QLP 41-018

ASPIRE Pilot

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Funding Period: April 2008 – September 2008

Objective:

Overweight and obesity are prevalent in over 70% of VA patients, imposing a tremendous burden on the healthcare system due to increased need for treatment of obesity-related chronic disease and disability. Managing Overweight/Obesity for Veterans Everywhere (MOVE!) is a policy directing all VAMC facilities to offer comprehensive, evidence-based, tiered, patient-centered weight management programming. However, our recent study, "Barriers and Facilitators in Uptake of MOVE! in the VA" found that some aspects of MOVE! are not being implemented including Level 1 programming. Level 1 MOVE! is designed to provide self-management support for veterans through telephone-based support and is the foundation for later MOVE! treatment. Furthermore, all VAMC's in our study reported difficulty providing phone support due to lack of dedicated time to make calls and/or lack of confidence and skills to perform weight counseling over the phone. We developed a 12-week, telephone-based weight loss counseling intervention called THRIVE to fill this gap in patient care. The objective of this pilot study is to determine whether THRIVE can be feasibly implemented in a single VAMC, integrating with CPRS to foster collaborative communications with the MOVE! program coordinator.

Methods and Results

Fourteen sedentary (M step counts = 3702 per day), obese (M BMI = 37.56), mostly chronically ill (average number of conditions reported=3.2), middle aged (M = 53.87) male (67%) and female (33%) participants enrolled in our 12-week phone-based version of ASPIRE. Participants met face-to-face with a lifestyle coach during their baseline assessment, where they received a pedometer, a food record book, and a treatment manual outlining the small change program. Participants then scheduled weekly phone calls with the lifestyle coach for approximately 30 minutes, during which they reviewed food and activity records, weekly topics from the treatment manual, and problem-solved issues related to nutrition and physical activity goals according to the small change approach. Based on the 10 participants that have completed treatment to date, veterans lost a significant amount of weight (-4.46kg; $p<.01$) using intention-to-treat analyses. In addition, phone-visit adherence rates are above 90% and completion rates are 92% and only 1.6 phone calls were needed for each completed visit. We conducted a focus group with completers to obtain feedback about their experience. Participants overwhelmingly were positive in their reports about their experience in the program and provided valuable feedback for minor corrections and improvements to treatment and monitoring materials. The only criticism of the program was that "it was not permanent" and that there was no "follow-up program." Perhaps most notable however, when asked about whether the participants felt that it was the treatment mode (phone) or the treatment characteristics that were most helpful, participants indicated that it was "the treatment" itself that they loved and they "would have driven the hour each way every week" to do a group program that "made them feel good, not judged, and that it is was ok if they had good and bad days." They also praised the Stoplight system used to log dietary intake as being "simpler than having to count calories."

Conclusion:

Based on these positive results, we are developing an IIR study to submit in December 2009. This program has the potential to significantly reduce the prevalence of overweight and obese veterans which is linked to better health and reduced risk factors for diabetes and other prevalent chronic diseases in the veteran population.