subpar. 6f). Recent analyses have found that overweight and/or obesity shortens life expectancy substantially (see subpars. 6g and 6h). It is estimated that overweight and obesity in the U.S. could account for 14 percent of all deaths from cancer in men, and 20 percent of cancer deaths in women (see subpar. 6i). Direct health care costs of obesity have been estimated to be substantial: 5.7 percent of total U.S. health care expenditures (see subpar. 6c). The overall direct and indirect cost associated with obesity in the year 2000 was estimated to be \$117 billion (see subpar. 6a). Obesity likely outranks both smoking and drinking in its deleterious effects on health and health costs (see subpar. 6a).

**Table 1. Selected adverse health effects of obesity (see subpar. 6c).**

Premature Mortality	Diabetes
Coronary Artery Disease	Hypertension
Congestive Heart Failure	Dyslipidemia
Colon Cancer	Restrictive Respiratory Disease
Breast Cancer	Gall Stones
Prostate Cancer	Osteoarthritis
Endometrial Cancer	Pregnancy Complications
Gall Bladder Cancer	Menstrual Irregularities
Strokes	Sleep Apnea

c. Like obesity, physical inactivity has similarly been linked with adverse health outcomes. Numerous medical studies have documented that physical activity reduces the risk of premature mortality, coronary heart disease, hypertension, colon cancer, diabetes, and that it promotes mental health and a healthy musculo-skeletal system. Even moderate amounts of physical activity (e.g., 30 minutes of brisk walking daily) can confer health benefits (see subpars. 6d, 6k, and 6l). Unlike obesity, the health risks of physical inactivity have been firmly established even among the aged (see subpars. 6a and 6m), a fact particularly relevant to the veteran population, given its age demographics.

## **2. Federal Health Policy Recognizes Seriousness of National Trends**

a. The Healthy People 2010 report (see subpar. 6k) lists overweight and obesity among the leading health indicators in this country, and has established a target goal for obesity of less than 15 percent for adults. The National Institutes of Health (NIH) have recommended clinical attention to obesity, and have developed clinical practice guidelines for the assessment and treatment of overweight and obesity, based upon extensive review of scientific evidence (see subpar. 6c). In 1996, the U.S. Preventive Services Task Force (USPSTF) recommended screening for obesity (B-level recommendation) (see subpar. 6m) and an updated review of the evidence for screening and treatment has currently been published (see subpars. 6aa and 6bb). The recent Surgeon General's "Call to Action to Prevent and Decrease Overweight and Obesity" mandates a coordinated national response to improving Americans' body weight (see subpar. 6a). In addition, the Internal Revenue Service (IRS) has adopted a new policy allowing people diagnosed as obese to claim weight loss expenses as medical deductions.

b. With regard to physical inactivity, the 1996 Report of the Surgeon General on Physical Activity and Health endorsed "a massive national commitment" toward reversing trends in physical inactivity (see subpar. 6d), and the Healthy People 2010 goal is to double to 30 percent the number of adults who regularly engage in moderate exercise of 30 minutes duration (see subpar. 6k). Further, the Robert Wood Johnson foundation has issued a "National Blueprint: Increasing Physical Activity Among Adults Age 50 and Older" (see subpar. 6n). In June 2002, President Bush issued the "Healthier US" initiative, which calls for special emphasis upon increasing physical activity among Americans, in addition to other health enhancement activities (see subpar. 6o).

**3. Status of the Veteran Population.** Data have shown that excess weight is more prevalent in the veteran population than in the general U.S. population (Table 2). A national sample from the 1999 Large Health Survey of VA Enrollees found that 45 percent of respondents were at least moderately overweight (see subpar. 6p). That survey used a higher BMI as the criterion for overweight status, so the reported rates are lower than more recent estimates. Excess weight prevalence was highest in those enrollees between the ages of 40 and 69. According to the same survey, although physical activity in veterans was more common than in the general population, most veterans did not meet Federal recommendations for weekly moderate physical activity. These findings and inferences define a significant gap in preventive services for the spectrum of the Veterans Health Administration (VHA) patient population.

**Table 2. Overweight and obesity prevalence within VHA, compared with overall U.S. population**

Sample	Overweight or Obese (BMI ≥ 25)	Obese (BMI ≥ 30)
National Health and Nutrition Examination Survey (NHANES) 1999 (see subpar. 6q) (Overall US Population)	61%	26%
VHA Large Health Survey (see subpar. 6p)	45%	--
VA Medical Practice Clinic Sample, San Francisco, CA (see subpar. 6r)	69%	29%
VA Specialty Clinic Sample Minneapolis, MN (see subpar. 6s)	75%	34%
VA Primary Care Sample Charleston, SC (see subpar. 6t)	70%	27%
NCP (see subpar. 6u)	Women = 68% Men = 73%	Women = 37% Men = 33%
VA Users from Behavioral Risk Factor Surveillance Survey (BRFSS) Data (see subpar. 6v)	69%	21%

**4. VHA Weight Management and Physical Activity Programs.** Weight loss and increased physical activity can reverse many of the adverse effects of overweight and/or obesity (see subpars. 6a and 6w). Yet, less than 1/2 of the VA medical centers reported having any Weight Management and/or Physical Activity Program, according to a survey conducted by the National Center for Health Promotion and Disease Prevention (NCP) in June 2002. Existing programs were found to vary widely in quality, types of services, and outcomes measured. Many of these programs are very limited in scope, and operate with scant resources. This suggests that current practices are inadequate to address this highly prevalent risk for expensive and debilitating chronic disease in the VHA patient population.

**5. VA NCP Activities to Support Physical Activity to Combat Obesity**

a. As the VA Central Office for “All Things Prevention,” NCP has a mandate to address the growing problem of overweight, obesity, and physical inactivity among veterans. NCP is a

central resource where front-line providers seek guidance for preventing chronic and acute illness. The continual input witnessed by NCP from practitioners in the field suggests that there is a need for additional guidance.

b. By organizing minimum, standard, evidence-based approaches, consistent outcomes measures, and regular program evaluation and updates, NCP will help to better serve the health of U.S. veterans, and take the lead in translating research into practice for an issue of paramount health importance to many Americans. These programs have the potential to significantly diminish a root cause of mortality and prevalent sources of morbidity among veterans, thus reducing both the burden of individual patient suffering and that of the enormous potential health care costs. This initiative establishes VA as the benchmark for the provision of weight management and physical activity services.

c. Current VHA recommendations (see subpar. 6x) are that all veterans need to have their height and weight measured every 2 years, and need to have access to counseling to limit dietary intake of fat and cholesterol, to maintain caloric balance, and to emphasize foods containing fiber. Female veterans should be advised to consume adequate amounts of calcium. Annually, all veterans need to be encouraged to engage in a program of physical activity tailored to their health status and personal life style. They need to have access to counseling regarding optimizing their level of physical activity. These recommendations establish a solid foundation, but lack strong emphasis and direction for intervention and long-term change, lack mechanisms for accountability, and result in highly variable levels of preventive services regarding weight and physical activity.

d. NCP is engaged in developing and disseminating a weight management and physical activity initiative tailored for use throughout VHA. This initiative utilizes current evidence-based methods, and conforms to NIH guidelines for weight management evaluation and treatment. It is designed to avoid the need for additional resources, to not require highly specialized staffing, and to be easily adaptable to ongoing clinical operations within VHA.

e. Centralized coordination through NCP facilitates development of seamless and consistent comprehensive care at the local level across sites. In order to develop the many facets of this initiative, NCP seeks input from, and collaboration with, many VHA and non-VHA sources, including Employee Education Service (EES), Primary Care, Nursing, Nutrition and Food Services, Mental Health, Physical Medicine and Rehabilitation, Social Work, Pharmacy, VA Public Health, Office of Quality and Performance (OQP), Centers for Disease Control and Prevention (CDC), Agency for Health Care Research and Quality (AHRQ), Department of Defense (DOD), and others. Major components of this initiative include:

(1) A standardized, partially computer-based, and individually-tailored weight management and physical activity program for veterans.

(2) A VHA Directive on Weight Management and Physical Activity.

(3) Evidence-based clinical practice guidelines for the evaluation and treatment of overweight and obesity.

(4) Performance measures related to weight management and physical activity identification and treatment.

(5) Multi-modality staff training, with continuing education credits.

(6) A “tool kit” of materials, manuals, and instructions for health care providers.

(7) Promotional and awareness enhancement materials and activities.

(8) Ongoing program evaluation and refinement.

(9) Dissemination of program evaluation findings.

(10) Recommendations for a research agenda.

(11) An Executive Council comprised of nationally prominent experts in the area of weight management and physical activity.

f. Effective intervention must be multifaceted and/or multidisciplinary. Essential core components include:

(1) Counseling regarding nutrition, physical activity, and behavioral and/or psychosocial issues;

(2) Long-term, ongoing evaluation and treatment of overweight and obesity in veterans;

(3) Medical record documentation of weight and physical activity status;

(4) Education and training of VA health care providers to enhance practice patterns; and

(5) Awareness and/or involvement of VA employees in general.

g. VA employees are potential role models for healthy lifestyles. Their involvement can facilitate an environment in which healthy eating and exercise patterns are not only possible, but also visible and encouraged. Employees need to be able to personally participate in clinical interventions and programs. On-site healthy food options and availability of safe, accessible exercise facilities need to be incorporated into each VA worksite. Changes need to be consistent with recommendations from the Centers for Disease Control (CDC) Community Preventive Services Task Force to promote physical activity (see subpar. 6y).

h. **Evidence-Based Recommendations for Patients.** VA patients should be strongly encouraged and assisted with their decisions to lose excess weight and to engage in regular physical activity. Interventions for patients need to include three key factors:

(1) Every patient needs to be periodically screened for overweight and inactivity.

(a) Evaluation of overweight needs to be based upon a BMI of 25 or over, and/or a waist circumference of 40 inches for males and 35 inches for females.

(b) Evaluation of physical activity needs to be based upon the recommended 30 minutes of accumulated moderate activity on most days, aimed at the home or office and/or workplace setting.

(c) Co-morbid or complicating conditions (e.g., physical disabilities, depression, limited access to services) need to be identified during initial evaluation to enable treatment to be tailored to the individual.

(2) Every patient needs to receive counseling regarding healthy diet and physical activity.

(a) Patients who are overweight need to be advised to lose weight and to exercise, and be offered treatment for this problem.

(b) Treatment needs to be tailored to reflect the individual's health status, complicating conditions, age, ethnicity, and stage of readiness to engage in weight control behaviors.

(c) Necessary treatment components include information and instructions regarding:

1. Nutrition, diet, and eating behavior;
2. Physical activity;
3. Behavior modification;
4. Maintenance strategies; and
5. Ongoing support.

(d) Treatment needs to be coordinated among various care providers, and tailored to an individual's needs.

(e) Treatment needs to reflect the recent USPSTF finding that there is evidence to support the use of intensive behavioral dietary counseling interventions for patients with risk factors for diet-related chronic disease (see subpar. 6z).

(f) Recommendation on screening and treatment for obesity (see subpars. 6aa and 6bb).

(g) Treatment and/or follow up should be continued on an ongoing basis.

(3) Weight status and physical activity level need to be documented in the medical record for all patients, along with record of health sequelae of obesity and inactivity. For overweight or

inactive patients, additional outcome measures of importance include measures of quality of life and satisfaction with the weight and/or physical activity services.

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## ATTACHMENT D

### IMPLEMENTATION PLAN

In collaboration with the Department of Veterans Affairs (VA) Central Office and field staff, the National Center for Health Promotion and Disease Prevention (NCP) has developed a VA Weight Management and Physical Activity Initiative. Assessment and treatment procedures, clinical algorithms, and patient and provider information and instructional materials for this initiative, the Managing Overweight and/or Obesity for Veterans Everywhere (MOVE!) Program, are undergoing continued review and development.

**1. Executive Council.** NCP convened a weight management and physical activity Executive Council, comprised of nationally prominent experts in the area of weight management and physical activity. The Council advises NCP on all major aspects of MOVE! and related activities. The Council convenes for face-to-face meetings as needed, and otherwise interacts utilizing electronic mail and telephone conference calls (see Att. E).

**2. Veterans Health Administration (VHA) Steering Committee.** It is planned that a committee comprised of VHA Central Office leadership from many services, as well as field representatives, will be convened to guide the actual implementation of MOVE! VHA-wide.

**3. The First Weight Management Training Meeting.** The first draft of the VA Weight Management and Physical Activity Initiative was presented during a meeting held April 10-11, 2003. Patient and provider materials and manuals, clinical algorithms, and related program components were presented to representatives sent from the various medical centers to receive training in weight management and physical activity counseling skills, and to become familiar with and evaluate the MOVE! Program. Participants were invited to attend based on their interest in conducting, coordinating, and/or facilitating the implementation of weight management and physical activity programs in their respective medical centers. This training meeting established a corps of knowledgeable and skilled VA health professionals to serve as “champions” for weight management and physical activity in VHA. In addition to imparting weight management and physical activity skills, discussion with the participants focused on strategies for the actual implementation of MOVE! in the field. Materials, procedures, and implementation strategies were further refined in accordance with feedback from the participants.

a. **Pilot Programs and Evaluations.** Seventeen VA medical center sites have been selected to conduct initial trials utilizing the procedures, algorithms, and materials with patients. Staff is asked to implement the MOVE! Program in the manner specified in the program handbook. Evaluation of all aspects of MOVE! is sought from staff users, as well as from patients. Users are asked to assess their satisfaction with the materials and procedures, their usefulness, ease of comprehension, and practicality of the behavioral, nutritional, and physical activity instructional handouts. A written questionnaire utilizing Likert scale measures is to be utilized for this evaluation. Suggestions for improvement will be actively solicited. ***NOTE:** Further modifications of the materials, procedures, and clinical algorithms will be made based upon these evaluations.*

b. **Integration into the Computerized Patient Record System (CPRS).** Initial discussions with the Chief Information Office (CIO) regarding incorporation of the MOVE! Program into the Health-e Vet website, and future integration into CPRS, have been positive. **NOTE:** *Discussions with the CIO continue, as both programs are further developed.*

4. **Planned Directive.** A Veterans Health Administration (VHA) Directive regarding implementation of the Weight Management and Physical Activity Initiative is planned. It is anticipated that this Directive will allow medical centers to embrace MOVE!, implement the procedures without additional resources, and effectively address the second leading cause of early death and disability in the United States (U.S.). Endorsement from clinical administrative leaders in VA Central Office and the VISNs is critical. Support from these leaders is sought through personal contacts, presentation of MOVE! during conference calls, and provision of opportunities for review and input during the development process.

a. **MOVE! Program Distribution.** The MOVE! Program handbook, materials, staff procedural instructions, clinical algorithms, and all related items necessary to implement the MOVE! Program are to be distributed to each medical center as soon as the initial development and subsequent refinements are complete.

b. **Promotional Campaign.** The distribution of MOVE! Program handbooks and materials is to be accompanied by an intensive promotional campaign, including: e-mail notices, brochures, posters, newsletters, personal contacts, conference calls, and other strategies meant to heighten staff awareness and enthusiasm. These “marketing” efforts are directed to: primary and ambulatory care leaders and staff; Preventive Medicine Program Coordinators; and mental health, nursing, patient education, and other related leaders and personnel; Veterans Integrated Service Network (VISN) clinical and administrative leaders; and patients.

**NOTE:** *In addition to distributing the program materials, the promotional brochures, and promotional posters, NCP staff conducts frequent telephone follow-up.*

c. **Staff Training.** MOVE! includes instructions and suggested scripts for patient interactions, so that staff who are not weight management specialists can enroll, assess, counsel, and follow patients. A major educational effort is to be mounted to enhance VA staff members’ knowledge and skill in weight management, and to heighten their enthusiasm. Training modules are being developed in print, on the NCP website, as well as video teleconferencing and videotape. NCP staff members are available for consultation, and will conduct additional training as necessary. Notice of these various training opportunities will be widely-distributed throughout VHA, and will be readily available to all interested VA staff.

d. **Clinical Practice Guidelines.** In collaboration with the Office of Quality and Performance (OQP), clinical practice guidelines for weight management and physical activity in VHA will be developed. These guidelines will be adapted from the National Institutes of Health (NIH) evidence-based The Practical Guide: Identification, Evaluation, and Treatment of Overweight and Obesity in Adults. In addition to recommendations regarding routine patient weight management, the guidelines will include criteria for the addition of weight control medications to other treatment and for inpatient care, residential care, and bariatric surgical procedures.

e. **Web-Based Weight Management Resources.** The NCP will publish the entire MOVE! Program on their intranet web site ([vaww.nchpdp.med.va.gov](http://vaww.nchpdp.med.va.gov)), as well as parts of the program on the internet web site ([www.nchpdp.med.va.gov](http://www.nchpdp.med.va.gov)). Professional training and staff resources related to weight management and physical activity will also be present on the intranet web site.

f. **Research Agenda.** Predictive models for health risk assessment are being developed from VA patient data to aid in identification of veterans at highest risk for weight problems, as well as for the health consequences of inactivity and obesity. *NOTE: Targeting those at highest risk may promote more cost-effective and efficient use of resources.*

**5. Continual Evaluations, Feedback, Modifications.** In a fashion similar to that sought during the initial clinical trials, ongoing evaluation of all aspects of MOVE! is being solicited from VA staff users, as well as from patients. Once again, program procedures and materials will undergo refinement based on ongoing evaluative feedback before being disseminated to the field.

**6. Ongoing Guidance and Support.** NCP continues to monitor and guide the utilization of the MOVE! weight management and physical activity programming. As new research findings in the area of overweight and obesity become available, NCP interprets those findings and relays that information to the field. Changes in the MOVE! Program are made in accordance with those findings. NCP staff continues to be available for consultation on weight management and physical activity, and to offer additional training in weight management, as needed.

**7. Status of Weight Management and Physical Activity Initiative**

a. Initial design of the initiative has been completed (see Att. B).

b. Initial development, validation, and automation of the enrollment assessment questionnaire is finished, and revisions are underway.

c. Patient and provider educational materials have been developed.

d. The initiative has received field input. *NOTE: On April 10, 2003, NCP held a Weight Management training course, during which the MOVE! draft initiative was presented to a representative group of VA providers from 21 VISNs for feedback and suggestions for implementation.*

e. Seventeen VA medical facilities are serving as pilot sites (see Att. F).

f. The Institutional Review Board (IRB) for Research and Development (R&D) approval process has been completed for the National Center for Health Promotion and Disease Prevention, and for all the pilot sites.

g. An extensive program evaluation format is being developed for the pilot sites to monitor the implementation process at the various facilities, MOVE! personnel, patient outcomes and satisfaction, and adequacy of program materials.

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h. A MOVE! training module was incorporated into the VA Prevention Coordinators training course, held August 11-14, 2003, in Albuquerque, NM.

i. A Weight Management and Physical Activity Executive Council comprised of VA, other government, and academic national experts has been established for the Initiative (see Att. E).

**ATTACHMENT E**

**WEIGHT MANAGEMENT EXECUTIVE COUNCIL**

<b>Member Name</b> <i>(in alphabetical order)</i>	<b>Organization and/or Affiliation</b>
James Anderson, MD	Professor, University of Kentucky Metabolic Research Group VA Medical Center Lexington, KY
Charles Billington, MD	Professor, University of Minnesota Director, Center for Obesity Research and Education, VA Medical Center Minneapolis, MN
Mary Burdick, PhD, RN	Chief of Staff VA National Center for Health Promotion and Disease Prevention Durham, NC
Patricia Deuster, PhD, MPH	Professor and Director Applied Human Biology Division Department of Military and Emergency Medicine Uniformed Services University of Health Sciences Bethesda, MD
Joseph Francis, MD, MPH	Associate Director Health Services Research and Development Quality Enhancement Research Initiative Veterans Health Administration Department of Veterans Affairs Washington, DC
Janet Fulton, PhD	Epidemiologist Division of Nutrition and Physical Activity National Center for Chronic Disease Prevention and Health Promotion Centers for Disease Control Atlanta, GA
Richard Harvey, PhD	Assistant Director for Preventive Behavior VA National Center for Health Promotion and Disease Prevention Durham, NC

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Philadelphia, PA

**Executive Secretary**

Jacqueline Howell, MPH, RN

**ATTACHMENT F**

**LOCATIONS OF PILOT PROGRAMS**

1. VA Medical Center, Asheville, NC.
2. VA Medical Center, Albany, NY.
3. Community-Based Outpatient Clinic, Albany Clifton Park, NY.
4. VA Medical Center, Albuquerque, NM.
5. VA Medical Center, Baltimore, MD.
6. VA Medical Center, Buffalo, NY.
7. VA Medical Center, Chicago Lakeside, IL.
8. VA Medical Center, Chicago Westside, IL.
9. VA Medical Center, Des Moines, IO.
10. VA Medical Center, Durham, NC.
11. VA Medical Center, Minneapolis, MN.
12. VA Medical Center, Murfreesboro, TN.
13. Community-Based Outpatient Clinic, Pueblo, CO.
14. VA Medical Center, San Diego, CA.
15. Puget Sound Health Care System, Seattle, WA.
16. Puget Sound Health Care System, American Lake, WA.
17. VA Medical Center, White River Junction, VT.