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Understanding women veterans' preferences for peer support interventions to promote heart healthy behaviors: A qualitative study

Karen M. Goldstein[a,b,*], Leah L. Zullig[a,c], Eugene Z. Oddone[a,b], Sara M. Andrews[a], Mary E. Grewe[d], Susanne Danus[a], Michele Heisler[e,f], Lori A. Bastian[g,h], Corrine I. Voils[i,j]

[a] Center for Health Services Research in Primary Care, Durham Veterans Affairs Healthcare System, 508 Fulton Street, Durham, NC 27705, USA
[b] Department of Medicine, Division of General Internal Medicine, Duke University Medical Center, 411 West Chapel Hill Street, Suite 500, Durham, NC 27701, USA
[c] Department of Population Health Sciences, Duke University, 2200 West Main Street, Suite 720A, Durham, NC 27707, USA
[d] Cooperative Studies Program Epidemiology Center - Durham, Durham Veterans Affairs Healthcare System, 508 Fulton Street, Durham, NC 27705, USA
[e] Ann Arbor VA Medical Center, 2215 Fuller Road, Mailstop 152, Ann Arbor, MI 48015, USA
[f] University of Michigan, Institute for Healthcare Policy & Innovation, 2800 Plymouth Road, Ann Arbor, MI 48019, USA
[g] VA Connecticut Healthcare System, 950 Campbell Ave, West Haven, CT 06516, USA
[h] Department of Medicine, Yale University, 330 Cedar Street, New Haven, CT 06520, USA
[i] William S. Middleton Memorial Veterans Hospital, 2500 Overlook Terrace (151), Madison, WI 53705, USA
[j] Department of Surgery, University of Wisconsin School of Medicine & Public Health, 600 Highland Avenue, K6/100 CSC, Madison, WI 53792-1690, USA

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ABSTRACT

Peer support may be an effective strategy to improve heart healthy behaviors among populations who have a strong communal identity, such as women veterans. Women veterans are a particularly important group to target as they are the fastest growing sub-population within the Veterans Affairs healthcare system. Our goal was to identify aspects of peer support and modalities for providing peer support that are preferred by women veterans at risk for cardiovascular disease (CVD). In 2016, we conducted 25 semi-structured individual interviews with women veterans from the Durham VA Healthcare System aged 35–64 who were at risk of CVD, defined as presence of at least one of the following: hypertension, hyperlipidemia, obesity (BMI ≥ 30), non-insulin dependent diabetes or prediabetes, or current smoking. Interview guide design and data analysis involved conventional content analysis. Important themes for effective peer partnerships included sharing a common behavior change goal, the need for trust between peers, compatibility around level of engagement, maintaining a positive attitude, and the need for accountability. Peer support interventions may prove beneficial to address the burden of common and preventable conditions such as CVD. Among women veterans, peer support interventions should account for individual preferences in peer matching and provide opportunities for peers to engage in relationship building in-person initially through trust-building activities.

1. Introduction

Women veterans engage in unhealthy behaviors like physical inactivity and smoking at higher rates than civilian women (Lehavot et al., 2012). They are also more likely to be obese or overweight and 79% of women veterans over the age of 65 years have at least one major cardiovascular disease (CVD) risk factor (Maher et al., 2017). While 50% of CVD is due to modifiable health behaviors (Patel et al., 2015), most Americans do not achieve diet and exercise goals. Successful engagement in heart healthy behaviors, such as exercise and diet, can be promoted by peer support. Peer support is an evidence-based approach to increasing engagement in health-related self-management through the provision of social support by someone of similar background and life experience (Dennis, 2003). Such support can increase self-efficacy for and reinforce the practice of healthy behaviors (Dennis, 2003; Heisler, 2006), leading to improved clinical and patient-centered outcomes (e.g., lower hemoglobin A1c, improved patient satisfaction) (Rhee et al., 2012; Mosack et al., 2012; Parry and Watt-Watson, 2010).

Peer support is particularly well-suited for populations sharing a common identity and sense of commitment to communal well-being, such as military service veterans. Soldiers provide support and guidance to each other and have a common identity during active duty (Matthias et al., 2016). After separation from service, support from military friends is associated with better health (Lehavot et al., 2013). Among

* Corresponding author at: Division of General Internal Medicine, Duke University, Durham, NC, USA.
E-mail addresses: Karen.goldstein@duke.edu (K.M. Goldstein), Leah.zullig@duke.edu (L.L. Zullig), Gene.oddone@duke.edu (E.Z. Oddone), Susanne.danus@va.gov (S. Danus), mheisler@med.umich.edu (M. Heisler), lori.bastian@va.gov (L.A. Bastian), voils@surgery.wisc.edu (C.I. Voils).

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veterans with diabetes, peer support has led to greater hemoglobin A1c reductions than traditional nurse management or financial incentives (Heisler et al., 2010; Long et al., 2012). Women veterans often have lower levels of social support than male veterans (Frayne et al., 2006), thus may be particularly primed to benefit from peer support.

Prior peer support research for complex health behaviors has mostly focused on disease management rather than prevention (Fisher et al., 2017). In the context of disease management, sharing a common health behavior or being at a similar disease stage are important for promoting effective peer support (Heisler et al., 2010; Leahey and Wing, 2013). Many features of peer support, including ongoing assistance and emotional support, are well-suited to improving heart healthy behaviors. However, it is unclear how best to customize a peer support intervention around CVD risk reduction for female veterans.

Our objective for this study was to explore: 1) women veterans' previous experiences with social support and peer support; 2) perceived barriers and facilitators to participation in peer support interventions; and, 3) women veterans' preferred features for peer support interventions designed to support heart healthy behaviors. To frame this work, we drew upon the Social Cognitive (SCT) (Bandura, 1977) and Self Determination Theories (SDT) (Ryan and Deci, 2008), as well as the key social support constructs (House, 1981). Specifically, we considered the SCT construct of self-efficacy and SDT's construct of personal need fulfillment through relatedness, competence, and autonomy. We considered types of social support (i.e., emotional, instrumental, informational, and appraisal) as well as the additional benefit of reciprocal peer support, mutual reciprocity (Israel, 1982) (Fig. 1).

2. Methods

2.1. Study design

We conducted semi-structured, telephone-based interviews with women veterans who were at risk for CVD. Data were analyzed using conventional content analysis, which is ideal when little is known about a phenomenon and the goal is description (Hsieh, 2005). This approach was appropriate because women veterans' experiences with peer support interventions have not been described previously. We interviewed women until thematic saturation was reached (Namey et al., 2016).

2.2. Setting and participants

Our target population were female patients at risk for CVD in the women's health clinic at the Durham Veterans Affairs Medical Center (VAMC). Flyers were posted in the clinic, and recruitment letters were mailed to eligible veterans who were identified randomly after an initial administrative data pull. Eligibility criteria included: age 35–64 years; enrolled in the Durham VAMC; and presence of at least one CVD risk factor (hypertension, hyperlipidemia, obesity [BMI ≥ 30], non-insulin dependent diabetes or prediabetes, or current smoking). Patients were excluded if they were unable to provide informed consent during telephone screening, or if through electronic medical record review were noted to be hospitalized; had active psychosis or dementia; or were assigned to the first author's primary care panel. Patients who did not call to opt out were called to screen for eligibility and interest in participation. Those patients with confirmed eligibility and interested in participation were scheduled for a telephone interview. Interview participants were provided a modest financial incentive. This study was approved by the Durham VA Healthcare System's Institutional Review Board.

2.3. Data collection and analysis

Between May and July of 2016, semi-structured telephone interviews lasting an average of 40 min were conducted by two female study team members (KMG and MEG) trained in qualitative interviewing. Interviewers did not have a prior relationship with the participants; although KMG is a physician, we excluded her patients to avoid coercion. Participants provided verbal informed consent at the beginning of the interview. The interview guide was developed initially based on the theoretical frameworks discussed above. We then revised the guide through an iterative process with listed co-authors based on their expertise and prior work conducting peer support and dyadic interventions in the VA (Heisler et al., 2010; Heisler et al., 2017; Heisler et al., 2013; Voils et al., 2013) and knowledge of CVD among women Veterans(Biswas et al., 2002) (see Table 2). Participants were asked about: experiences changing health behavior and related social support; experiences with peer support; ways in which another women veteran could support them in making lifestyle changes; and desired characteristics in a peer support partner (Table 2). Prior work has found that sharing personal experiences and characteristics help establish another person as a peer (Brownson and Heisler, 2009) and that having social contacts engaged in health behavior change influences one's own behavior change engagement (Leahey et al., 2011); thus, we explored which characteristics were most important to women veterans in a peer support partner. All interviews were digitally recorded and transcribed by a VA transcription service. A random 10% subset of transcriptions were verified for accuracy. The interviewers took brief, structured notes after each interview to identify questions participants had difficulty responding to, guide subsequent interviews, and allow for interim analyses to determine thematic saturation. We planned a priori to conduct 25 interviews to reach thematic saturation based on current guidance (Hagaman, 2016) and expected heterogeneity of the population, and reviewed the transcripts and interview notes to verify that additional interviews were not warranted.

To characterize the sample, we obtained sociodemographic information and clinical diagnoses from VA administrative data and through questions administered during the telephone interview.

We employed a number of strategies to promote authenticity and trustworthiness of the data (Shenton, 2004). The investigators had "prolonged engagement" with women veterans through research and clinical roles. Patients identified as meeting inclusion criteria during the administrative data pull were randomized for initial contact. In addition, we reassured participants that their participation was voluntary

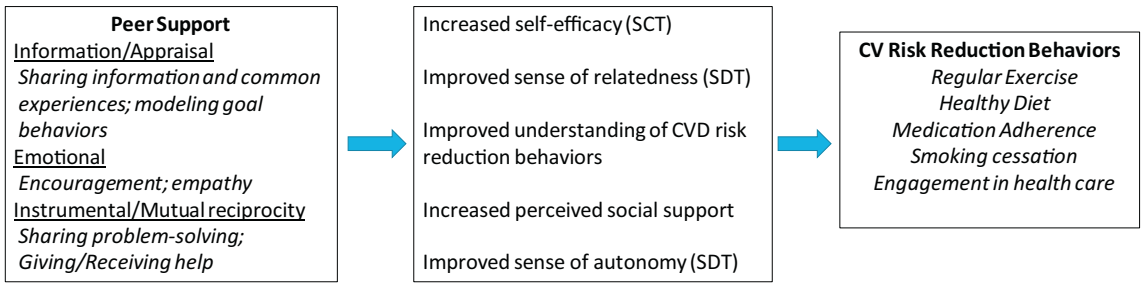

Fig. 1. Conceptual model of peer support for CVD risk reduction among women veterans.