Feasibility of Implementing Videoteleconference Self-management TO Prevent Stroke

V-STOP

Jane Anderson, PhD, RN, FNP-BC
Nancy Petersen, PhD
Pamela Willson, PhD, RN, FNP-BC, CNE
Self-management TO Prevent

Risk Factor Management

Clinics

Self Management

Classes

Clinical Decision Support Tool

Stroke
Primary & Secondary Stroke Prevention Guidelines

- American Heart Association/American Stroke Association (AHA/ASA)
  - Recently Updated Guidelines
    - Guidelines for the Prevention of Stroke in Patients with Stroke or Transient Ischemic Attack –
      - October 2010
    - Guidelines for the Primary Prevention of Stroke
      - December 2010
<table>
<thead>
<tr>
<th>Stroke Etiology Risk Factor</th>
<th>AHA/ASA Stroke Secondary Prevention CPGs Outcome Measures</th>
</tr>
</thead>
</table>
| NonCardioEmbolic/Cardioembolic Stroke | 1. **Antiplatelet/Anticoagulation Therapy Prescribed**  
Aspirin, Plavix, Aggrenox or Warfarin |
| Hypertension                | 2. **Hypertension Medications Prescribed**  
Angiotensin Converting Enzyme Inhibitor-Thiazide Diuretic  
Angiotensin-Receptor Blockers |
| Hypertension + Diabetes     | 3. **Oral hypoglycemic agents/Insulin Prescribed** |
| Diabetes                    | 4. **Dietary Counseling Provided** |
| Hypercholesterolemia        | 5. **Statin Agent Prescribed** |
| Smoking                     | 6. **Smoking cessation recommended**  
Pharmacologic support offered/prescribed |
| Overweight/Obesity BMI      | 7. **Dietary Counseling and/or Exercise Training Provided** |
| Physical Inactivity         | 8. **Exercise Training - Provided** |
| Heavy Alcohol Consumption   | 9. **Reduced alcohol consumption recommended**  
Referral to alcohol dependency counseling |
| Patient specific risk factors | 10. **Patient Education Materials Provided** |
Guidelines for Stroke Patient Education

• The American Heart American Stroke Association
• Veteran Administration Department of Defense
  – All stroke and TIA patients should receive education on stroke risk factor reduction
• The Joint Commission
  – Patient education should be individualized for each patient admitted with stroke and TIA
  – 8 specific areas of stroke education are recommended for Primary Stroke Centers (PCS) Certification
**Joint Commission areas of focus and specific patient education topics for Primary Stroke Center Certification**

<table>
<thead>
<tr>
<th>Areas of Focus for Individualized Patient Education after Stroke or TIA</th>
<th>Specific Patient Education Topics for Stroke Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Etiology</td>
<td>1. Causes of stroke</td>
</tr>
<tr>
<td>Treatment of Stroke or TIA event</td>
<td>2. Stroke workup and treatment plan</td>
</tr>
<tr>
<td>Personal stroke risk factors</td>
<td>3. Personal stroke risk factors</td>
</tr>
<tr>
<td>Lifestyle modifications</td>
<td>4. Self-management actions to prevent stroke</td>
</tr>
<tr>
<td>Prescribed medications</td>
<td>5. Review of prescribed medications</td>
</tr>
<tr>
<td>Discharge/Follow up</td>
<td>6. Plan follow up care including rehab</td>
</tr>
<tr>
<td>Safety</td>
<td>7. Warning signs of stroke</td>
</tr>
<tr>
<td></td>
<td>8. Activation of emergency medical system</td>
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</tbody>
</table>
Joint Commission Standards for Self-Management

• Supporting Evidence (SE)

• Patients are:
  – SE 1 - Involved in the decision-making process for managing their disease or condition.
  – SE 2 – Given lifestyle changes that support patient self-management actions.
  – SE 3 - Educational needs are addressed in the context of self-management.
STOP Stroke Program Format
Face-to-Face & Telephone

STOP Stroke Course

Face-to-Face Group
SM Teaching
Telephone SM Counseling

STOP Stroke Clinic

Face-to-Face
Risk Factor
Management
Clinic
STOP Stroke Program Evaluation

N = 60 Participants

My overall satisfaction with course: 4.7
Direct my self-management activities: 4.5
Establish self-management at home: 4.3
Support my self-management: 4.5
Appreciate relaxation exercises: 4.5
Complete my action plan: 4.3
Increase my physical activity: 4.5
Stay on track managing risk factors: 4.2
Understand my stroke risk: 4.5
Identify personal risk factors: 4.5
Travel Distance and Parking

- We found travel distance to be the most significant barrier to dissemination of this intervention.
Face-to-Face Format

STOP Stroke Course
  2 - Face-to-Face Group Classes
  4 - Telephone Counseling Sessions

STOP Stroke Clinic
  2 – Face-to-Face Clinic Visits

Clinical Video Teleconference Format

STOP Stroke Course
  2 – CVT Group Classes
  4 - Telephone Counseling Sessions

STOP Stroke Clinic
  2 – CVT Clinic Visits
Overall Objectives

• Determine system/patient/provider barriers and facilitators to implementing V-STOP

• Describe the effects of V-STOP on:
  – Access to care
  – Acceptability of the program
  – Knowledge about stroke risk
  – Self-management behaviors
  – Self-efficacy
  – Quality of Life (QOL)
Theoretical Framework

Self-efficacy Theory
&
Patient Self-management Framework

STOP Stroke Program

Action Planning
Modeling
Problem Solving
Decision-making

SELF
E
F
I
C
A
Y

Exercise Behaviors
Diet Adherence
Medication Adherence

Self-management Behaviors

Symptoms Management
Communication with Healthcare Providers

Short-term Health Outcomes
Long-term Health Outcomes
Study Design

• Mixed Methods
  – Qualitative
    • Focus Group
    • Content Analysis
  – Quantitative
    • Descriptive Statistics
    • Pre/post – Paired T-Test
Research Questions

• What are system/patient/provider barriers and facilitators to implementing V-STOP?

• What is the effect of V-STOP on primary outcomes of knowledge about stroke risk management and self-management of stroke risk factors?

• What is the effect of V-STOP on secondary outcomes of self-efficacy for chronic disease management, health status and functional status?

• What is the effect of V-STOP on biophysical measures of blood pressure, Body Mass Index, Hemoglobin A1C (in diabetic patients) and lipid profile?

• What is the effect of V-STOP on access to care and patient satisfaction?
Setting

• Community Based Outpatient Clinics (CBOC)
  – Beaumont, Texas
  – Richmond, Texas
• Approximately 20% of patients with stroke/TIA receive their primary care in an affiliate CBOC

<table>
<thead>
<tr>
<th># Patients seen in Stroke Clinics @ MEDVAMC</th>
<th>Patients’ Assigned Primary Care Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>364</td>
<td>Houston</td>
</tr>
<tr>
<td>42</td>
<td>Beaumont (BOPC)</td>
</tr>
<tr>
<td>24</td>
<td>Galveston (GOPC)</td>
</tr>
<tr>
<td>21</td>
<td>Lufkin (CWOPC)</td>
</tr>
<tr>
<td>18</td>
<td>Conroe (COPC)</td>
</tr>
</tbody>
</table>
Sample Size & Eligibility Criteria

Sample size:
- Phase 1, Goal N = 10 - Actual N = 13
- Phase 2, Goal N = 20 - Actual N = 25

Eligibility criteria:
1. **Inclusions**
   - male and female Veterans who are age 18 or older
   - history of stroke/TIA
   - at risk for stroke/TIA due to multiple stroke risk factors
   - have the ability to read and speak English
   - have access to a telephone
   - willing to participate in video teleconference group self-management education

2. **Exclusion**
   Individuals who demonstrate severe cognitive or speech deficits.
Description

**V-STOP Phase 1 Format**

- 2 V-Tel Group SM Education Sessions (2.5 hours) per session
  - **Class 1**
    - Understanding Stroke/TIA Risk
    - Acute vs. Chronic Disease
    - Stroke Symptoms Cycle
    - Making an Action Plan
    - Health-related problem-solving
  - **Class 2**
    - Adoption of exercise programs for strength, flexibility and endurance
    - Nutritional change – portion control
    - Use of cognitive symptom management relaxation techniques
    - Taking medications
    - Communication with health professionals
- 4 Individual SM Telephone Counseling Session (15 – 20 minutes) per session
  - Review progress with action plan
  - Discuss accomplishments and/or problem solve barriers
  - Determine confidence in goal attainment
  - Record self-management behaviors practiced
- 2 V-Tel Individual Clinic Visits
  - Clinical follow-up for stroke risk factor management
Aim 1 - Test the feasibility of implementing V-STOP at two CBOC

Phase 1

- Identify system, patient, and provider barriers and facilitators to implementing V-STOP
- Refine the V-STOP based on feedback from participant and clinicians

N = 13
All Clinicians
<table>
<thead>
<tr>
<th>Barriers Themes - Patients</th>
<th>Barrier Themes - Clinicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Too much information for 2 classes</td>
<td>• No time to help with technology malfunction</td>
</tr>
<tr>
<td>• Too long – 2.5 hours</td>
<td>• Limited clinic space</td>
</tr>
<tr>
<td>• More specific information on dietary changes</td>
<td></td>
</tr>
<tr>
<td>• Less telephone more classes</td>
<td></td>
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</tbody>
</table>
### V-STOP Phase 1 Format

#### Facilitator

<table>
<thead>
<tr>
<th>Facilitator Themes - Patients</th>
<th>Facilitator Themes - Clinicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provided a Support System</td>
<td>• Made Staff More Aware</td>
</tr>
<tr>
<td>• Personalized Information</td>
<td>– High Risk Patients</td>
</tr>
<tr>
<td>• Peer Encouragement</td>
<td>• Mechanism to Help</td>
</tr>
<tr>
<td>• Convenient Location</td>
<td>– High Risk Patients</td>
</tr>
<tr>
<td>• Information Easy to Understand</td>
<td>• Opened Communication</td>
</tr>
<tr>
<td>• Encouraged Behavior Change</td>
<td>– Patient &amp; Staff</td>
</tr>
<tr>
<td></td>
<td>• Endorsed Need to Continue</td>
</tr>
</tbody>
</table>
### Description

### Revised V-STOP Format

- **3 V-Tel Group SM Education Sessions** *(1.5 hours)* per session
  - **Class 1**
    - Acute vs. Chronic Disease
    - Stroke Symptoms Cycle
    - Making an Action Plan
    - Health-related problem-solving
  - **Class 2**
    - Adoption of exercise programs for strength, flexibility and endurance
    - Communication with health professionals
    - Review progress with action plan
    - Discuss accomplishments and/or problem solve barriers
  - **Class 3**
    - Nutritional change – portion control
    - Use of cognitive symptom management relaxation techniques
- **1 SM Telephone Counseling Session** *(15 – 20 minutes)* per session
  - Review progress with action plan
  - Discuss accomplishments and/or problem solve barriers
- **2 V-Tel Individual Clinic Visits**
  - Understanding Stroke/TIA Risk
  - Taking medications
  - Clinical follow-up for stroke risk factor management
Barriers Addressed

• No time to help with technology malfunction
  – Sent team member to CBOCs as facilitator/troubleshooter
  – Involved IT staff at hub site to facilitate VTEL activation to CBOC

• Limited clinic space
  – Arranged 2 VTEL rooms at each CBOCs to insure backup space
  – Establish system for planning and scheduling of VTEL room use at the CBOCs
Aim 2 - Describe the Effect of V-STOP

Outcomes

Access - Acceptability
Patient Knowledge
Self-management Skills
Patient Outcomes

<table>
<thead>
<tr>
<th>Baseline</th>
<th>Wk 1</th>
<th>Wk 2</th>
<th>Wk 3</th>
<th>Wk 4</th>
<th>Wk 5</th>
<th>Wk 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Collection</td>
<td>V-STOP Intervention</td>
<td>Data Collection</td>
<td>Data Collection</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Results

• Primary outcome measures
  • Stroke risk knowledge
  • Self-management of stroke risk factors

• Exploratory outcome measures
  • Self-efficacy for managing chronic disease
  • Health status
  • Functional status
  • Biophysical measures

• V-STOP Course Evaluation Outcomes
  • Access/Acceptability Measures
## Demographics

**Sample N=13**

- **Gender**
  - 100% males

- **Race**
  - 62% White
  - 38% African American

- **Educational Level**
  - 58% High school or less
  - 42% High school plus

**Chronic Conditions**

- COPD 69%
- High BP 92%
- Diabetes 38%
- Arthritis 46%
- CAD 31%
AGE

Mean Age: 59.7
Median Age: 60
Minimum: 42.8
Maximum: 73
Stroke Risk Scorecard

- No mean difference from baseline at 18 months ($p=0.7938$)

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>High Risk</th>
<th>Caution</th>
<th>Low Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>$&gt;140/90$ or I don’t know</td>
<td>120-139/80-89</td>
<td>$&lt;120/80$</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>$&gt;240$ or I don’t know</td>
<td>200-239</td>
<td>$&lt;200$</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Yes</td>
<td>Borderline</td>
<td>No</td>
</tr>
<tr>
<td>Smoking</td>
<td>I still smoke</td>
<td>I’m trying to quit</td>
<td>I am a non-smoker</td>
</tr>
<tr>
<td>Atrial Fibrillation</td>
<td>I have an irregular heartbeat</td>
<td>I don’t know</td>
<td>My heartbeat is not irregular</td>
</tr>
<tr>
<td>Diet</td>
<td>I am overweight</td>
<td>I am slightly overweight</td>
<td>My weight is healthy</td>
</tr>
<tr>
<td>Exercise</td>
<td>I am a couch potato</td>
<td>I exercise sometimes</td>
<td>I exercise regularly</td>
</tr>
<tr>
<td>I have stroke in my family</td>
<td>Yes</td>
<td>Not sure</td>
<td>No</td>
</tr>
</tbody>
</table>

Score (each box=1)
Caregivers

• 85% of the Veteran’s did NOT have a caregiver
## Access Affects Attendance

<table>
<thead>
<tr>
<th>Drive Distance</th>
<th>Attendance Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home to Clinic</strong></td>
<td><strong>Classes</strong> 69%</td>
</tr>
<tr>
<td>– 22.4 miles</td>
<td><strong>Clinic visits</strong> 93%</td>
</tr>
<tr>
<td><strong>Home to MEDVAMC</strong></td>
<td><strong>Phone visits</strong> 93%</td>
</tr>
<tr>
<td>– 109.5 miles</td>
<td></td>
</tr>
<tr>
<td><strong>Miles saved</strong></td>
<td><strong>Total visits</strong></td>
</tr>
<tr>
<td>– One way - 87.1 miles</td>
<td>– 6 encounters 46%</td>
</tr>
<tr>
<td>– Round trip - 174.2 miles</td>
<td>– 7 encounters 54%</td>
</tr>
</tbody>
</table>
Acceptability
Telemedicine Care Delivery

- Mean Score for Each Domain
- Likert Scale with 1 = Strongly Disagree & 5 = Strongly Agree

4.9 4.7 4.8
Quality of Care Similar to In-person VideoConference Interaction

Interaction
Acceptability
V-STOP Program

Overall Satisfaction with V-STOP
CBOC Facility
Clinic Visit with Nurse Provider
Add Self-Management Classes
Group Self-Management Class
Telephone Counselling Session
Participate in Relaxation Exercise
Eat a Healthy Diet
Problem Solve
Participate in Exercise
Management of Risk Factors
Acute vs Chronic Disease
Understand Stroke Symptoms
Understand Personal Risk Factors

• Mean Score for Each Item
• Likert Scale with 1 = Strongly Disagree & 5 = Strongly Agree
Exploratory Outcomes

• Patients’ knowledge about stroke risk, self-efficacy for chronic disease self-management, and self-management behaviors.
  – *Stroke Knowledge Test
  – *Self Efficacy for Managing Chronic Disease
  – Exercise Behaviors
  – Cognitive Symptoms Management
  – *Communication with Health Care Provider
Stroke Risk Knowledge

- Participants showed a significant increase in knowledge about stroke risk

<table>
<thead>
<tr>
<th>Stroke Risk Knowledge Test</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Mean Pretest</td>
<td>8.5</td>
<td>1.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Posttest</td>
<td>9.8</td>
<td>0.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Difference</td>
<td>1.23</td>
<td>1.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T Value</td>
<td>3.81</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>P Value</td>
<td>0.0025*</td>
<td></td>
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</table>
# Self-Efficacy Scores

<table>
<thead>
<tr>
<th></th>
<th>Mean BL</th>
<th>SD</th>
<th>Mean 12 Wks</th>
<th>SD</th>
<th>Mean 18 Wks</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>7.0</td>
<td>2.3</td>
<td>7.6</td>
<td>2.0</td>
<td>7.0</td>
<td>3.0</td>
</tr>
</tbody>
</table>

## Mean Difference Self-Efficacy Scores BL, 12 Wks, & 18 Wks

<table>
<thead>
<tr>
<th>Mean Diff</th>
<th>SD</th>
<th>t Value</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>BL to 12 Wks</td>
<td>0.6057</td>
<td>3.50</td>
<td><strong>0.004</strong>*</td>
</tr>
<tr>
<td>BL to 18 Wks</td>
<td>0.0546</td>
<td>0.15</td>
<td>0.8848</td>
</tr>
<tr>
<td>12 Wks to 18 Wks</td>
<td>-0.5511</td>
<td>-1.51</td>
<td>0.1560</td>
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</table>
# Communication with Healthcare Provider

<table>
<thead>
<tr>
<th>Mean BL</th>
<th>SD</th>
<th>Mean 12 Wks</th>
<th>SD</th>
<th>Mean 18 Wks</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.5</td>
<td>1.5</td>
<td>2.7</td>
<td>1.5</td>
<td>2.9</td>
<td>1.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mean Difference</th>
<th>Communication with Healthcare Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Diff</td>
<td>SD</td>
</tr>
<tr>
<td>Mean Diff</td>
<td>BL to 12 Wks</td>
</tr>
<tr>
<td>Mean Diff</td>
<td>BL to 18 Wks</td>
</tr>
<tr>
<td>Mean Diff</td>
<td>12 Wks to 18 Wks</td>
</tr>
</tbody>
</table>
Selected Patient Outcomes

- Health & Disability HAQ 8
- Blood Pressure
- HgA1C
- BMI
## (HAQ8) – Mean Disability Scores

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Mean BL</td>
<td></td>
<td>SD</td>
<td></td>
<td>Mean 12 Wks</td>
<td></td>
<td>SD</td>
</tr>
<tr>
<td>0.423</td>
<td></td>
<td>0.380</td>
<td></td>
<td>0.356</td>
<td></td>
<td>.388</td>
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<td>Mean 18 Wks</td>
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<td>SD</td>
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<td></td>
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<td></td>
<td>0.346</td>
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<td>0.463</td>
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</table>

### Mean Difference in Disability 12 Wks & 18 Wks

<table>
<thead>
<tr>
<th>Mean Diff</th>
<th></th>
<th>SD</th>
<th></th>
<th>t Value</th>
<th></th>
<th>P Value</th>
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</thead>
<tbody>
<tr>
<td>BL to 12 Wks</td>
<td></td>
<td>0.1209</td>
<td></td>
<td>-2.01</td>
<td></td>
<td>0.0678</td>
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<td>SD</td>
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<td>t Value</td>
<td></td>
<td>P Value</td>
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<tr>
<td>BL to 18 Wks</td>
<td></td>
<td>0.2075</td>
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<td>-1.34</td>
<td></td>
<td>0.2062</td>
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<tr>
<td>12 Wks to 18 Wks</td>
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<td>0.1872</td>
<td></td>
<td>-0.19</td>
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<td>0.8562</td>
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# Mean Blood Pressure Values

<table>
<thead>
<tr>
<th></th>
<th>Mean BL</th>
<th>SD</th>
<th>Mean 6 Wks</th>
<th>SD</th>
<th>Mean 12 Wks</th>
<th>SD</th>
<th>Mean 18 Wks</th>
<th>SD</th>
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</thead>
<tbody>
<tr>
<td><strong>Systolic Blood Pressure</strong></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean BL</td>
<td>133</td>
<td>10.7</td>
<td>136</td>
<td>13.6</td>
<td>141</td>
<td>17</td>
<td>129</td>
<td>6.9</td>
</tr>
<tr>
<td>Mean 6 Wks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean 12 Wks</td>
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<td></td>
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<tr>
<td>Mean 18 Wks</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Diastolic Blood Pressure</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean BL</td>
<td>70.5</td>
<td>8.11</td>
<td>76.9</td>
<td>12.8</td>
<td>82.8</td>
<td>19.2</td>
<td>78.1</td>
<td>15.4</td>
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</table>
# Blood Sugar Control and Body Mass Index

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<thead>
<tr>
<th>HgbA1C</th>
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</tr>
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<tbody>
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V-STOP Summary

• Barriers and facilitators were identified and addressed
• Knowledge about stroke risk management and self-management were increased
• Self-efficacy for chronic disease management, health status and functional status were improved
• Blood pressure, Body Mass Index, Hemoglobin A1C (in diabetic patients) were improved
• Accessible and high patient satisfaction levels
• A clinical video teleconference delivery model is feasible for the delivery of patient self-management and clinical management of stroke risk factors.
Thank You!

- Contact information:
  - Jane Anderson  Jane.Anderson@va.gov
  - Pamela Willson  Pa.Willson@Elsevier.com