Age + Action

June 17–20, 2019 | Washington, DC

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National Council on Aging

Health Coaches for Hypertension Control

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June 17, 2019

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Health Coaches for Hypertension Control

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2009-2012. Dye, Principal Investigator. J. Williams, Co-Investigator; B. Aybar-Damali, Co-Investigator. Health Coaches for Hypertension Control. Health Resources and Services Administration (HRSA). Award: DO4RH12726-01-00. http://www.raconline.org/success/project-examples/753

2012- 2013. Dye, Principal Investigator. J. Williams Co-Investigator. Expanded Health Coaches for Hypertension Control. USDA – National Institute of Food and Agriculture. Award: 2012-46100-20122.

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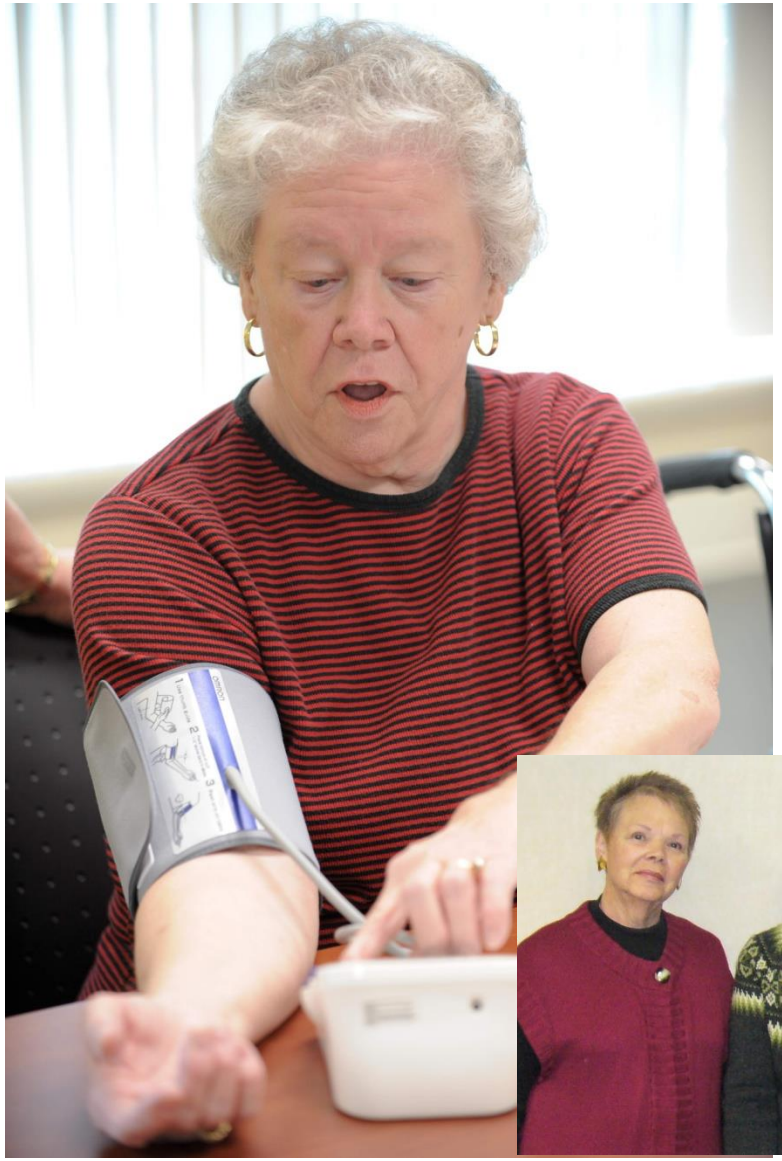
Health Coaches for Hypertension Control



The HCHC program used trained, volunteer community members called “Health Coaches” to teach and support older adults with hypertension in chronic disease self management.

Background

Compared to those living in urban areas, rural residents are:
more likely to have chronic conditions, are less educated and are poorer.

Both hypertension (HTN) and ischemic heart disease are higher in rural counties than urban areas. Lack of awareness of having HTN and lack of knowledge of how to control HTN after diagnosis places individuals at great risk for stroke and heart disease.

The American Heart Association lists lack of physical activity, poor diet (especially one high in salt), overweight and obesity as major risk factors for hypertension.

The county of interest (Oconee County, South Carolina) has high rates of all hypertension risk factors. **In South Carolina, hypertension 2011 prevalence was 33.2% which was higher than the national rate of 28.7%; incredibly, 2010 rates in Oconee county were even higher than the state's at 41.7% .**

Hypertension in Oconee Co. compared to SC

	Oconee County	South Carolina
Prevalence (%)	41.7	33.2
Age-Adjusted death rate (per 100,000)*	58.5	53.3

*Mortality statistics are 2007.

Source: State of South Carolina, Department of Health and Environmental Control, Bureau of Community Health and Chronic Disease Prevention, County Chronic Disease Fact Sheet February 2010 http://www.scdhec.gov/hs/epidata/county_reports.htm

2015 and 2016 SC BRFSS results

- Adults told they have HTN by healthcare professional –
  - 39.28% (SC), 39.60% male, 38.96% female
  - 39.37% (AAA Region I) includes Oconee County
- Risk factors
  - 1 out of 5 smoke
  - 2 out of 3 overweight or obese
  - ½ do not get recommended amount of physical activity

Project Partners

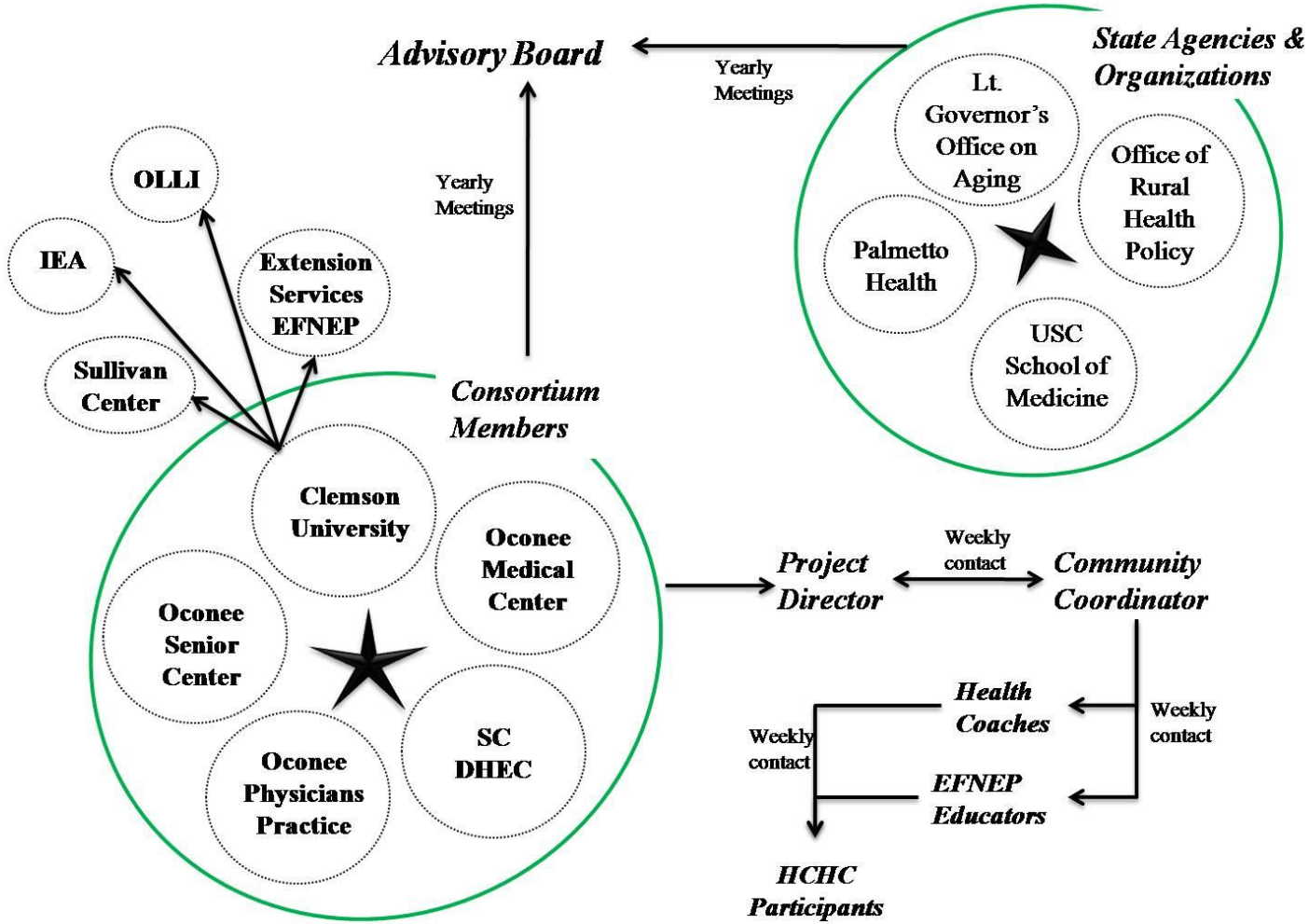
Primary Partners and Roles

Develop, coordinate, implement, and refine the program

Provide clinical measurement services and meeting space for the project

Assist in curriculum development, participant recruitment and future replication

Additional Partners



Note: OLLI: Osher Lifelong Learning Institute; IEA: Institute for Engaged Aging; EFNEP Expanded Food and Nutrition Education Program
DHEC: Department of Health & Environmental Control

Data collection, literature review

- Needs Assessment
  - Focus groups
  - Discussion with agency leaders
  - Review of strategic plans at national and state level
- Selection of behavior change strategies
- Incorporation of best practices
  - CDC , "*Community Health Worker's Heart Disease and Stroke Prevention Sourcebook*",
  - NIH "*Your Heart, Your Life*"
  - USDA-funded program, Expanded Food and Nutrition Education Program (EFNEP) provided by Extension – protocols for recruiting and training lay educators, content used in HCHC supplemental modules
- Selection/development of measures – eg. HRA, self-efficacy, stage of change

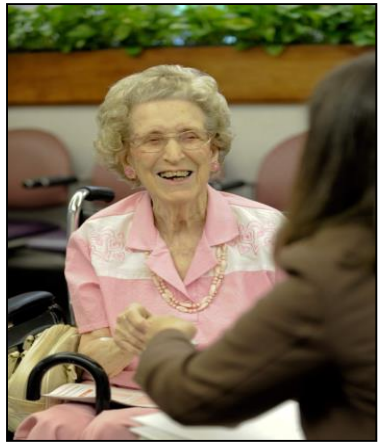
“Best Practices”

- Use of Health Risk Appraisal to increase perception of health risk of current health behaviors, to serve as basis for Individualized Action Plan, and to serve as baseline measure and outcome measure
- Development of Individualized Action Plan
- Peer-led educational classes
- Telephone counseling
- Group support
- Use of Personal Health Diary
- Civic Engagement benefits for Health Coaches

Challenges to lifestyle behavior changes in priority population

- Inability to follow recommended health care regimen due to a lack of understanding and recall and a lack of support
- Inability to take medications as prescribed and to recognize significant side effects
- Inability to recognize “red flag” signs and symptoms that indicate a worsening of a chronic illness that requires intervention.
- Characteristics of the “rural culture” of independence, self-reliance, privacy and willingness to endure hardship, including serious health problems, that influence a rural elder to wait until they are more ill before seeking health care services.
- Lack of knowledge of community resources
- Lack of coordination of health care and related resources
- Lack of transportation, especially for those in remote areas

Methods



Trained community volunteers engaged program participants in eight core educational modules about hypertension self-management and eight additional modules in nutrition and physical activity in first project (n=146).

The modules followed guidelines of the Joint National Committee 7 (JNC 7) recommending lifestyle modifications including weight reduction through following a DASH eating plan and increasing physical activity to 30 minutes most days of the week.

Participants completed health risk appraisals with blood work and surveys on knowledge, stage of readiness, and self-efficacy with data collection at baseline, 8 weeks and 16 weeks in first project (n=146) and at baseline and 8 weeks in second project (n=185) which used batched randomization to intervention or wait-list control groups.

Development of materials – training and class

- Communicating with Older Adults (3 hours)
  - Effective communication strategies to accommodate sensory loss
  - Incorporating Principles of Adult Education in communication strategies
  - Health Literacy Challenges of Older Adults and how to overcome them
- Hypertension Overview– What it is, What it Can Do and How to Control It (3 hours)
  - Cardiovascular Disease and Hypertension
  - Hypertension and Stroke
  - Weight Management
- Nutrition Basics with Emphasis on Sodium Intake (3 hours)
- Physical Activity Basics for those with Hypertension (3 hours)
- Tobacco Use Cessation (self-implemented strategies and referral to tobacco cessation classes)
- Principles of Behavior Change (3 hours)
- Medication Management (1 hour)
- Human Subject Protection
- Community Resources and Making Referrals (2 hours)

HCHC Curriculum Modules by Session

- Session 1: Understanding Health Risk Appraisal (HRA) results, Developing Short-Term Action Plan
- Session 2: Hypertension
- Session 3: Nutrition
- Session 4: Tobacco Use Cessation
- Session 5: Physical Activity
- Session 6: Medication Management
- Session 7: Stress Management
- Session 8: Developing Long-Term Action Plan

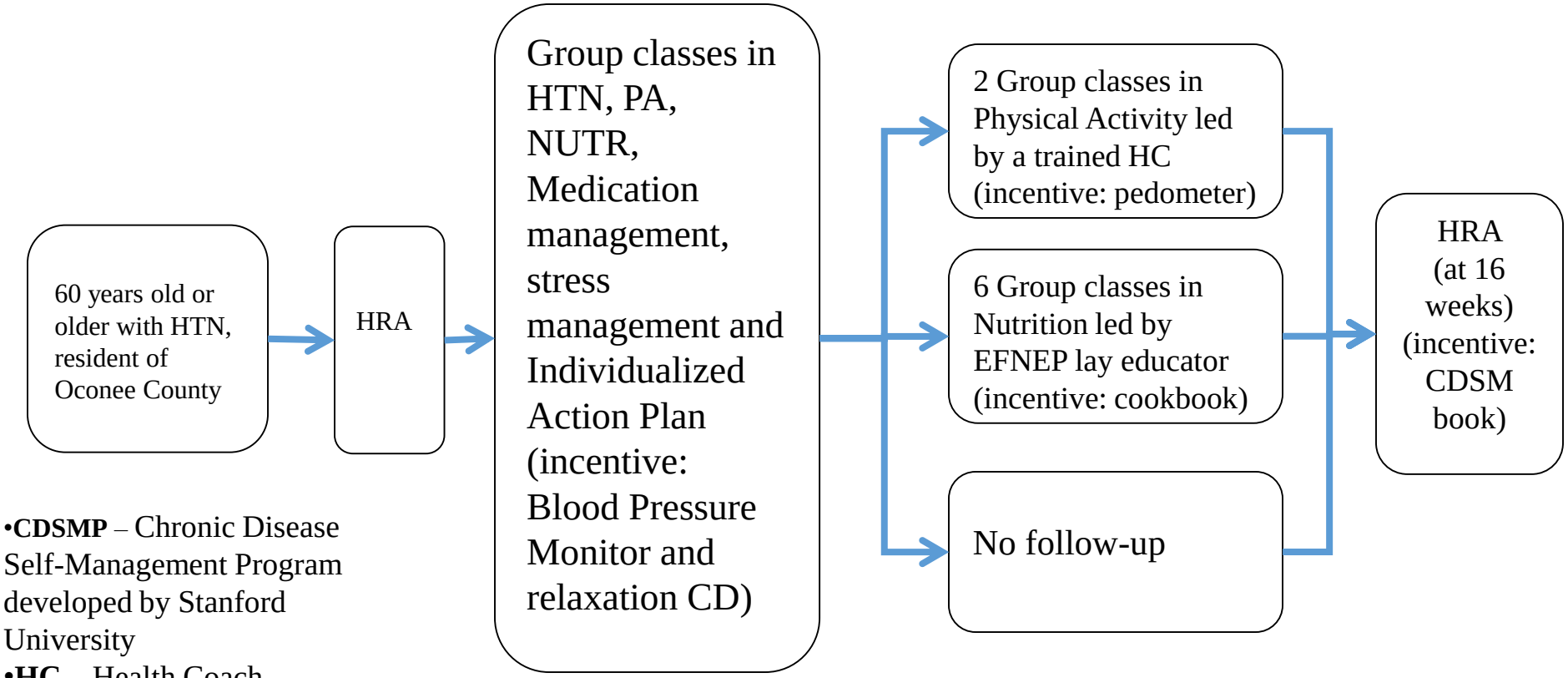
Evaluation – process, impact, outcome

- Recruitment, training retention, oversight of Health Coaches
- Recruitment of participants
- Delivery of program activities – fidelity, dose delivered, dose received – exposure and satisfaction, reach
- Outcomes –
  - Clinical – systolic BP, BMI, waist circumference
  - Knowledge, Perception (self-efficacy, attitudes, etc), stage of change,
  - Skill – personal action plan, goal-setting, self-monitoring
  - Behavior – dietary, physical activity, stress management, tobacco use

Two populations – two designs

- Original HCHC with 146 community members 60 years and above. Pre/Post data baseline and at 16 weeks.

- Expanded HCHC (EHCHC) with 185 community members 45 years and above completed 8-week, core program. Participants batch randomized to intervention or wait-list control groups.



- **CDSMP** – Chronic Disease Self-Management Program developed by Stanford University
- **HC** – Health Coach
- **HTN** – Hypertension
- **PA** – Physical Activity
- **NUTR** – Nutrition
- **BP** – Blood Pressure
- **HRA** –Health Risk Appraisal
- **EFNEP** – Expanded Food & Nutrition Education Program

Table 1. Participant Demographics and Cardiac Related Health Issues, N=146

*Self-report of a diagnosis with specific health issue(s)

Demographic/Health Issue	Distribution
Age	
Minimum	59
Maximum	89
Mean (SD)	71.55 (6.48)
Sex, n (%)	
Female	100 (68.5%)
Male	46 (31.5%)
Race/Ethnicity, n (%)	
White	125 (85.6%)
Black/African-American	15 (10.3%)
Hispanic	1 (0.7%)
Other	2 (1.4%)
Missing	3 (2.1%)
Cardiac-Related Health Issues*, (%)	
Diabetes	20.8%
Emphysema, bronchitis, or asthma	10.9%
Stroke	8.7%
Congestive heart failure	5.6%
Heart attack, angina, by-pass, or angioplasty	5.6%
Kidney disease	4.7%

Table 2. Changes in Pre-Post Readiness to Change and Self-Reported Behaviors

Readiness to Change (Indicate how ready you are to…)	Baseline	16-week Follow-up	P-value*
not smoke or use tobacco	n = 106	n =107	0.289
I haven't thought about changing	8 (7.5%)	4 (3.7%)	
I plan to change (in next 6 months)	2 (1.9%)	1 (0.9%)	
I plan to change this month	3 (2.8%)	3 (2.8%)	
I recently started doing this	0 (0.0%)	0 (0.0%)	
I do this regularly (within past 6 months)	93 (87.7%)	99 (92.5%)	
be physically active	n = 140	n = 136	< .001
I haven't thought about changing	11 (7.9%)	4 (2.9%)	
I plan to change (in next 6 months)	13 (8 .3%)	10 (7.4%)	
I plan to change this month	25 (17.9%)	8 (5.9%)	
I recently started doing this	28 (20.0%)	43 (31.6%)	
I do this regularly (within past 6 months)	63 (45.0%)	71 (52.2%)	
practice good eating habits	n = 139	n = 135	< .001
I haven't thought about changing	2 (1.4%)	2 (1.5%)	
I plan to change (in next 6 months)	13 (9.4%)	5 (3.7%)	
I plan to change this month	28 (20.1%)	4 (3.0%)	
I recently started doing this	38 (27.3%)	49 (36.3%)	
I do this regularly (within past 6 months)	58 (41.7%)	75 (55.6%)	
lose weight or maintain a healthy weight	n =138	n = 131	< .001
I haven't thought about changing	4 (2.9%)	5 (3.8%)	
I plan to change (in next 6 months)	22 (15.9%)	5 (3.8%)	
I plan to change this month	31 (22.5%)	13 (9.9%)	
I recently started doing this	37 (26.8%)	57 (43.5%)	
I do this regularly (within past 6 months)	44 (31.9%)	51 (38.9%)	
handle stress well	n =135	n =133	0.001
I haven't thought about changing	8 (5.9%)	7 (5.3%)	
I plan to change (in next 6 months)	14 (10.4%)	5 (3.8%)	
I plan to change this month	24 (17.8%)	10 (7.5%)	
I recently started doing this	27 (20.0%)	35 (26.3%)	

Table 3. Changes in Pre-Post Clinical Measures

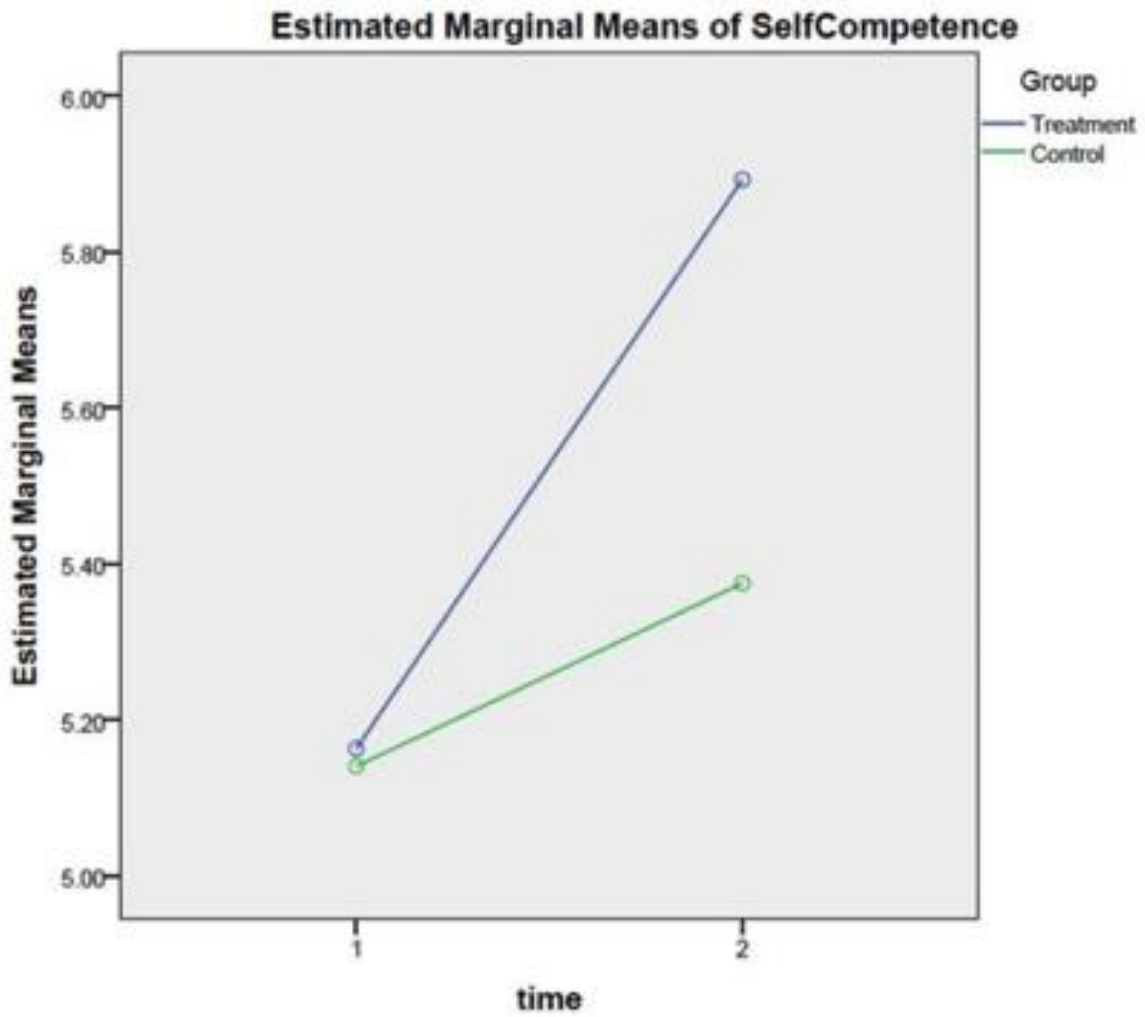
	Baseline		16-week Follow-up		Significance	
Measure	Mean	SD	Mean	SD	Difference	P-value*
Systolic BP (mm Hg)	146.31	18.027	140.53	19.245	-5.781	**0.001**
Diastolic BP (mm Hg)	77.65	10.25	76.53	9.186	-1.116	**0.128**
Weight (lbs.)	184.24	42.328	181.77	41.349	-2.475	**0.000**
Waist Circumference (in.)	41.62	37.042	38.32	5.698	-3.401	**0.253**
Total Cholesterol (mg/dl)	185.76	44.261	183.28	42.738	-2.477	**0.309**
HDL Cholesterol (mg/dl)	53.74	15.286	53.37	14.724	-0.370	**0.523**
LDL Cholesterol (mg/dl)	105.74	35.845	104.60	37.063	-1.144	**0.467**
Triglycerides (mg/dl)	137.73	75.775	126.55	65.216	-11.171	**0.016**
Glucose (mg/dl)	110.20	34.739	105.10	32.430	-5.096	**0.004**

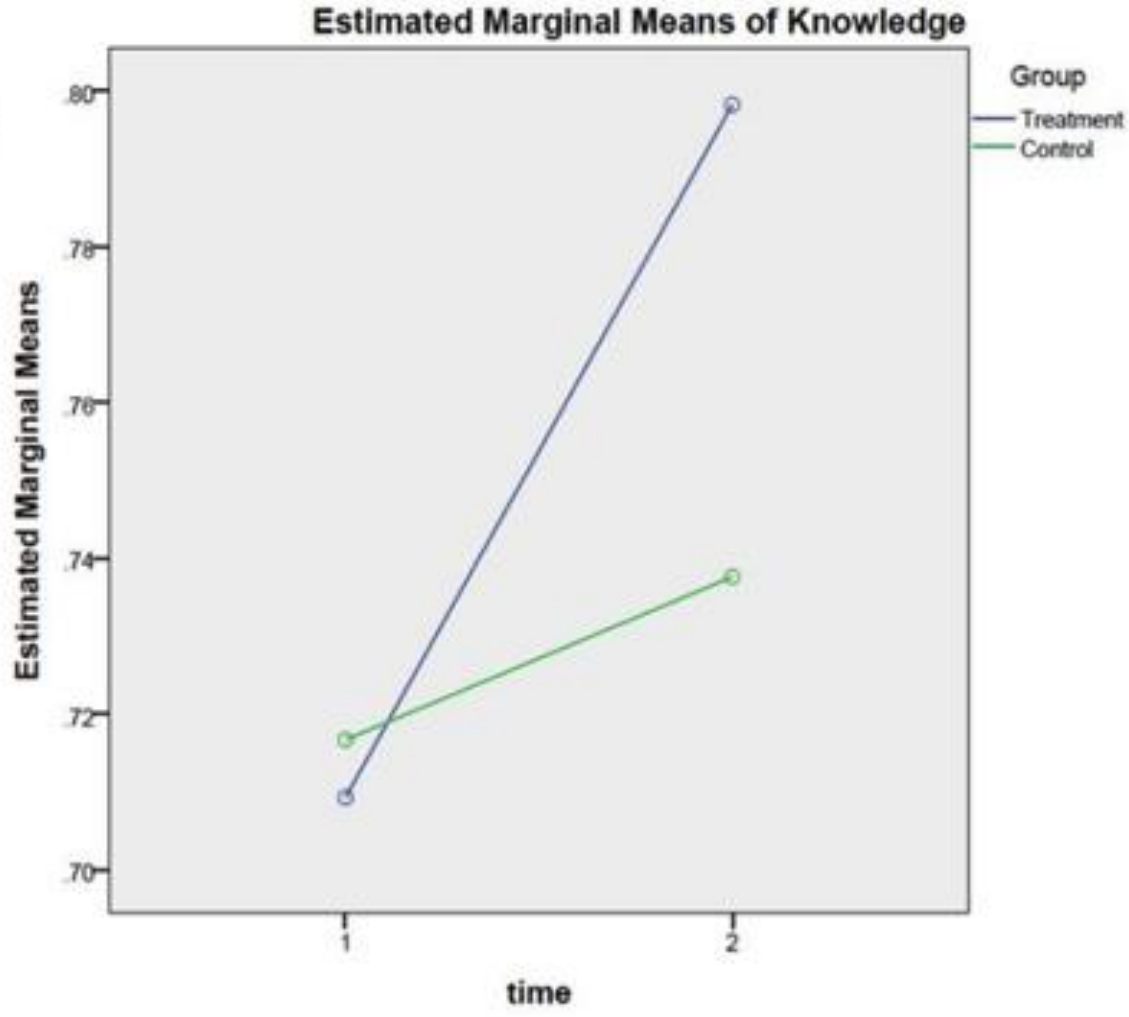
*Student's t-test. Bonferroni-corrected alpha level for multiple comparisons: 0.05/9=0.0055

Expanded HCHC project (n=185)

In EHCHC project, compared with control group participants, a higher proportion of treatment group participants moved from the cognitive to behavioral stages of motivational readiness for being physically active ($P < .001$), practicing healthy eating habits ($P = .001$), handling stress well ($P = .001$), and living an overall healthy lifestyle ($P = .003$).

They also demonstrated a greater average increase in perceived competence for self-management, $F(1.134) = 4.957$, $P = .028$, $\eta 2 = .036$, and a greater increase in mean hypertension-related knowledge, $F(1.160) = 16.571$, $P < .0005$, $\eta 2 = .094$.


Estimated Marginal Means of SelfCompetence
Estimated Marginal Means
6.00
5.80
5.60
5.40
5.20
5.00
1
2
time
Group
Treatment
Control


Estimated Marginal Means of Knowledge
Estimated Marginal Means
.80
.78
.76
.74
.72
.70
1
2
time
Group
Treatment
Control

Conclusions

Small changes in blood pressure of 2 to 3 mmHg
25 percent to 50 percent decrease in the incidence of hypertension
annual reduction of stroke (6%), coronary heart disease (4%) and all-cause mortality (3%).

(Halm & Amoako, 2008, NHANES data).

In the first study (n=146) with those aged 60 years and above, participants reduced mean systolic blood pressure by 5 mmHg ($p=0.001$) and reduced mean weight by 2.475 lb ($p<0.001$) indicating the potential to reduce stroke, coronary heart disease and all-cause mortality among program participants.

Although 40.4% of our analytic sample met the Healthy People 2020 definition of controlled hypertension at baseline, the proportion of HCHC participants meeting this definition at 16 weeks post intervention increased to 51.0%.

Conclusions, con’t

- A US national probability sample survey, the Medical Expenditure Panel Survey, found that in 2001 the mean incremental annual per capita direct cost for a hypertensive individual was $1131 with prescription medicines, inpatient visits, and outpatient visits accounting for more than 90% of expenditures.
- The cost of providing HCHC to an individual is $191 for materials and supplies. The yearly salary of $40,000 for a full-time program coordinator to recruit, train, and direct 5 volunteer community Health Coaches who can serve 200 individuals each year adds $200 to individual costs for a total of $391 per person.

Educational Materials Item Descriptions	Participant Itemized COST	Health Coach Itemized COST
Binder	$3.00	$6.00
Dividers, Color Copies, and purchased handouts	$7.00	$7.00
Partic. 300 copied pages @ .05 per page HC 800 copied pages @.05 per page	$15.00	$40.00
Wellsource Health Risk Appraisal Survey Booklets and Report Materials ($6/set)	$18.00	$6.00
Automatic Blood Pressure Monitor – Omron BP-785 (retail $110)	$85.00	$85.00
Pedometer - Yamax Digiwalker SW-200	$15.00	$15.00
DASH Cookbook	$15.00	$15.00
Stress Management CD - Time for Healing	$15.00	$15.00
Book - Living a Healthy Life with Chronic Conditions	$18.00	$18.00
Total Participant Materials and Supplies Costs	$191.00	$207.00

Conclusions, con’t

HCHC also benefits the volunteer Health Coaches, most of whom are retirees. Retirees are often seeking civic engagement, volunteer opportunities, and meaningful work throughout their later years.

Enduring lifestyle changes necessary for chronic disease self-management require that psychosocial determinants of health behavior are instilled, which is typically beyond standard medical practice. We recommend peer-led, community-based programs as a complement to clinical care and support the increasing health system interest in promoting population health beyond clinical walls.

NIH Stage Model applied to Health Coaches for Hypertension Control

- Stage 0 – Basic Science
- What are the high-risk populations for hypertension? (distribution of health outcomes in a population) Oconee County, prevalence, behavioral risk factors (BRFSS)
- What are the determinants of hypertension? (lifestyle)
- Why do people engage in behaviors linked with hypertension?
- What strategies have proven effective in changing lifestyle?
  - Applicable frameworks – Chronic Care Model, Healthy People goals
  - Applicable behavior change theories – SCT, Transtheoretical Model (SOC)
  - Lay Health Advisors, Community Health Workers/ Health Coaches (peer to peer)
  - Health Literacy strategies

Stage II, Stage III, Stage IV, Stage V

Stage II –Stage III. Efficacy -- effectiveness

- implementation in Oconee County (n=331)
  - close oversight of program activities,
  - process, impact, and outcome evaluation

Stage IV – implementation using only Health Coach manuals and participants notebooks to maintain fidelity

Stage V – Designation by NCOA as Evidence-Based Program in 2018. Dissemination through CU Extension and state health department staff in Wyoming (2018) with plans for trainings in other states.

HCHC Training, Sample of Materials

- 1-day training for health professionals to be a Master Trainer to train lay leaders
- Includes Health Coach Manual, Participant Workbook, Visuals for each session, Training Powerpoints, Evaluation instruments
- Cost of $755 per individuals with credentials and experience in health promotion and working with older adults.
- I will come on site with provision of travel expenses and $1000 for travel time in addition to $755 training fee which includes all materials.
- tcheryl@clemson.edu

Health Coaches for Hypertension Control

Health Coach Manual

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Objectives

By the end of this session, health coaches will be able to –

- Describe the link between hypertension and disease.
- Describe what causes high blood pressure. (CDC)
- Define high blood pressure. (CDC)
- Distinguish between different kinds of high blood pressure.
- Describe and demonstrate how blood pressure is measured. (CDC)
- Describe why it is important to monitor blood pressure on a regular basis.
- Describe ways to treat and control high blood pressure. (CDC)

Materials and Supplies

Flipchart, markers, and a home blood pressure monitor for each participant.

Extra copies of the handout "What Do Blood Pressure Numbers Mean?"

Participant notebook with handouts: Hypertension (Participant Objectives); Your Blood Pressure; What is Blood Pressure?; Why is High Blood Pressure Harmful?; High Blood Pressure; Risks for High Blood Pressure; How Is Blood Pressure Measured? (CDC); Categories for Blood Pressure Levels in Adults; What Do Blood Pressure Numbers Mean? (CDC); Controlling High Blood Pressure; Prevent and Control High Blood Pressure: Mission Possible (CDC); Heart Health Wallet Card (CDC); Session 2 Review; My Plan for Action; Fact Sheet (Appendix); How to Prepare for a Doctor's Visit (Appendix)

Posters:

- What is Blood Pressure (2)
- Why is High Blood Pressure Harmful (3)
- Why is High Blood Pressure Harmful (Cont.) (4)
- Factors that Contribute to High Blood Pressure (5)
- Controlling High Blood Pressure (8)
- The Relationship Between Blood Pressure and Body Weight (9)

Facilitator Tip

- Be honest with self-disclosure to develop rapport with participants

Session Outline

1. Overview
2. Lesson

A. Why Is High Blood Pressure Harmful?
B. What Causes High Blood Pressure?
C. How Is High Blood Pressure Diagnosed?
D. What Are the Warning Signs of High Blood Pressure?
E. How Is Blood Pressure Measured?
F. What Do the Blood Pressure Numbers Mean?
G. Where Can You Get Your Blood Pressure Checked?
H. How Is High Blood Pressure Prevented, Treated, and Controlled?

3. Summary
4. Goal setting – An introduction and assessment

Resources

Facts About the DASH Eating Plan. NIH Publication No. 03-4082. Reprinted 2003. Available from the NHLBI Health Information Center at 301-592-8573 or at the Web site: www.nhlbi.nih.gov. The booklet can be downloaded at the Web site: www.nhlbi.nih.gov/health/public/heart/hbp/dash/index.htm

Heart and Stroke Fact Sheet. AHA/ASA Web site: www.americanheart.org

Honoring the Gift of Heart Health: A Heart Health Educator's Manual for American Indians and Alaska Natives. National Heart, Lung, and Blood Institute and Indian Health Service; National Institutes of Health; U.S. Department of Health and Human Services.
www.nhlbi.nih.gov/health/prof/heart/other/aian_manual/index.htm

Prevent and Control America's High Blood Pressure: Mission Possible.
www.hin.nhlbi.nih.gov/mission

Protect Your Heart! Prevent High Blood Pressure. National Heart, Lung, and Blood Institute; National Institutes of Health; U.S. Department of Health and Human Services; Public Health Service. NIH Publication No. 97-4060. September 1997. www.nhlbi.nih.gov/health/public/heart/other/chdblack/protect1.htm

Spice Up Your Life! Eat Less Salt and Sodium. National Heart, Lung, and Blood Institute; National Institutes of Health; U.S. Department of Health and Human Services; Public Health Service. NIH Publication No. 97-4062. September 1997.
www.nhlbi.nih.gov/hbp/prevent/sodium/spice.htm

The Community Health Worker's Heart Disease and Stroke Prevention Sourcebook. Centers for Disease Control and Prevention; U.S. Department of Health and Human Services.
http://www.cdc.gov/DHDSP/library/chw_sourcebook/pdfs/sourcebook.pdf

Your Guide to Lowering Blood Pressure. National Heart, Lung, and Blood Institute. NIH Publication No. 03-5232. Reprinted 2003.
www.nhlbi.nih.gov/hbp/index.html

Your Heart, Your Life: A Lay Educator's Manual. National Heart, Lung, and Blood Institute; National Institutes of Health.
www.nhlbi.nih.gov/health/prof/heart/latino/latin_pg.htm

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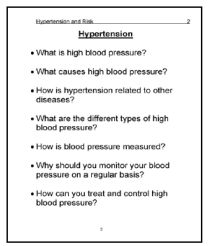
1. Overview

REMINDER: Ask them to review their 1 week action plan from the last session (page 6). Celebrate the successes of those who accomplished their goal.

➢ **Say:**
Today we are going to talk about Hypertension. This is Session 2 in your workbook.

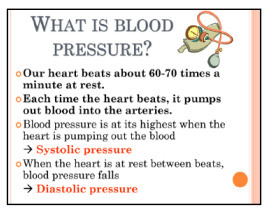
Ask participants to turn to page 2 in their workbooks titled "Hypertension". These are the questions we will be answering today. Read through these questions together.


Hypertension and Risk 2

Hypertension

- What is high blood pressure?
- What causes high blood pressure?
- How is hypertension related to other diseases?
- What are the different types of high blood pressure?
- How is blood pressure measured?
- Why should you monitor your blood pressure on a regular basis?
- How can you treat and control high blood pressure?

Display Poster 2, "What is Blood Pressure?"


WHAT IS BLOOD PRESSURE?

- **Our heart beats about 60-70 times a minute at rest.**
- **Each time the heart beats, it pumps out blood into the arteries.**
- Blood pressure is at its highest when the heart is pumping out the blood
  → **Systolic pressure**
- When the heart is at rest between beats, blood pressure falls
  → **Diastolic pressure**

First let's talk about the basics of Blood Pressure.

Ask participants to turn to the color handout on page 3 in their workbooks. Here you will see a picture of how your blood moves through your blood vessels.

Health Coaches for Hypertension Control

Participant Workbook

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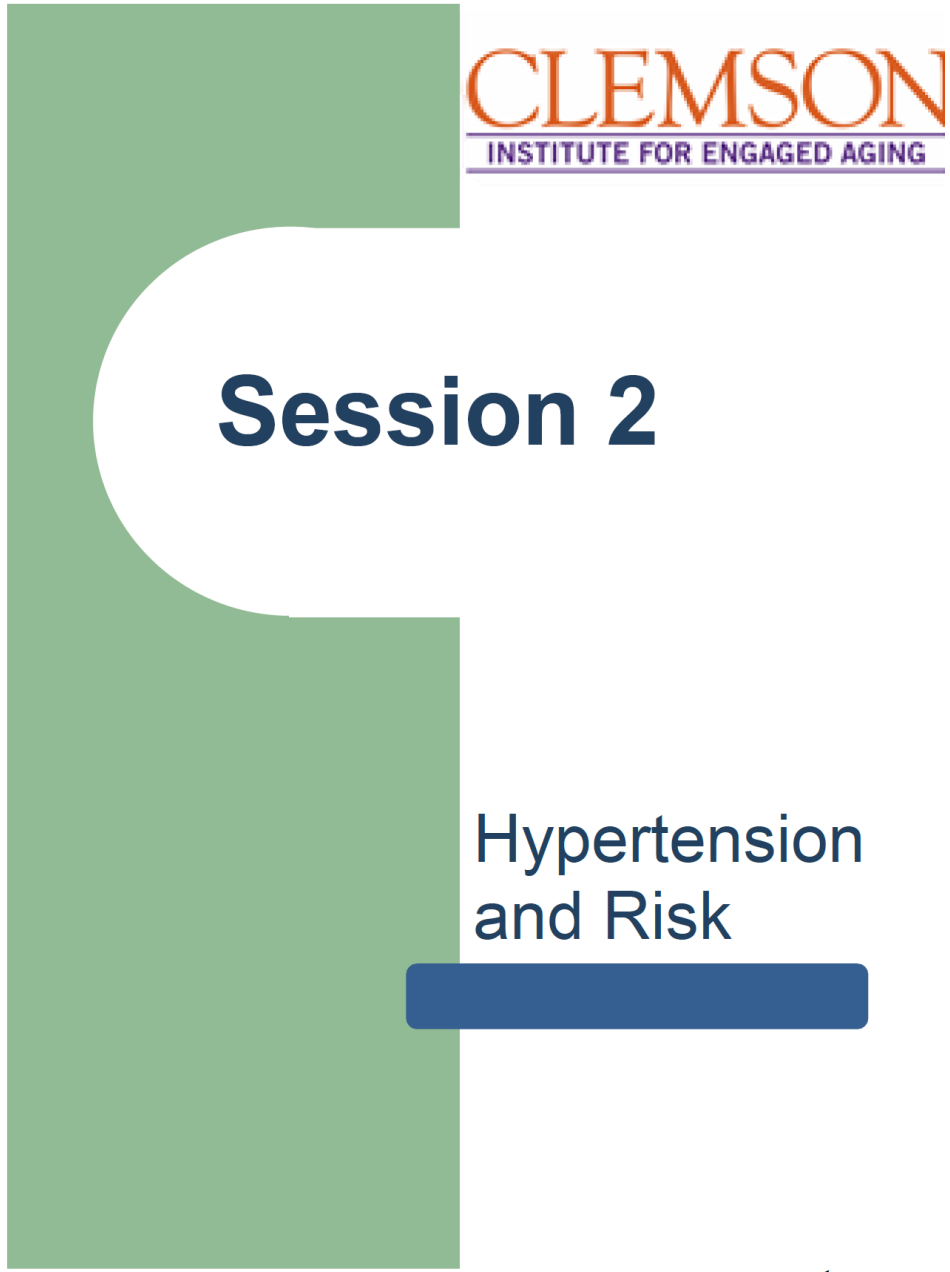
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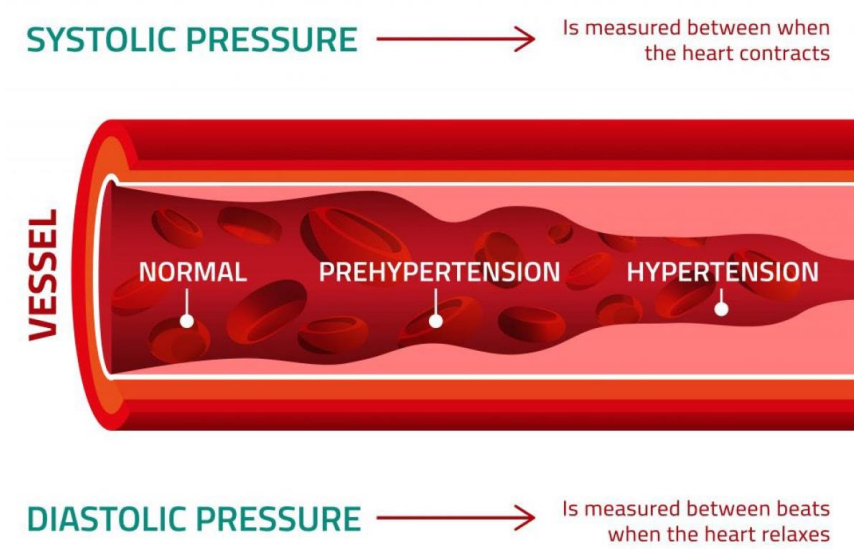
Session 2
Hypertension and Risk
1

Hypertension

- What is high blood pressure?
- What causes high blood pressure?
- How is hypertension related to other diseases?
- What are the different types of high blood pressure?
- How is blood pressure measured?
- Why should you monitor your blood pressure on a regular basis?
- How can you treat and control high blood pressure?


SYSTOLIC PRESSURE
Is measured between when the heart contracts
VESSEL
NORMAL
PREHYPERTENSION
HYPERTENSION
DIASTOLIC PRESSURE
Is measured between beats when the heart relaxes
Blood Pressure
VECTOR INFOGRAPHIC
Blood Pressure is the pressure exerted by circulating blood upon the walls of blood vessels.

Evaluation – Process, Impact, Outcome

Process – dose, fidelity

- Health Coach observation
- Health Coach checklist
- Participant feedback form
- Participant Personal Diary

Impact

- Participant knowledge assessment
- Beliefs
- Behavior

Outcome

- Clinical measures of blood pressure, weight,

FIDELITY – Social Interactions	No	Yes, Somewhat	Yes, Mostly	Yes, Completely	N/A
HCs show rapport with participants. NOTES:	1	2	3	4	N/A
HCs demonstrate active listening. NOTES:	1	2	3	4	N/A
HCs are accepting of/open to participant comments. NOTES:	1	2	3	4	N/A
HCs support/encourage participants. NOTES:	1	2	3	4	N/A
Participants support/encourage each other. NOTES:	1	2	3	4	N/A
Group interactions are constructive (e.g., discussions result in clarification or clarity about issues/topics, interactions involve effective problem-solving, etc.). NOTES:	1	2	3	4	N/A
CONTEXT (Notes on environmental issues that may have an impact on the session: e.g., bad weather, scheduling miscommunication, etc.)					

FIDELITY – HC attributes & skills that facilitate effectiveness (from: Millis et al.; Porter et al.; Linse)	No	Yes, Somewhat	Yes, Mostly	Yes, Completely	N/A
ORGANIZATION:					
• HCs begin the session on time.	1	2	3	4	N/A
• HCs follow the module outline.	1	2	3	4	N/A
• HCs use class digression effectively.	1	2	3	4	N/A
• HCs make full use of class time.	1	2	3	4	N/A
NOTES:					
ROLE MODELING/PROFESSIONALISM/DISCIPLINE:					
• HCs field questions effectively.	1	2	3	4	N/A
• HCs exhibit confidence in self and participants.	1	2	3	4	N/A
• HCs accommodate different participant needs (e.g., poor vision, hearing difficulties, response times, instruction speed).	1	2	3	4	N/A
• HCs show flexibility in responding to teachable moments.	1	2	3	4	N/A
NOTES:					
MECHANICS:					
• HCs effectively use learning tools (e.g., food labels) associated with module.	1	2	3	4	N/A
• HCs appropriately use posters associated with module.	1	2	3	4	N/A
• HCs refer participants to specific pages in workbook.	1	2	3	4	N/A
• HCs transition effectively (e.g., HC2 takes over from HC1).	1	2	3	4	N/A
NOTES:					
IMPARTS KNOWLEDGE:					
• HCs fully explain material.	1	2	3	4	N/A
• HCs do not impart “mis-information”.	1	2	3	4	N/A
• HCs use examples and encourage students for examples.	1	2	3	4	N/A
• HCs communicate sources/reasons behind information.	1	2	3	4	N/A
NOTES:					
ENCOURAGES CRITICAL THINKING:					
• HCs redirect questions to encourage group discussion.	1	2	3	4	N/A
• HCs maintain effective guidance or control of discussions.	1	2	3	4	N/A
• HCs relate topics to life and asks participants to do so.	1	2	3	4	N/A
NOTES:					

Health Coaches for Hypertension Control Session Observation Form

Team: _____ Topic:_____ Date: ___/___/___

Completeness (Dose Delivered)	No	Yes, Somewhat	Yes, Mostly	Yes, Completely	N/A
Ask each participant to share how they did with their previous week's action plan. NOTES:	1	2	3	4	N/A
At the beginning of the class, explains learning objectives/questions to be answered in the current module. NOTES:	1	2	3	4	N/A
Each learning objective is covered as intended (refer to module specific "cheat sheet"). NOTES:	1	2	3	4	N/A
At the end of class, summarizes/reviews learning objectives/questions. NOTES:	1	2	3	4	N/A
At the end of class, implements the module quiz. NOTES:	1	2	3	4	N/A
At the end of class, facilitates goal-setting for each participant for the coming week. NOTES:	1	2	3	4	N/A
At the end of class, distributes/collects session feedback form. NOTES:	1	2	3	4	N/A
Able to complete module in allotted time. NOTES:	1	2	3	4	N/A
The session included modifications to the module. NOTES:	1	2	3	4	N/A

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Health Coaches for Hypertension Control

ID ☐☐☐

Participant Baseline Beliefs About Hypertension Survey

Please take a few minutes to provide us with some very important information. On the next few pages are statements about hypertension and health behaviors related to hypertension. Please tell us how you feel after you read each statement.

* **There are no right or wrong answers**
* **Answer all the questions as honestly and accurately as you can**

Hypertension Self Management Effectiveness

Please bubble in your opinion about the following statements:

If I don't manage my hypertension, I will have a heart attack.	Not very Likely			Somewhat Likely			Very Likely
	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
If I don't manage my hypertension, I will have heart failure.	Not very Likely			Somewhat Likely			Very Likely
	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
If I don't manage my hypertension, I will have a stroke.	Not very Likely			Somewhat Likely			Very Likely
	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
If I don't manage my hypertension, I will have kidney disease.	Not very Likely			Somewhat Likely			Very Likely
	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

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Hypertension Self Management Importance

How important are the following in keeping your blood pressure at healthy levels and avoiding heart disease and stroke?

Keeping my medical appointments.	Not very Important ○ 1	○ 2	○ 3	Somewhat Important ○ 4	○ 5	○ 6	Very Important ○ 7
Aerobic physical activity (like walking) 30 minutes most days of the week.	Not very Important ○ 1	○ 2	○ 3	Somewhat Important ○ 4	○ 5	○ 6	Very Important ○ 7
Stopping smoking.	Not very Important ○ 1	○ 2	○ 3	Somewhat Important ○ 4	○ 5	○ 6	Very Important ○ 7
Eating fruits.	Not very Important ○ 1	○ 2	○ 3	Somewhat Important ○ 4	○ 5	○ 6	Very Important ○ 7
Eating vegetables.	Not very Important ○ 1	○ 2	○ 3	Somewhat Important ○ 4	○ 5	○ 6	Very Important ○ 7
Measuring my blood pressure correctly every day.	Not very Important ○ 1	○ 2	○ 3	Somewhat Important ○ 4	○ 5	○ 6	Very Important ○ 7
Keeping my weight at a healthy level.	Not very Important ○ 1	○ 2	○ 3	Somewhat Important ○ 4	○ 5	○ 6	Very Important ○ 7
Managing my stress.	Not very Important ○ 1	○ 2	○ 3	Somewhat Important ○ 4	○ 5	○ 6	Very Important ○ 7

Taking my prescription medications correctly.	Not very Important ○ 1	○ 2	○ 3	Somewhat Important ○ 4	○ 5	○ 6	Very Important ○ 7
Reducing the sodium (salt) in the foods I eat.	Not very Important ○ 1	○ 2	○ 3	Somewhat Important ○ 4	○ 5	○ 6	Very Important ○ 7

Hypertension Self Management Confidence

Please rate how confident you feel about reaching these goals:

I will keep my medical appointments.	Not very Confident ○ 1	○ 2	○ 3	Somewhat Confident ○ 4	○ 5	○ 6	Very Confident ○ 7
I will do aerobic physical activity (like walking) at least 30 minutes a day on most days of the week. If I notice chest pain, shortness of breath, or chest tightness, I will seek medical attention.	Not very Confident ○ 1	○ 2	○ 3	Somewhat Confident ○ 4	○ 5	○ 6	Very Confident ○ 7
I will stop smoking.	Not very Confident ○ 1	○ 2	○ 3	Somewhat Confident ○ 4	○ 5	○ 6	Very Confident ○ 7
I will eat more servings of fruit.	Not very Confident ○ 1	○ 2	○ 3	Somewhat Confident ○ 4	○ 5	○ 6	Very Confident ○ 7
I will eat more servings of vegetables.	Not very Confident ○ 1	○ 2	○ 3	Somewhat Confident ○ 4	○ 5	○ 6	Very Confident ○ 7
I will measure my blood pressure correctly every day.	Not very Confident ○ 1	○ 2	○ 3	Somewhat Confident ○ 4	○ 5	○ 6	Very Confident ○ 7

I will keep my weight at a healthy level.	Not very Confident ○ 1	○ 2	○ 3	Somewhat Confident ○ 4	○ 5	○ 6	Very Confident ○ 7
I will manage my stress effectively.	Not very Confident ○ 1	○ 2	○ 3	Somewhat Confident ○ 4	○ 5	○ 6	Very Confident ○ 7
I will take my prescriptions medications correctly.	Not very Confident ○ 1	○ 2	○ 3	Somewhat Confident ○ 4	○ 5	○ 6	Very Confident ○ 7
I will reduce the amount of sodium (salt) in the foods that I eat	Not very Confident ○ 1	○ 2	○ 3	Somewhat Confident ○ 4	○ 5	○ 6	Very Confident ○ 7

Perceived Competence for Hypertension Self-Management

Please bubble in your opinion about the following statements:

I feel confident in my ability to manage my hypertension.	Not at all True ○ 1	○ 2	○ 3	Somewhat True ○ 4	○ 5	○ 6	Very True ○ 7
I am capable of handling my hypertension now.	Not at all True ○ 1	○ 2	○ 3	Somewhat True ○ 4	○ 5	○ 6	Very True ○ 7
I am able to do my own routine hypertension care now.	Not at all True ○ 1	○ 2	○ 3	Somewhat True ○ 4	○ 5	○ 6	Very True ○ 7
I feel able to meet the challenge of controlling my hypertension.	Not at all True ○ 1	○ 2	○ 3	Somewhat True ○ 4	○ 5	○ 6	Very True ○ 7

Personal Health Diary

Number: _____

Day/Date:___/___/____	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Blood Pressure (same time each day, left arm)							
Steps Per Day							
Sodium Intake (mg)							
Fruits (Servings) Serving size = 1 medium fruit, ¼ cup dried fruit, ½ cup fresh, frozen, or canned fruit, ½ cup fruit juice							
Vegetables (Servings) Serving size = 1 cup raw leafy, ½ cup cut-up raw or cooked, ½ cup vegetable juice							
Stress Management activities (Yes or No)							
Taking Medication as Prescribed (Yes or No)							

Publications

- **Dy**e CJ, Williams J, Evatt JH. “Activating Patients for Sustained Chronic Disease Self-Management: Thinking Beyond Clinical Outcomes”. **Journal of Primary Care and Community Health**. 2016. DOI:10.1177/2150131915626562.
- **Dye, CJ,** Williams JE, Evatt JH**. “**Improving Hypertension Self-Management with Community Health Coaches”. **Health Promotion Practice**. DOI:10.1177/1524839914533797. 2014.
- **Dye CJ, Williams, JE, Kemper KA, McGuire F.** " Impacting Mediators of Change for Physical Activity among Elderly Food Stamp Recipients”. **Educational Gerontology.** 38:788-798, 2012.
- **Dye CJ**, Willoughby F, Battisto D. “Advice from Rural Elders: What it Takes to Age in Place.” **Educational Gerontology**. 37: 1-20, 2011.

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