

A Coaching by Telephone Intervention for Veterans and Care Team Engagement

A.C.T.I.V.A.T.E

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Funding:

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Partners:

Durham VA Medical Center

VHA National Center for Health Promotion and Disease Prevention (NCP)

Anticipated Impacts on Veterans Health:

Veterans participating in the intervention may have greater reduction in modifiable cardiovascular risk.

Project Background:

This project is the first of a four-project Prevention Coaching Lab CREATE grant entitled “Transforming Prevention into Action” aimed at effectively engaging patients and their families to improve their health and medical care. Over half of all deaths, and many illnesses, can be attributed to four modifiable risk factors: tobacco use, overweight/obesity, physical inactivity, smoking and alcohol use. Veterans have a high prevalence of obesity, inactivity, smoking and alcohol misuse. The Veterans Health Administration (VHA) has implemented a diverse menu of prevention programs to help Veterans engage in more healthy lifestyles. However, few Veterans enroll in these programs. There is evidence to suggest the low level of participation in prevention programs may be due, at least in part, to a lack of awareness about the available programs and why they might benefit them, which may block patients from being activated for prevention.

Project Objectives:

The objective of this randomized, 2-arm effectiveness-implementation trial is to determine if a telephone-based shared decision making (SDM) intervention, using a Health Risk Assessment (HRA) and a Prevention Coach who are linked in with the Veteran's healthcare team, will increase patient activation and enrollment in prevention programs compared to usual care.

Study Design:

The study will be performed at the Durham and Ann Arbor VAMCs. Each arm will have 225 patients; patients will be VA users with at least one modifiable risk factor (obese, inactive, or tobacco user) who are not currently enrolled in a prevention service, but who are enrolled in VA primary care. The SDM intervention will be conducted by a prevention coach, be telephone based, and will use the output from VHA's new Health Risk Assessment (HRA) to engage Veterans in a conversation where individual preferences are matched to behaviors and choices for specific prevention services. The resulting prevention action plan will be shared with the Veterans primary care team (PACT), and documented in the medical record.

Outcomes will be obtained at the enrollment visit (baseline), and 1 month and 6 months after enrollment by blinded research personnel. The co-primary outcome will be change in the Patient Activation Measure (PAM) and proportion enrolled in effective prevention services. The secondary outcome is 10-year risk of coronary events, as measured by Framingham Risk Score. Process evaluations of the intervention and its implementation will also be conducted to inform future dissemination and implementation should the intervention prove effective.

Potential Impact:

This project will be the first to test an HRA in a SDM framework in the context of a large healthcare system. In addition to adding to the scientific knowledge-base, our study will also provide essential guidance about how patients and PACT can integrate the HRA into a SDM process to: 1) activate patients; 2) actively engage them in prevention services (in the VA or the community); 3) ultimately lead to reductions in risks and improvements in health; and 4) provide guidance for dissemination and implementation.

We are very excited to work with Ann Arbor VAMC staff who are very engaged: Kimberlee Buzenberg (HPDP), Lindsey Bloor (HBC), Lisa Falzetta (Nurse Manager), Linda Longshaw (Nurse Manager), Linda Graham (LPN), and Patricia Fries (LPN).

