Cyberseminar Transcript

Date: January 8, 2019

Series: HSR&D Career Development Award Enhancement Initiative Spotlight on Women’s Health

Session: How Can Peer Support Promote Cardiovascular Health Behaviors Among Women Veterans?

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Rob (Moderator): I’d like to introduce our presenters today. We have Karen Goldstein, MD, MSPH and her mentor, Eugene Oddone, MD, MSH, who are both core investigators at the Center of Innovation to Accelerate Discovery and Practice Transformation, acronym (ADAPT). Karen, can I turn things over to you?

Karen Goldstein: Yeah, great. Thank you. Alright, hopefully you can see my slides there. So, thank you for the introduction, Rob. And thank all of you for joining with us today. We are excited to be sharing with you some of the work that we have done that has part of my Career Development Award, that has been overall focused on peer support to reduce cardiovascular risk among women Veterans. So, I don’t have any conflicts of interest, nor does Gene, and I want to make sure to acknowledge the funding and support that I have received for this Career Development Award and from our center, including for a pilot study, that we will talk about in a little bit. So, I think we are starting off with a couple of poll questions.

Rob: Okay, and I have just launched that first poll question. The question being: Did you get the 150 minutes of moderate to vigorous physical activity recommended for optimal heart health in the last week? The answers are streaming in. People are choosing either “Yes,” “No,” or, “What is physical activity?” And Karen, we have about 64% of our audience members voted, it usually levels off right around 80%, so I am going to give people a few more moments.

Karen Goldstein: This is not designed to make anyone feel bad. This is mostly to show that we all struggle with similar things to what our patients do.

Rob: People are just trying to figure out what 150 minutes really means.

Karen Goldstein: Yeah, that’s a tricky one.

Rob: Okay, well we’ve got over 85% voted and it seems to have leveled off, so I am going to close the poll and share the results, and I will tell you that 53% got the 150 minutes, 44% said “No,” and 3% said, “What is physical exercise?”

Karen Goldstein: Yes, there are many days where I feel like that. I think it has become quite a shock, being in the research world, how much my day is sitting at my desk. I have to get up and walk around. So, that is great, good for you for those who were able to get that. Sometimes over the holidays it is easier, and sometimes it is much harder to get that kind of exercise. So, that is helpful. And then we have one more question for you.

Rob: Right, and I have just launched that poll. The question being: What is your experience with peer support? This one has a few more options for answers; “I have never heard of it,” “I have heard of it, but that is about it,” “I have provided peer support,” “I have received peer support,” “I have provided and received peer support.” And we have got about half of our audience voted so far, and that just jumped up to 70%, so things are going a little bit faster this time around, but we will give people a few more moments, okay? Things have leveled off, so I am going to go ahead and close the poll and share out the results, and 6% of your audience said that they have never heard of it. The majority, 51%, say they have heard of it, but that’s about it, 11% say, “I have provided peer support,” and only 3% say they have received peer support, and 29% say, “I have provided and received peer support.” So, 51% have heard of it but that’s about it, and 29% for having provided and received. And, now we are back on your slides.

Karen Goldstein: Okay, great. Well, thank you guys for providing those answers. That is really helpful to get a sense of everyone’s familiarity with peer support, and hopefully we will be able to provide something really for all of you in the audience and we would love to hear your questions at the end and we would love to learn from you, as well. Okay, so I just want to start off this conversation talking a little bit about the objectives that we set out at the beginning of this Career Development Award. I have a distinct memory of sitting in Gene’s office, when he was trying to get me to nail down my thoughts about what, exactly, I was hoping to accomplish, how I was going to do it, and what was needed, what did we need to know to be able to move that forward. And, it took a little while, for those of you that have written those kinds of proposals, to really get down to the key questions, but it helps me to go back and think a little bit about what we set out to do as we move along.

So, what we are trying to do is improve cardiovascular disease and morbidity and mortality among women Veterans, and how we want to do it is by using peer support to promote heart healthy behavior, such as physical activity, and I think as I mentioned, we recognize this is something all of us need to do, and trying to figure out how to do it is the best for everybody, including for our patients. And in thinking about that, what we felt we really needed to know and understand better was, we know that peer support can work, and we will talk a little bit more about that in a minute, but the question was really, what is the best way to employ peer support around heart health behaviors in a growing population of women Veterans. And, even more specifically, we wanted to know, do we need to be tailoring the way we employ peer support among women Veterans by gender? Is that something that is necessary, and if so, how are we going to do it? And I will just make the point here that I am using the term, “gender,” primarily because we are thinking about behavioral interventions that are operating at the level of someone’s self-identified gender, but recognizing those definitions and the use of those are not always distinct from an individual’s sex at birth, so there are some issues with the terminology there, but I just wanted to be clear about the reason for using it the way we are here.

So, in order to start thinking about this, I think it is helpful to think about the women Veteran population, and how it has been changing over time. So, the figures you see here are fresh from the new Sourcebook, or I guess fresh now is 2019, but the most recent Sourcebook, which is really a wealth of information about the Veteran population by men and women, that is put out by Susan Frayne and her group at the WHEI Project, and so what you are seeing here is the number of Veterans over time, starting in fiscal year 2000 and going up to fiscal year 2015, so women are on the left in yellow and men are on the right in that sort of dark blue, and the Y axis there is on a different scale, as you might imagine, but I think the key thing here to notice is that the rate of increase in women is greater than we are seeing for men. So, during that 15-year period, there was a 2.8-fold increase in women Veterans receiving care through the VA, compared to a 1.7-fold increase for men.

This is maybe not surprising, if you think about the bigger picture, which is, we are seeing a lot more women serving in active duty and then transitioning to becoming a Veteran, in addition to that, we are also seeing an increased percentage of women Veterans using the VA for their care, so that was around 10% back in fiscal year 2000, and up to about 22% in fiscal year 2015. So, there has really been this tremendous evolution in the women Veteran population over that time, and in the care that we provide, and there has really been, as many of you are probably aware, a huge effort by the VA nationally, to develop those services for women Veterans, both at a national and an individual facility level, and that is really reflected by this increased demand. So, I think that is sort of one of those key pieces, and I still find that I get surprised looks and comments occasionally, when I tell people that I work around women Veterans in the VA, although, a lot less so than I used to, which I take as a good sign.

So, this is another figure from the Sourcebook that came out last year, and this gives us a little bit better sense of the age range of the patients that we see in the VA, which can then help us understand what are some of the health issues, particularly around heart disease. So, this is showing you on the Y-axis, again, the number of women Veterans, and on the X-axis is their age. If you look at this red line, I think you can see my cursor here, so this red line here is from fiscal year 2000, and shows you that at that time the largest population of women Veterans that we cared for had an average age around 45, and there was this sort of smaller peak over here in the 70s for women, and as this sort of mountain grows over time, you are seeing that not only is the number of women that we care for in the VA growing, but also the age is shifting. So, this dark blue line is fiscal year 2015, and you can see that there are three peaks. We’ve got one peak over here, in the late 20s, that really represent our OEF/OIF Veterans, and we have this smaller peak out here in the 80s, and then we have got this largest portion of our population with an average age in the early 50s. These are the women that we are thinking, really, all of them, but certainly thinking a lot about them getting to the age where they are likely to be developing cardiovascular disease. So, again, not only are the numbers going up, but we are seeing sort of a shifting to the right of the age of the women we are taking care of, which has implications for their healthcare needs.

So one way to think about this is to get a better understanding of who has cardiovascular risk factors, and this data comes from a report that came out in 2017, the State of Cardiovascular Health in Women Veterans, and that found that amongst this sort of key population, so age 45-64, three-quarters had at least one risk factor for cardiovascular disease, and that includes sort of the traditional risk factors, like obesity, hypertension, hyperlipidemia, but also depression and PTSD, which we have come to appreciate confer a risk that is really on par with smoking, so it is a pretty significant factor.

If we are looking at women above this age, so 65 years and older, about a third have a diagnosed cardiovascular condition. So, again, what we are looking at when we are thinking about the age of patients that we are taking care of, is we really have this large population of women that are at this time period where they are at risk for heart disease, and we can see that that is going to be moving and aging into a time when we are going to see women experiencing more heart disease, and so it is a great time to try to plan ahead and do what we can do to decrease their risk of those kinds of events.

This other population, the sort of younger population, has some particular risks, and is sort of particularly vulnerable. So, this slide that we have here is showing some data that was published by Sally Haskell and her team, that was looking at Veterans and the incidence of cardiovascular risk factors as they left the military and enrolled in the VA. And I think the key thing here is to see how quickly that risk goes up. So, if you looked at women who, just at the time of enrollment in the VA, a little over a third of them had at least one cardiovascular risk factor. At five years, that went up to 50%, and at 10 years that was 70%. We used to think about Veterans in this context of the healthy soldier effect, so you have individuals who had to meet certain health requirements to get into the military, during their military service they had requirements for physical activity, they had weight requirements, they were under medical care, and that that would somehow sort of carry with them as they went on into their post-Veteran life, and what we are seeing is there is a loss of that at an earlier stage, so there is this rapid decline in really physical well-being and certainly an increase in cardiovascular after leaving. And unfortunately, our Veterans are catching up to the civilians, and we know that the U.S. population has a lot of risk, so there is a lot of need to address this.

Coming back to women Veterans, in addition to thinking about how is it their age, what are the specifics of the age and their risk, it is also helpful to think about how their risk factors may differ from men. There has been a lot of conversation in the last couple of years about how presentation of women with a heart attack, for example, could be really different for men. They may not get the sort of standard crushing chest pain that feels like an elephant sitting on her chest, the way we were sort of traditionally taught, and they may have maybe some pain, but also more symptoms around nausea or shortness of breath, or fatigue, and so there has been a lot of effort to educate and raise awareness, not only amongst providers about that, but amongst patients. And I think there are some differences in cardiovascular risk factors that are worth noting as well.

And so, there are some areas where we see women Veterans having greater prevalence of these risk factors, so one being physical inactivity, and one being obesity. Some of the other things you may not be aware of, but certainly depression occurs at a greater rate across all age-groups within the Veteran population. We are starting to learn a lot more about pregnancy-related risk factors on long-term cardiovascular risk, so things like gestational diabetes, pre-hypertension, pre-eclampsia, and there is a lot of work going on right now looking at pregnancy and what is happening to women who are getting pregnant and what kind of complications are they developing. People often refer to pregnancy related complications such as these as like a stress test for long-term life; these women who are developing these conditions we know to be at long-term risk.

And then social support is something we are going to focus on. So, social support is another area where, unfortunately our women Veterans, it is particularly common amongst women Veterans, and appears to be more so than men. And again, similar to depression, social support has been associated with increased cardiovascular risk on the level of smoking.

So again, specifically looking at some of the data around social support, we see that women are less likely to be married than the men Veterans we take care of. They are less likely to have someone come with them to a doctor’s visit and to help them with medications, more likely to live alone after age 45, and have higher rates of homelessness compared to men Veterans. This is something that often makes me reflect on when I first started at the VA in 2010, I was in a number of different clinic settings, including the general primary care clinic, as well as women’s health, and I was really struck by the fact that the 98% of the men I saw in the general primary care clinic, a lot of them would come in with a partner, with a spouse, with a girlfriend, someone that came in and sat with them through the visit, listened to the advice, listened to our discussion, had their bag of meds in hand and a list of questions, and was really participating in their care; and I had been taking care of women in our comprehensive health clinic over that same time period and of the 200-some women I followed there, there is a handful, less than 10, that come in with someone, whether that be a partner or a spouse or a child. And I don’t think that is something that is completely unique to the VA and to the Veteran population, but it is certainly something that we see a lot, and I think has a lot of implications for how we go about helping people around their health.

As I mentioned, not only is it important for the way that individuals engage with health behaviors, but it is also relevant for their cardiovascular risk in and of itself. So, we know that low social support is associated with increased cardiovascular risk and poor cardiovascular outcomes.

That brings us to peer support. So, prior to coming to the VA, peer support was something I had seen sort of firsthand from a clinic I worked at in Philadelphia, where we took care of patients with HIV. One of the things that really was sort of hit home from that experience for me was, I can certainly give people advice and I can prescribe medications, and I can counsel them and use motivational interviewing techniques, but it is not the same as having someone who has really walked in their shoes say, “Look, you can do it, I’ve done it too, and this is what it looks like. It is just a different conversation, and an important one, in addition to all of the sort of direct medical care that we do.

So what is peer support? You can think about peer support as basically individuals who have shared sociocultural backgrounds to a patient’s, and/or a shared health condition experience, providing assistance to one another, just as I was describing. Someone who has walked in their shoes, who is helping them in a number of ways, providing support. Some of the most important features are that it is a non-hierarchical relationship, so there is not a significant power differential the way you might see in a traditional doctor-patient or provider-patient relationship. Peer support tends to be more flexible and more accessible, and the key thing is to realize this isn’t designed to take the place of traditional healthcare, but something that really supplements the traditional formal healthcare systems that we have in place.

It can be delivered in a number of different ways. So, peer support can be delivered through support groups, so that might be something you are familiar with, something like AA support groups, where people are there supporting each other and sometimes those are led by professionals, sometimes those are led by peers. You can have peer coaches, so an individual who is a little bit farther down the path. They have a similar condition, but their self-management skills are a little bit stronger, they have had the condition for a little while longer, and they are able to help someone who is at an earlier stage in the process. Patient navigators is another kind of role, so maybe someone from a similar community who can help them find their way around the healthcare system. Consumer Providers are likely one that you, if you are from the VA, are familiar with. So the VA has embraced this concept and has hired across the country what are known as Peer Support Specialists; these are individuals that are primarily housed in the mental health clinics, although they are starting to branch out into other spaces, where they are individuals who have a history of a mental health diagnosis that is currently under good stable control, but they are a formal part of the healthcare team, so they might lead groups, participate in key meetings, work individually with clients and patients, and part of the way they bring their skillset is from their experience, their life experience, and can sort of serve as both a role model and someone who can relate on that lived experience level.

And then Reciprocal Peer Support is another model, and we will come back to this in a little bit, but the concept here is, you have two individuals who are really at the same place and attacking a self-management issue or a health behavior, and are there to really support each other mutually. So, it is not about just one person receiving and one person giving, people are helping each other equally.

So, as I mentioned, the VA has really embraced peer support in a number of ways, and there is a growing body of evidence that points to the fact that this is a technique that can really be helpful and useful amongst Veterans. So, the first bullet there really points to some of the literature supporting and showing that Peer Support Specialists have been really a helpful presence for patients, including improving patient empowerment, facilitating engagement in care, and improving recovery orientation. There have also been a few randomized clinical trials that have looked at this in the setting of diabetes, so Michelle Heisler conducted a study that compared patients with diabetes receiving reciprocal peer support versus nursing support and found that the patients with peer support had a greater reduction in hemoglobin A1c. Judith Long at the Philadelphia VA and her team also did a study where they were comparing peer coaching to financial incentives or usual care in patients with diabetes and found that peer support had a greater reduction in A1c. There has also been some work done around weight loss in patients with serious mental illness, and then some smaller studies that have shown promise around CPAP adherence support and pain and self-management delivery.

So, when we think about this sort of body of evidence around peer support, one of the things that is notable is that the peer support literature in the VA has really been predominantly and really mostly exclusively done among men. We know that from other settings and other times we have worked with and talked with women Veterans that they have expressed preferences for gender-specific care. Maybe not all women Veterans, but many, and there has been evidence showing that that is associated with better satisfaction with care. On the other hand, most cardiovascular risk behaviors that we want to promote are really not gender-specific, right? All of us could benefit from exercise and eating better and not smoking, and taking our medications as prescribed. So, we kind of got to this point of balancing these sort of key factors, and that brings us to this question, which is, do we really need gender-tailored peer support programs to decrease cardiovascular risk, and if we do, how do they need to be tailored?

Eugene Oddone: This is Gene. I am going to jump in here a second, because this was a big inflection point for Karen and myself and her other mentors. Karen has told you her strong interest in women’s health, she was actually the director of our women’s health clinic for years before she came into her CDA, and we wrote and kind of talked about in the CDA, this reciprocal peer support model being conducted kind of exclusively for women Veterans, but as she just alluded, it is difficult to sort of consider a potentially effective intervention for one gender only, given that both men and women suffer so much from this. So, we had a lot of discussions a couple of years ago about whether or not this should be gender-specific intervention or is there some way to determine if men should be included, and if so, how; so Karen, in the next part of the talk, as she moves along, will talk a little bit about how we addressed that sort of tension in how to sort of design and test this intervention when we got to the pilot stage.

Karen Goldstein: Thanks. So, one of the big things that has been a focus of my Career Development Award is really thinking about this process of developing an intervention and wrapping my head around it, and I spent a lot of time a couple of years ago going around to our center, where we have really some tremendous colleagues who have done a lot of clinical trials, asking them how exactly they go at developing intervention and it was sort of fun to hear the sort of variations on people’s approaches. But one of the models that we came back to was this model you are seeing here, which is based on the ORBIT model, or the Obesity Related Behavioral Intervention Trials, with a few adjustments in here, but to think about this process starting from what you know about risk factors and environmental factors, defining the intervention, testing the proof of concept, and then moving on to efficacy and effectiveness interventions and then I have added on the implementation piece here.

So, we are not going to talk about all of the things we did, but I want to highlight a couple of studies. This one here that I am going to be talking about for a few minutes was a qualitative project that we did, where we wanted to talk to women Veterans about what their thoughts were about peer support, what kind of experiences have they had, and what might they want out of a peer support intervention, and would they want it. So, we really aimed with this project to, as I said, assess women’s previous experiences; we wanted to hear what they thought the barriers and facilitators would be to participating in this kind of intervention, and then we also talked to them about specific types of features that might be important for them.

So, we interviewed 25 women using a semi-structured interview guide, by phone; they had to have at least one risk factor for cardiovascular disease, and between the ages of 35 and 64, and they were all patients in our comprehensive women’s health clinic here in Durham. The average age was 50, and about half were receiving care from the VA only, and you can see that about a third were living alone and 44% were currently employed. Interviews were transcribed and we used an approach using conventional content analysis.

So, I am going to highlight the key themes that we came away with after these interviews. So, the first one was trust, and I suspect those of you who are taking care of patients, and in particular women Veterans, are probably not surprised by this, but one of the key messages we heard was that women felt they were going to need some key time and opportunity to develop comfort and familiarity with a new peer partner. They didn’t feel like they could just jump in cold, especially without having ever met them before, that that was going to take some time. And so, we started to think about these messages we heard from women and tried to think about how we might translate them into an intervention.

One of the key things that is often done in peer support interventions that we recognized would be important is early relationship building activities and opportunities for some initial meetings face-to-face, so that patients could meet their partner, could develop some sense of trust, that could really support them in an ongoing relationship that might be remote, recognizing that really most of our Veterans are not going to be able to come in every week to meet someone in person, or a lot are working, busy, multi-tasking patients.

The other thing that we came away with was the importance of considering things like trauma informed care concepts in approaching interventions. We had a number of women we spoke to who disclosed that they had PTSD. We didn’t recruit specifically for this, but women talked about that or they talked about their own experiences around having a history of trauma, as well as those of their friends or colleagues or other sorts of Veteran individuals in their community, and recognizing that participating, especially in group settings, could be a significant barrier to some individuals, so we tried to think a little bit about what are the places that we can give people choices, when reasonable. We have tried to think about making sure that people have a clear understanding of what is going to happen and what the expectations are from the outset, so they are not feeling surprised by these things. So, I think that has been a key piece of this that is evolving.

We also heard from women that they really cared a lot about engagement compatibility, so this concept that they wanted their partner that they are working with to be sort of at the same place, both working on the same goal, but also having the same level of commitment. Women said things like, “Well, I don’t want to show up and have the other person just never be there, and feel like I am constantly pulling them up to catch up to me.” They really wanted to find someone who was at their same stage. This helped us think a little bit about peer matching criteria. We spent a tremendous amount of time thinking about it; it almost started to feel like we were involved in some sort of dating system. Like, how do you find people and pair them together, not expecting that they become best friends, but that they might be compatible and get along for the purpose of providing support. So, we wanted to find a way to identify what were their goals and how might we pair people up around their behavioral goals, recognizing that if you create a ton of matching criteria, then you just have too many things to match on and it is just not practical. And, we have also been interested in finding ways to assess patient engagement and commitment to behavior change from the outset.

Need for accountability and motivation came across very clearly, and this resonates with existing literature on barriers to changing health behaviors. Women really thought this could be a great way to have some accountability in their lives for the things they wanted to change. They really saw value there. So, this helped us think about what are the ways we can provide additional accountability in women who were clear that that was something they wanted more of, so as a program, providing more feedback and information about their progress towards goals, and to make sure that we were encouraging and promoting and supporting really proactive communication between women or between peer partners and regular contacts, so really enforcing that accountability aspect.

Again, I would just also take a second to reflect there that the accountability too, you think about if you are seeing a patient in clinic, you are not going to see them for three to six months, one of the struggles is, the patient--you may get them all riled up and they are ready to make these changes, but then what is happening for six months? There is nobody there making sure they are doing the things they set out to do, so thinking about peer support as a way to continue that.

And then there were a couple of other themes that we thought were important, so one was that patients recognized that people have different levels of readiness to engage. So, somebody might say, “Okay, I can see that my friends might really want to do this, but maybe I am not quite fully ready to jump in with both feet,” and that helps us think about the importance of flexibility, which is a benefit of peer support. You know, intervention design and flexibility can sometimes be a challenge, but that was something we thought to include. And again, this brought us back to that same question of gender-specific groups, because there were some people we spoke to who said, “I would be okay with a mixed-gender group, and I know friends or I know other Veterans who would not,” and so this again comes back to what Gene was talking about, which is this constant theme of, to what extent do things need to be gender-specific.

And then finally, a lot of women seem to resonate with a concept of peer support, because they identify themselves as helpers, and they really felt that there was some appeal because it spoke to their sense of altruism. So we thought to really highlight that when approaching patients to participate, saying, “This is not only an opportunity for you to get support, but for you to help somebody else,” and I have been really just completely touched by how that has resonated with folks and it also is a rationale for using a mutual peer support model, where you get to both give and receive help.

There were some other activities that we did in building up to this, but now I am going to shift and just talk a little bit about the sort of definition and tailoring process of all of that information and how that got us to our pilot study. I have highlighted for you some of the published literature and kind of what we found, so we knew that women were at increased risk for cardiovascular disease, there are different kinds of risk factors that may potentially be at play, social support is pretty low for many women, but that overall peer support seems to work well within the Veteran population. There has been a fair amount written about, for example, that Veterans have experience in providing and giving support during the military and that sort of relationship is already encouraged, in addition to the fact that as you come into a VA setting, or really any setting, you have that shared life experience that can be a source of initial sort of bonding. We had a number of preliminary findings, some of which I haven’t previously presented in detail, but I will just touch on here; one being that we found in another project that women Veteran users of VA care are at particularly high risk of cardiovascular disease compared to non-users, and that there is some evidence that patients who have preferences for gender-specific care, and/or have a history of PTSD, are associated with increased risk of cardiovascular disease.

We talked about the importance of trust and accountability and the role of altruism as a motivator for participating. In addition to that, there was a lot of other sort of aspects that fed into intervention development, so certainly a huge piece has been mentor experience. One of the consultants for my Career Development Award is Michelle Heisler, out of Ann Arbor, who has done a number of peer support studies, who was able to share her experience conducting peer support studies and with trials in general. Gene has done a lot of work around trials in general, but also specifically around cardiovascular risk, so that was incredibly helpful to think about some of the other nuts and bolts and how they intertwined. And the other members of the team, including Corrine Voils has done a lot of work around peers and couples, as well as trials; Lori Bastian, again, a lot of experience with trials and women’s health. Maren Olsen is the final to remember of my core member team who has really worked across the board on trials in the center, so there has been a lot of input there, and then we also took all these concepts and presented some of them to our Veteran engagement panel here in Durham, so many of you, depending on where you sit, may have a Veteran engagement panel at your site, but it is a group of individuals who have really volunteered to get together on a regular basis and think about and provide feedback to researchers around anything from starting concepts for a research project from a trial itself to findings to communication. And so, we went to them and presented some of our ideas for intervention and they have us some really helpful and incredible feedback around what they thought we should include from a didactic standpoint, how we might go about matching up peers, and even gave us the name for the study, which was hugely helpful to me.

Eugene Oddone: So, I am going to pause here again and this was another kind of major point in Karen’s CDA. She was super ambitious at the beginning, had a lot of very specific projects, all of which she did, some of them were secondary data analyses of existing women health survey data, the qualitative study that you saw, but her big, main goal was to develop and test an intervention around this reciprocal peer support, and so it is creating something de novo, so there are all these things and these quadrants that she shows you on this slide, but then now how do you push it forward. You can read and read and read, you can do qualitative studies and qualitative studies, but sometimes you have to kind of sort of put something down on paper and say, “This is what we are going to do.” And I remember over several meetings, kind of just figuring out, “Okay, what are our key points, what are the central things, how are we going to design a pilot study, how are we going to get it funded to do,” and with several important questions in the background, the gender-specific thing like Karen has been highlighting, what are really the elements of it, and then we spent a lot of time thinking about that, but then it is finally time to do it, and so she is going to show you what that is now.

Karen Goldstein: Yeah, at some point it definitely felt like you just sort of have to leap off the edge and see what happens. So, this is obviously sort of skimming over tons of conversations, as Gene was saying, and meetings and drafts, and sort of talking things out in elevator speeches, and whatnot, but one of the key ways I think was helpful was to think about all of these different pieces of information put together and identify what kind of behavior change techniques we thought would be important. So, these were ones using some of the concepts put forth by Michie and so some of the key things that we really wanted to include were, one, peer support is not replacement for really increasing awareness and transmitting knowledge, unless you have someone who is a very advanced sort of peer supporter, but in the way we were conceptualizing it, that wouldn’t be what we would be asking of our peers. So, we wanted to make sure we were including some key piece that involved making sure people understood what the health consequences were of health behaviors and their cardiovascular risk, and how would we provide them some instruction on what we thought they should be working on. Obviously, social support was a big piece of what we hoped to include in the intervention, that has benefits not only from the support, be it emotional or appraisal, having someone say, “Look, you are working really hard, you have made great efforts, even if it is not perfect,” that sort of feedback and encouragement. Social comparison, so being able to see somebody else who is struggling through the same thing can be reassuring and seeing someone’s successes can be really exciting, and then having someone that can model that behavior change gives people something to kind of look toward.

And then goal setting, so some of the more concrete things, so helping them identify the barriers for themselves with these behaviors, having them set reasonable, real six-month goals, be able to monitor themselves in thinking about reaching their goals and provide that encouragement and problem solving.

So, we took these key techniques and translated those into the key pieces of the intervention. You can see those here. Those include having some expert-led group sessions, so an opportunity to, in a very interactive way, actually provide some of that didactic information. We talked quite a bit and referred to this concept of reciprocal care partners that we knew we wanted to include, not only because there was this opportunity for every participant to both give and receive help, but also, you think about it helps you spread the reach of someone like a peer coach, who can’t take care of everybody, but if you pair everybody up together who needs help, you can really kind of spread out that amazing resource. But then in recognizing that there was some need for flexibility, and you are going to have some individuals who maybe just aren’t at a level where they are ready to engage with another person and provide support, or who are going to come up with struggles, or maybe around the holidays, or something happens and they need a little bit of extra support, that is a time where someone who is a little bit farther down the road might be better suited to help sort of pick them up. And so those are the key concepts that we wanted to include.

So, we put those together in an intervention and set out with these pilot aims, to examine the feasibility and acceptability of an intervention combining these two types of peer support for Veterans at increased risk, and I will point out here again somewhat of what Gene was saying, even though my whole Career Development Award is focused on women Veterans, that is where I provide all of my care, I had to go back and be like, “Oh, right, there are men Veterans, and I need to remember them, too.” So, we set out to pilot this in men and women with the goal of really getting sort of half and half and be able to try to start looking at gender differences around the feasibility of this model, and to start to figure out, are there really differences between men and women.

This is just to give you a little better sense of how we were approaching this, so this is an abbreviated pilot, we have some group interactive sessions early on in the course of the study that are giving people an opportunity to meet each other face-to-face, doing some relationship building activities, to providing support, we give them some food, it is a nice sort of friendly environment, and then the goal is for those individuals to work with their reciprocal care partner on a regular basis throughout the study, and then we built in some opportunities to provide additional peer coaching support at the group sessions, but also throughout the intervention to those people who may sort of fall off the plan with their reciprocal peer buddy, or just not a good fit for them.

Activities to date, it has been very exciting to actually get going, as you can imagine, after many years of thinking about this and sort of planning. I would hate to think about how many years since we first had these conversations, but we enrolled three really fantastic peer coaches who have been really dedicated and excited to be involved, and we have 10 reciprocal peer support partners, and we were actually able to get it split down the middle between men and women, which was exciting, especially since we started recruitment basically right before the holidays. We have had two group sessions, which were well-attended, and then the patients have been setting up text reminders so that we can sort of verify that they have been communicating with their partner and people have been willing to do that, which has been great. And we also provided patients with activity monitors as a tool for them to use, both for their self-monitoring, and as a way to sort of focus down some of their goals and communications with their partners.

In addition to feasibility and acceptability analysis that we will do through quantitative and qualitative work, this also is where we are going to be looking at some gender-based differences and trying to figure out, were there differences between men and women in their experience of the group setting, what about in their communications with their partner, and what about their recruitment process, so we are in a process of looking at all of that right now.

So that really brings us to sort of the later stages of this, and as you can tell, it is not always as pretty and linear as we see here, but we are starting to look ahead to a larger trial, taking some of the lessons that we are learning in the pilot study, and also thinking a little bit about implementation and sort of while they are here sort of one, in a sequential order, really thinking more about at the next stage of conducting a larger trial, what are the pieces that we can start to put together to help us understand what implementation might look like. And I think this is another good example that when writing the Career Development Award proposal, I had a very sort of clear set of, “This is what I am going to do and these are the training opportunities that I need,” but then a lot of other things can bubble up along the way, and just this fall I was able to complete an NIH training program to really learn more about implementation that has helped me think a lot about how can those really be better integrated and not sequential, to make things factor a little more smoothly. So, we are thinking a lot about what are the frameworks that we want to use to think about those determinants of adoption in the long run for an intervention like this. So, still lots of work to do, despite the time going fast.

I want to say thank you, really, to everybody. Obviously, to the mentors, including Gene, who is my primary mentor, and consultants on my Career Development Award, my many co-investigators, and the amazing staff at our center here who really have done so much to help with all of this. Everything from conducting and delivering the intervention that we have developed to the IRB paperwork and keeping me in line along the way. I also wanted to highlight here some of the other groups that I’ve had a chance to work with. I remember pretty early on, Lori Bastian saying to me something along the lines of, “You set out this whole plan for yourself around your Career Development Award, but really, everything you are doing is part of this getting you ready to be an independent investigator,” and so I have had some tremendous opportunities, both with the ESP program, joining the Women’s Health Research Network, I have been the site lead for them here in Durham since 2012, and I have participated in a number of multi-site trials and quality improvement efforts with them. I have been working with Michelle Heisler through the Michigan Center for Diabetes Translational Research and Peer Support Core, as well as Ed Fisher at UNC, who runs the Peers for Progress organization, so it has really been a pleasure.

I also want to point out, I would be remiss if I didn’t remind all of you that Go Red for Women month is in February, so if you don’t already know, the VA has a really amazing partnership with the American Heart Association, that gives the VA and our women Veterans access to a number of resources and educational materials and there are national and local events that will be coming down the line, so if you are not involved with those already, you can keep an eye out for it and there is a ton of really amazing resources online, and just one of the examples I will throw out here is the support network. So, it is an online support network for women who have cardiovascular conditions and women Veterans can sign up.

So, I will stop there and see if there are questions for us.

Rob: Great, thank you Dr. Goldstein. We don’t have any questions in the question pane currently, but we did get a couple in via email. Before I read those to you, let me just say to attendees, if you have a question for Drs. Goldstein or Oddone, please go ahead and use the questions pane in the GotoWebinar dashboard, that white control panel that popped up when you first joined. So, this person writes: I am a psychologist, working in private practice and have observed patients be successful with behavior change by attending 12-step recovery groups. How does peer support for cardiovascular health compare to that model?

Karen Goldstein: Yeah, so that is a great question. I think one of the sort of neat things about peer support in general is that it can look like a lot of different things, and there are certainly some classic models, even thinking about things like the diabetes prevention program, or the Stanford model, that can have a lot of similarities to that, where you have a lot of group-focused activities, and so that is certainly something you could look at, and we certainly wanted to have some group component to this intervention. I think one of the things that I have thought a lot about, partly from the clinic experience I have talking to women every week about some of their struggles, is that it is really hard to come in for group sessions for some people, and so one of the things I have thought a lot about is, how can we make these sorts of resources available to patients beyond the ones who can come in, find parking in our parking garage, and make it all the way in to a group setting. So, again, I think the answer is, it can be similar, it certainly could, but I think there are additional ways peer support can be molded beyond those sorts of settings.

Eugene Oddone: Right, and the other interesting thing about that, most 12-step programs are abstinent-based, so whether it be Alcoholics Anonymous or Narcotics Anonymous, it may be some different goals and abstinence-based programs versus programs that are designed to handle multiple risk factors, so we anticipate both the women and maybe the men in this study will want to be working on either physical activity or losing weight, or healthy diet. What Karen didn’t talk about too much is we have left cigarette smoking as a risk factor out of this, obviously that is a major risk factor for CVD, but we felt there was significant other resources and that it was kind of a very different risk factor to address, that we kind of left it out of this particular intervention.

Karen Goldstein: And I should say that one of the things that we are providing patients through our intervention is we have worked with some of our colleagues at NCP, so the National Center for Prevention, who have developed some really great materials as part of their Telephone Lifestyle Coaching program, and so we are providing people some basic didactic information that includes some information about smoking cessation with the resources, we are recognizing that for some people, that is the most effective thing you could do to decrease their cardiovascular risk, so yeah.

Rob: Thank you. Really great presentation. I am curious about strategies to identify individuals who are willing and able to serve as peer supports and/or coaches. What sort of experience/training do they come in with, and how much supplemental training is needed, relative to specific clinical outcomes and/or health behaviors?

Karen Goldstein: So, this is a fantastic question, and one that we both had ourselves, we got a lot of questions about this from reviewers, I think this is a big, big issue. I didn’t really get into it, but in addition to interviewing women Veterans, we also interviewed a number of stakeholders within the sort of VA facility about what their thoughts were, and one of the big things that came up again was, “What kind of training are you going to give people?” So, when you look at peer support studies outside the VA, that have been published and committed, there is a bit of a range in terms of the training. A lot of the range has to do with whether you expect the people delivering peer support to be experts in something. So, for example, if you want someone to be leading diabetes groups and providing peer support and delivering that didactic content, often there is a lot of education and training around that specific information and knowledge. So that is one big driver of how long the training is. The training courses can run anywhere from just like three or four hours to multiple days. Again, it is not clear from existing literature what is the most effective, but I think from looking at the literature, from talking to patients, and specifically from Ed Fisher and from working with Michelle Heisler around some of their experience, what we came down to was doing a more abbreviated training for the coaches, specifically really focusing on issues around confidentiality and how to communicate with other people, sort of a modified motivational interviewing inspired training, followed by ongoing support. That is one of the key things when you look, especially for peer coaches, is you don’t just train them once and then send them out to the world. You give them some training, some key skills, send them out to the world, and then bring them back and find out what happened and what didn’t work, you know, and then they can even support each other, as they are sort of re-learning and it gives you an opportunity to sort of provide advanced skills or to provide feedback or additional coaching, but that ongoing interaction for the coaches themselves is really important, and so that is a piece that we involve.

And then the reciprocal peer support partners, we did again even a more abbreviated training as part of the first group session where again, we just really said, “Here is what you need to do for active listening,” gave them some training around how to ask an open-ended question and what some of the sort of standard guidelines are, and sort of let them loose with the coaches being present to be able to provide them some feedback, and then we are going over that at recurrent in-person sessions.

I think the other piece of that question though is sort of interesting, is how you figure out people who want to do that. And we were pleasantly surprised, we set out to recruit coaches really by asking folks at the local facilities if they could make recommendations, because there is a piece of this, there are going to be some people who are just, it is a softer skill assessment than being able to look in the chart and say, “Oh, they have diabetes, they would be a great coach,” and so, we were tremendously fortunate, we spent a lot of time talking to folks in the facility. It certainly helps, I think, that I have been a clinician there, knew a lot of the folks running various programs, and was able to go to them and explain the concept and say, “Hey, do you have anyone that you think might be a good fit,” and so then we could send them a letter and say, “Hey, you have been nominated, would you be interested,” and then find out. And we had a great response, and I think one of the things I was so touched by was, especially for the coaches, they all, I think all of them, said that they were really honored to have been nominated, they were really touched that someone put their name forward, and that was really exciting. For the reciprocal peer support partners, we really went more based on what their risks were and then said, “Hey, would you be interested in doing this?” I think there was some helpful self-selection there.

Eugene Oddone: You know, one of our hopes going forward, as Karen takes this to hopefully an IRR level, is that in an actual effectiveness study, whatever we design that to be, that the early sort of peers could graduate to be peer coaches for subsequent cohorts, so we are hoping to look at a system that could sort of self-sustain itself in that way.

Karen Goldstein: And that is something that Michelle Heisler and her group have experienced in some of their studies, which is reassuring. So, yeah, thanks for the question.

Rob: Thank you. Next question: What measures do you use for baseline assessment in post-assessment outcomes?

Karen Goldstein: So, that is a great question. Certainly, there are a number of measurements that we are using, I am guessing maybe thinking a little bit about peer social support and measuring peer support and things like that. We are using a couple different measures that are really based off of prior work around measuring health-specific social support, and I have got my email there, I am happy to send you some specific things we have considered, if people want the names of the measures. I will say, back on the slide where I referenced Peers for Progress, if you look at their website, they have some really great manuals and resources that share a number of different existing measures that you can use for peer support and social support, and we are going to be using one of their process measures as well to get at things like, “Do you feel like you had someone you could talk to about your health?” You know, skill supporting. “Did you have someone to talk do when you were getting stuck?” So, in addition to that, obviously we are looking at a number of measures, such as blood pressure and weight and other sorts of things, activation, exercise, and we struggled a lot with the primary outcome and really, what goal we would focus at, at the next level.

Eugene Oddone: Yeah, and so for prevention interventions that allow patients with multiple risk factors in, this is a common issue, is how to choose outcomes that may span multiple different behaviors. A lot of people in the literature use cardiovascular risk score, like a Framingham. You know, we have done that a lot in prior studies. The Framingham is really, really hard to move, or to improve, unless people stop smoking. Smoking has the largest influence on life expectancy in that model, and so we did, we spent many sessions sort of figuring out what it is that we are going to measure. Like Karen said, we included kind of an activity tracker in this, and so one of the things we are doing in this pilot is looking to see if things like active minutes or steps, or some function of that, may be an interesting unifying measure across this, and part of that all depends on how many people are working on things like improving physical activity versus losing weight alone, or something like that.

Karen Goldstein: Yeah, and another big factor, I will just add, is we know that particularly for women, Framingham might not be as sensitive to cardiovascular risk, and as we think about women developing cardiovascular risk later in their life, you want something that we know is associated with long-term cardiovascular risk, but also something that we could see some more immediate benefit of. That is a good question.

Rob: Thank you. This last one is not a question, it is a comment, and it is long, so bear with me, okay? Hi Karen, great presentation. So glad I got on the call. Focus on women Veteran’s health and peer support is so pertinent, especially now, with Mission Act and Section 8051 of H.R. Opioid Bill. VA peer support would love to move more into primary and specialty care. I agree that you should have training specific for the health condition involved, but as important is the communication of the peer specialist’s own recovery and what has been effective from their lived experience. Keep up the good work, hope to hear more from you.

Karen Goldstein: Thank you, I really appreciate that. It is, I think, one of the most amazing things about doing this, is getting to see the patient’s excitement in sharing their own story and sitting in the groups. So, just even sitting in on the first group sessions of the pilot was just so exciting to see people really getting engaged and working together, so it has really been a joy.

Rob: That is all the questions that we have at this time, and we only have a few more minutes left, so let me give you an opportunity to make closing comments, if you’d like.

Karen Goldstein: Yeah, no, I think hopefully, you know, with any sort of luck we will be able to, at a later time, share some of the findings from this initial pilot, but so far it has been fun. It is always fun to actually get there and do that stuff you planned, and I really appreciated everyone’s time and attention today.

Rob: And Gene, do you have anything to say?

Eugene Oddone: No, I think that is a good coda. Thank you.

Rob: Great, well, thank you very much for your work and for preparing and presenting today on this very important topic. Attendees, please, when I close the Cyberseminar, stick around for just a very few moments and fill out the short survey that comes up when it closes. We really do count on your responses to continue to bring high quality Cyberseminars to you, such as this one. Once again, Drs. Goldstein and Oddone, thank you very much, and everyone, have a good day.

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