

# Franklin County Public Health & American Heart Association – Columbus, OH



**American Heart Association.**

## Synopsis

In spring of 2020, the Franklin County Board of Health passed a resolution declaring racism a public health crisis and subsequently outlined a series of action steps that led to the primary organizational goal of adopting equity as the foundation for its daily work. Franklin County Public Health's (FCPH) goal is equity at the core and foundation for the work being done each and every day, with a vision of leading the communities served toward achieving optimal health for all. Through programs and services provided by FCPH, the organization is striving to improve health through disease prevention, promotion of healthy lifestyle interventions, and defending the public against a variety of health threats through policy change, program implementation, community education, and partnering with other organizations throughout the community. It is also important that all activities and services provided are done with integrity, accountability, quality, and respect for all.

This project presented an opportunity to address

health inequities by providing resources focused on improving blood pressure self-management education for select Federally Qualified Health Centers (FQHCs) in Franklin County, while equipping Community Health Workers (CHWs) through training with tools needed to advance their knowledge to improve health outcomes for the individuals they serve.

## Challenge

In Franklin County, where cardiovascular disease continues to remain a leading cause of death, the prevalence of high blood pressure is 36.2% among adults 18 years and older in a population of over 1.3 million people.<sup>1,2</sup> According to a report released by the American Heart Association (AHA) in 2020, the percentage of adults in the U.S. with controlled high blood pressure continues to decline. Contributing factors to this decline include less effective treatment, lack of awareness and education around the importance of blood pressure

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### 7 SIMPLE TIPS TO GET AN ACCURATE BLOOD PRESSURE READING

The common positioning errors can result in inaccurate blood pressure measurement. Figures shown are estimates of how improper positioning can potentially impact blood pressure readings.

Sources:  
1. Pickering, et al. Recommendations for Blood Pressure Measurement in Humans and Experimental Animals Part 1: Blood Pressure Measurement in Humans. *Circulation*. 2005;111:697-716.  
2. Handler J. The importance of accurate blood pressure measurement. *The Permanente Journal*/Summer 2009/Volume 13 No. 3 51

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control, and lack of access and adherence to medication.<sup>3</sup> Hypertension control rates are also significantly higher among non-Hispanic white adults than non-Hispanic Black adults.<sup>4</sup> In 2018, the National Center for Health Statistics reported that Ohio ranked 10<sup>th</sup> in highest death rate from heart disease in the United States. Failure to control high blood pressure in Franklin County residents may continue to result in a growing number of heart attacks and stroke in a population already greatly impacted.<sup>5</sup>

The program was designed to drive blood pressure self-management education skills through targeted efforts, in collaboration with FQHCs to connect patients with the greatest need to tools and resources to improve self-management and understanding of the importance of hypertension control. Additionally, by providing training for CHWs, these trusted individuals can increase awareness of hypertension control, as well as empower and equip patients with critical knowledge of treatment plan adherence, all while offering community support and lifestyle change resources. The demand for resources for FQHCs and CHWs is great, and through strengthening support and training for these partners who are providing care for populations disproportionately impacted, we begin to address the burden of blood pressure and other chronic risk factors in Black and Hispanic/Latino people, as compared with white people in Central Ohio.



## Solution

This program aimed to address the declining blood pressure control rates in Franklin County through enrolling four FQHCs in a self-management education cohort comprised of members of the American Heart Association (AHA) led Franklin County Hypertension Network. Through participation in the four-month cohort, the organizations received support and resources for staff related to taking proper blood pressure

measurement, as well as resources for patients to improve education on healthy lifestyle interventions. All participating members of this project are also members of the hypertension network to ensure lessons learned and best practices captured and shared with the larger collective group. This initiative led by the AHA utilized resources and information from the American Heart Association and the AHA/American Medical Association's Target: BP™ initiative. Each participating FQHC subsequently identified individual patients diagnosed with hypertension to partner with throughout the cohort to engage with lifestyle intervention messaging, resources, and to provide individual support. The FQHC cohort representatives met virtually as a group monthly from November through May to review resources, discuss what was working, barriers to implementation and recruitment, and ideas for improvement. Additionally, the program ensured that each patient had access to a blood pressure monitor for ongoing tracking of blood pressure at home, along with education and information on how to accurately measure blood pressure at home.

The program also aimed to provide education and resources to a local CHW training program to maximize the reach of critical knowledge through the ability of the CHWs to connect with diverse individuals throughout the Franklin County community. Included in this effort was an opportunity for training for two local CHW certification programs designed to improve education on the importance of blood pressure control, with a focus on lifestyle interventions and controllable risk factors. Each CHW received training on proper blood pressure measurement, as well as a blood pressure monitor upon completion of the training. Materials and information were provided to each CHW outlining resources and support available to them upon completion of their training program.

## Results

Results from the program were captured via feedback forms from the cohort members that included reporting of individual patient success. Of the participating cohort organizations, one organization began individual patient intervention previously, one had conducted similar efforts in the past, and two had not undertaken such an initiative. The consensus from all cohort members was the immeasurable value of having the ability to offer support for lifestyle interventions for individuals experiencing chronic conditions such as hypertension.

This effort helped to establish a consistent mechanism for a supportive lifestyle intervention model at each participating cohort organization, and we are excited that all four organizations plan to continue the effort upon completion of this project.

Key highlights of success include the following:

- One patient was interested in improving her health so she could have more children. She used the hypertension group to focus on physical activity for both herself and her family, and noted how helpful the camaraderie and education she received from the group was in helping work toward her personal goals.
- One Spanish-speaking patient, unable to read and only able to speak Spanish, was eating a diet high in sodium and rarely incorporating fruits and vegetables. Through participation in the hypertension effort, the cohort was able to educate him on the DASH diet and he is working to add more fruits and vegetables to his diet.
- This program was successful at retaining participation and engagement through a focus on improving diet and examples of heart healthy cooking. The program partnered with patients to try new foods with a focus on alternatives to salt, as well as decreasing sodium consumption. Patients were accepting of substitutions/alternatives and are working on incorporating skills at home.
- This program created an opportunity to establish a relationship with patients. This has been critical to setting meaningful goals and understanding what is important to the individual. (Example – a patient wanting to reach a weight loss goal for an upcoming family event). Trust and understanding are critical for long-term success and behavioral change.

Each health center engaged with 10-20 individuals from February to May, with ongoing enrollment of patients into the program. One success identified by each of the cohort members was first establishing the program and then operationalizing a method of referral of patients by providers to the program for sustainability and growth



of the initiative. The long-term outcome is the ongoing effort, and subsequent benefit, of partnering with patients diagnosed with hypertension.

## Lessons Learned

This initiative successfully established partnering with patients' programs at participating organizations, and helped develop keys for success moving forward. One factor for success was a commitment of the cohort members to this initiative and a desire to improve patient blood pressure control rates. This story is an example of a program that should be replicated. An unintended success was the benefit of the support the cohort members provided to each other. During the monthly cohort sessions, the idea sharing and problem-solving the group provided to one another was an invaluable component. There is a great deal of work placed on the FQHCs and they were able to provide ongoing support to one another.

Another takeaway from this program was the time required to establish the framework necessary to begin. There was time needed both internally and externally to inform providers and patients of the program that slowed the initial enrollment progress and patient sessions. Moving forward additional time should be allocated to putting the required structure in place prior to beginning work with patients. Time constraints due to the COVID-19 surge in early 2022 also impacted the timeline for the project.



Participating health centers also cited better program participation and retention when the initial referral of the patient came from the provider versus another method of recruiting the patient to participate.

- 1 Franklin County HealthMap. 2022. <https://centralohioshospitals.org/wp-content/uploads/2022/04/COHC-HealthMap2022-Final-1.25.22.pdf>.
- 2 United States Census Bureau. Quick Facts Franklin County, Ohio. <https://www.census.gov/quickfacts/fact/table/franklincountyohio,OH,US/PST045221>.
- 3 American Heart Association (AHA). Americans continue to struggle controlling high blood pressure; 11% fewer adults have it in check. 2020. <https://newsroom.heart.org/news/americans-continue-to-struggle-controlling-high-blood-pressure-11-fewer-adults-have-it-in-check>.
- 4 Aggarwal R, Chiu N, Wadhwa R, et al. Racial/Ethnic Disparities in Hypertension Prevalence, Awareness, Treatment, and Control in the United States, 2013 to 2018. American Heart Association Journals. 2021. DOI: <https://doi.org/10.1161/HYPERTENSIONAHA.121.17570>.
- 5 Centers for Disease Control and Prevention. National Center for Health Statistics. Heart Disease Mortality by State. [https://www.cdc.gov/nchs/pressroom/sosmap/heart\\_disease\\_mortality/heart\\_disease.htm](https://www.cdc.gov/nchs/pressroom/sosmap/heart_disease_mortality/heart_disease.htm).

The CHW component was critical to the overall strategy for success, and while the CHW training was able to take place, additional time will allow for further and more impactful collaboration and engagement of this effort.

Lastly, a key lesson learned is that partnering with patients may look different based upon the individual health center and their patient population. Due to a variety of barriers and determinants, some saw greater success with group patient sessions, while others had to focus on incorporating education and interventions into existing appointments. In some cases, transportation and other barriers prohibited patients from being able to participate in self-management education support sessions.

One recommendation to help mitigate barriers for future programs is to have all educational materials and content organized in modules provided in advance of the program. Having access and training on interventions prior may provide better opportunity to respond immediately to the individual needs of the patient who may not be able to participate in an ongoing program.



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