ADAPTATION AND INITIAL FEASIBILITY OF A PRIMARY CARE-BASED DYADIC CARDIOVASCULAR RISK REDUCTION INTERVENTION: "HEART CARE PAIRS"

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Poster #

Background

- Hypertension (HTN) is the most prevalent yet modifiable risk factor for cardiovascular diseases (CVD).
- Primary care providers (PCP) face multiple challenges offering behavioral interventions for HTN. Behavioral health consultants (BHCs) add to the primary care team with training in behavioral modification.
- Supportive relationships play a clear role in prevention & management of HTN.

Project Aims

- **Aim 1**: Evaluate behavioral health, social needs of patient with HTN, potential care partner, and dyad using a convergent mixed methods design.
- **Aim 2**: Systematically adapt a lifestyle intervention for delivery by BHCs in primary care for patients with HTN and a chosen care partner.

Study Design

- For **Aim 1**, N=35 dyads will be recruited from primary care practices in Birmingham, AL.
  - Inclusions: Patient with HTN, willing to invite partner to participate, lower SES (Medicaid insurance, <$50k annually).
  - Patients and partners will complete surveys and qualitative interviews of their current health and social support needs.
- For **Aim 2**, the ADAPT-ITT (Assessment, Production, Topical experts, Integration, Training, Testing) Model will be applied.
  - Feedback will be solicited from PCPs (N=15) on feasibility of behavioral intervention components.
  - Focus groups (N=4) with patients with HTN will also be conducted.

Theoretical Framework

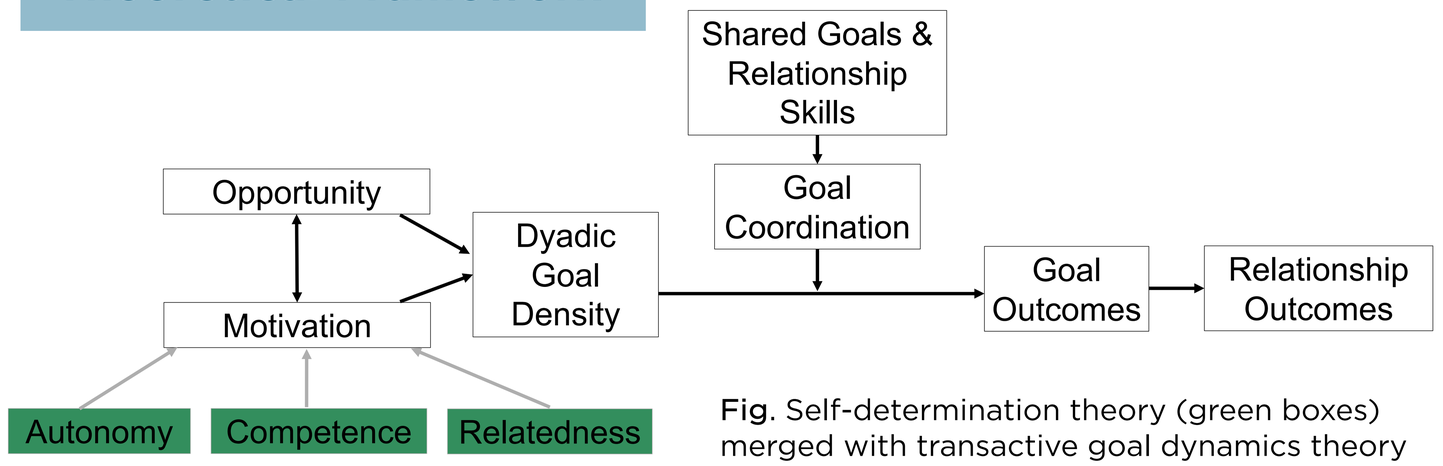

Fig. Self-determination theory (green boxes) merged with transactive goal dynamics theory (black boxes).

Outcomes

The primary expected outcome is a behavioral intervention protocol, that is community informed, acceptable and feasible for further pilot testing in primary care practices.

Educational Content	Support Skill & Goal Setting
Physical Activity	Ask for & acknowledge other's perspective Individual & Partner SMART Goals
DASH Diet, Sodium Reduction	Minimize efforts to control or criticize Individual & Partner SMART Goals
Heart Healthy Sleep Habits	Use non-judgmental language Individual & Partner SMART Goals
Stress Management and Resilience	Support movement towards change Individual & Partner SMART Goals
Optional: Smoking Cessation and/or Alcohol Reduction	Offering support for success and relapse Individual & Partner SMART Goals
Adherence to Medications and Lifestyle Recommendations	Empathic responding & encouraging self-advocacy Individual & Partner SMART Goals

Key Messages

- This project targets close social relationships as agents of change and aims to enhance autonomy, shared goal setting, and supportive interpersonal communication.
- Upon development and refinement of the "Heart Care Pairs" protocol, we will pilot test the intervention in primary care practices to assess efficacy and effectiveness on patient and practice outcomes.

Community Impact

Key Partners: Primary care practices serving lower income individuals in Alabama.

Potential Community & Public Health Benefits:

- **Community Health Services**: Development of behavioral health intervention for delivery in primary care.
- **Disease Prevention & Reduction**: The "Heart Care Pairs" intervention may reduce burden of HTN among those who receive the prospective intervention.
- **Health Care Quality**: Quality enhancements via team-based care, reducing workload on PCPs, and including care partner in services for support.

References

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