Improving Behavioral Counseling for Primary Cardiovascular Disease Prevention

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The US Preventive Services Task Force (USPSTF) has published an updated recommendation statement on behavioral counseling interventions to promote a healthy diet and physical activity for cardiovascular disease (CVD) prevention in adults without CVD risk factors and an updated evidence report and systematic review. The USPSTF recommends that clinicians individualize the decision to offer or refer adults without CVD risk factors to behavioral counseling interventions to promote a healthy diet and physical activity (C recommendation.)

As the USPSTF indicated, CVDs, including coronary heart disease and stroke, remain the leading cause of mortality in the US for male and female individuals and most races and ethnicities, including Black, Hispanic, and White adults. Over the past 5 decades, there have been significant declines in physical activity, with corresponding marked increases in obesity and cardiometabolic diseases. Certainly, efforts to reverse these trends are desperately needed.

In the updated evidence report and systematic review, Patnode et al included 113 randomized clinical trials (129,993 participants), 33 of which were published since the 2017 statement. Behavioral interventions improved participants’ dietary intake and physical activity levels and provided very modest, but statistically significant, reductions in blood pressure, low-density lipoprotein cholesterol, and adiposity-related indices at 6 to 18 months of follow-up vs control conditions. Limitations of the review included few data on the underlying CVD risk of the populations studied, interventions that were primarily conducted in or applicable to primary care settings, the inability to directly assess the relationship between dietary patterns, physical activity levels, and health outcomes and heterogeneity with respect to clinical and demographic characteristics, counseling interventions, settings, and behavioral outcomes. Scarce studies reported on CVD events and associated changes in quality of life.

Although medications are often used as the first-line strategy to stabilize or favorably modify traditional CVD risk factors, lifestyle changes are also associated with impressive mortality reductions, the magnitude of which are similar to or greater than those observed with cardioprotective medications. Moreover, the effects of lifestyle change and drug therapy on CVD risk reduction appear to be independent and additive.

In aggregate, these data and recent reports suggest that the single greatest opportunity to improve health and reduce premature death lies in favorably modifying unhealthy lifestyle behaviors. Unfortunately, barriers to this objective are inexorably embedded within the social determinants of health. Unhealthy behaviors are most prevalent in individuals with lower socioeconomic status, less education, and limited access to healthy food, exercise facilities equipment, the internet, and computers. These disparities are compounded by the sparse number of clinicians who reflect the ethnic diversity typifying the at-risk patients we hope to better serve. Accordingly, fundamental impediments to addressing the foundational causes of CVD are not easily rectified.

The likelihood that patients will or will not engage in a particular lifestyle behavior is governed by myriad socioeconomic, attitudinal, and cultural factors. Lack of or a suboptimal social support system, social isolation, or financial difficulties are often cited as common barriers to achieving lasting lifestyle behavior changes. Failure to identify and address underlying psychosocial factors, especially depression, anger, denial, and chronic life stress, can also be obstacles to a healthy lifestyle and directly promote or exacerbate atherosclerotic CVD.

Artinian et al provided evidence-based recommendations on implementing physical activity and dietary modifications for CVD risk reduction in adult men and women, including special considerations for interventions with non-Hispanic Black and Hispanic individuals and socioeconomically disadvantaged populations. The effectiveness and limitations of commonly used cognitive behavior strategies to facilitate behavior change were reviewed. The authors concluded that interventions designed to favorably modify the dietary habits or physical activity practices on one population cohort may be less effective in another, especially when the population is underserved or socioeconomically disadvantaged or differs in cultural health beliefs or practices from the population in which the intervention was initially tested.

Tailoring lifestyle counseling to patient readiness to change by using empathy to identify unhealthy lifestyle practices likely increases the probability of favorable outcomes. The 5 A’s approach has been reported to produce significant improvements in varied health behaviors, including smoking cessation, dietary choices, and physical activity (Figure). Although more clinicians now perform the first 2 A’s (assess the risk behavior and advise behavior change), it is the latter, less frequently performed A’s (agree on goals/action plan, assist with treatment, arrange for follow-up) that have the greatest impact on healthful behavior change.
Motivational interviewing is a powerful technique for helping patients to encourage a behavioral transformation. To accomplish this, the clinician must convey understanding, acceptance, and interest in the patient as an individual. Getting patients to consciously recognize the circumstances or scenarios that contribute to behavior change is critical. The next step is helping the individual to understand and accept the need for behavior change, using specific questions directed at the patient in this regard. The clinician should help the patient overcome inertia using downscaled goals and become independent and self-motivating, emphasizing that time is an ally to successful lifestyle modification. Patients should also be counseled on handling resistance and dealing with recidivism.

Finally, considering the recent attention directed at disparities in health care delivery at many levels, it should be noted that Black adults have longer life expectancy, driven predominately by the highest CVD mortality rate compared with other racial and ethnic groups. The marked disparity in a heart-healthy diet and physical activity behaviors among Black individuals, especially with lower socioeconomic status, educational attainment, or both, contributes to long-standing, unacceptable CVD outcomes and shortened life expectancy. Eliminating the persistent, unacceptably high CVD burden and mortality in Black adults remains a critical public health objective. Along with counseling, structural changes in health care and tailored community-based interventions are reasonable approaches to halt or reverse significant disparities in morbidity and mortality within certain population subsets. Unfortunately, despite prior USPSTF recommendations, as a society, the US remains stubbornly deficient in decreasing and eventually eliminating racial/ethnic disparities in CVD outcomes and implementing the appropriate multilevel approaches. The future health of the US population is dependent on these efforts.

Although the modifications described by the USPSTF in CVD risk factors were only modest, the improvements in physical activity were more substantial. Considering the role that physical activity, cardiorespiratory fitness, and sedentary behaviors have on health outcomes, improving these prognostic indices even modestly should reduce the incidence of CVD and cancers across populations, which should favorably and disproportionately impact the Black population relative to the incidence/prevalence of unhealthy lifestyles, risk factors, and underlying chronic disease.

ARThICAL INFORMATION

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REFERENCES


