Heart Smart GA Project

Emily Rosenfeld

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Mission Statement

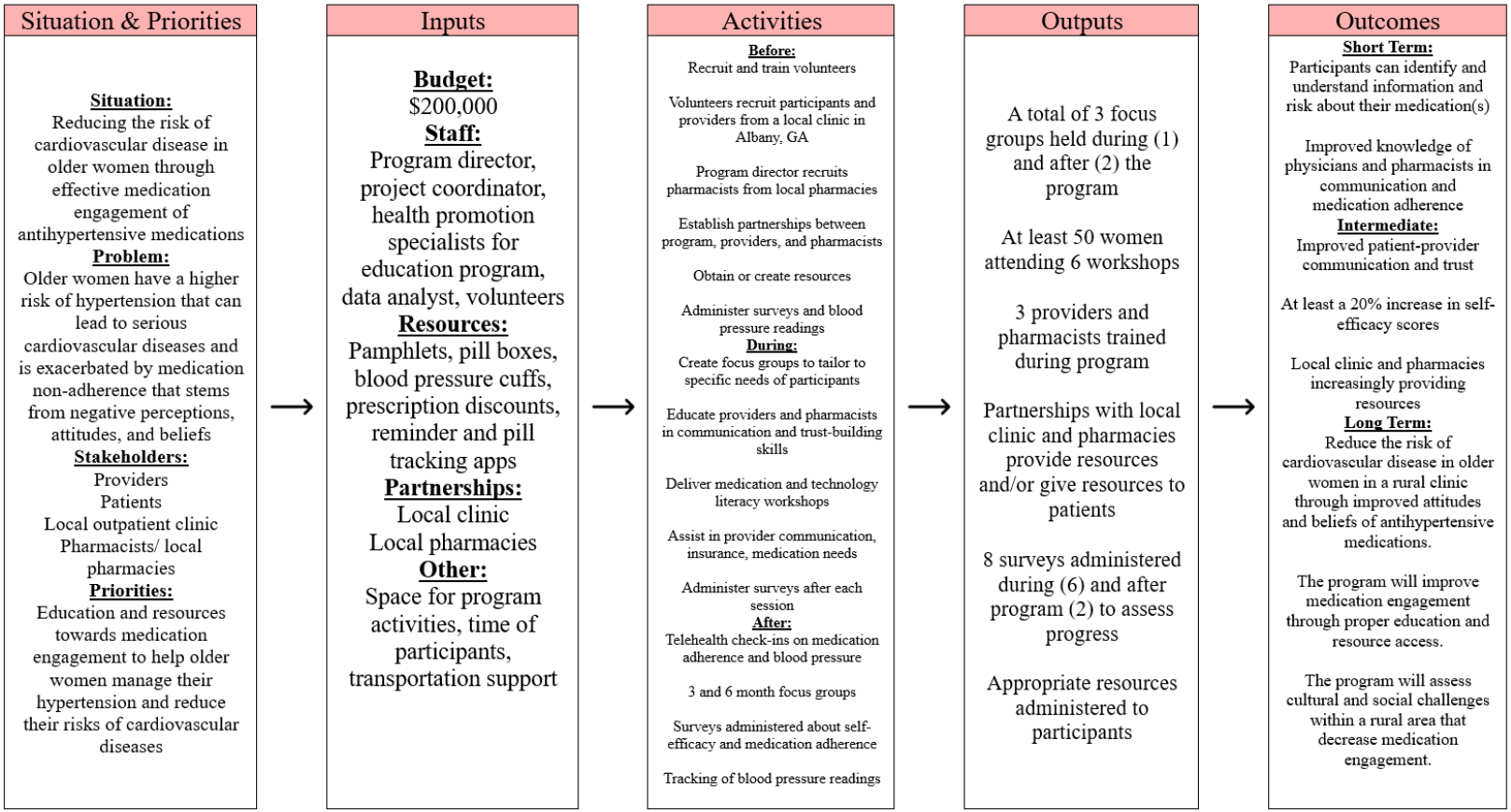
Through the application of the Heart Smart GA Project, this program aims to enhance the wellbeing of older women ages 65 and older by reducing their risk of cardiovascular disease through effective medication engagement. This program prioritizes accessible education and resources to empower individuals with hypertension to responsibly manage their health. Based in a rural clinic of Albany, Georgia, this program addresses systemic gaps in healthcare for a medically underserved and vulnerable population.

Program Goals & Objectives

1. The program aims to reduce the risk of cardiovascular disease in older women in a rural clinic through improved attitudes and beliefs of antihypertensive medications.
    - 1.1- Have at least a 20% increase in self-reported self-efficacy scores after weekly sessions over a six-week period.
    - 1.2- Patients will be able to identify 3 moderate side effects and 3 serious side effects from their antihypertensive medications.
    - 1.3- Have a 10mmHg decrease in systolic blood pressure for at least 3 months after the program ends through proper use of antihypertensive medication.
2. The program will improve medication engagement through proper education and resource access.
    - 2.1- Guide 3 physicians and 3 pharmacists in effective communication and trust-building skills to improve self-reported medication adherence of patients by 50%.
    - 2.2- Establish a variety of questions and comments that patients may use for effective communication about their hypertension care.
    - 2.3- Partner with a local pharmacy to validate and deliver educational resources to patients.
    - 2.4- Complete six weekly informational sessions over a six-week period that increases health literacy about hypertension in at least 50 participants.
    - 2.5- Train participants to use digital pillboxes, blood pressure monitors, and reminder apps to improve self-reported medication adherence by 50%.
3. The program will assess cultural and social challenges within a rural area that decrease medication engagement.
    - 3.1- Conduct focus groups with at least 50 rural older women to identify cultural beliefs and social norms that influence medication engagement

3.2- Guide 3 physicians and 3 pharmacists in appropriate cultural and social communication with patients.

Logic Model



Assumptions

- At least one clinic in Albany, GA will have a high prevalence of hypertension in older women
- Providers and pharmacists are willing to create a partnership, provider resources, and attend informational sessions for at least 2 years

External Factors

- Accessibility
- Technological changes/difficulties
- Cultural and social norms
- Time and availability of staff and participants

Needs Assessment

Hypertension is a highly prevalent disease in the United States, affecting around one-half of the entire population (Centers for Disease Control and Prevention, 2024). This trend is also seen to increase with age, as adults ages 60 and older have a higher rate of hypertension (71.6%) compared to ages 40-59 (52.5%) and ages 18-39 (23.4%). High blood pressure in older adults is most commonly due to nonmodifiable risk factors such as aging and gender, however women are seen to have a greater risk of high blood pressure at ages 65 and older and more specifically after menopause (American Heart Association, 2024; National Institute on Aging, 2022). While hypertension is often asymptomatic, it is also a risk factor for cardiovascular disease (CVD) such as heart disease that is the leading cause of mortality in the United States (Centers for Disease Control and Prevention, 2025b). Blood pressure, blood lipids, blood glucose, and body mass index (BMI) are the health factors that are monitored in CVD (Centers for Disease Control and Prevention, 2025b). There are many ways to reduce hypertension and CVD risks in older adults, such as with lifestyle changes, monitoring blood pressure, and managing other possible comorbidities, however using medications is often the most challenging task to reduce high blood pressure (Egan et al., 2024). Older adults are a more vulnerable population to medications based on limits to functionality and cognition, emphasizing the need for programs targeting this population, and specifically for women with higher hypertension risk (Egan et al., 2024).

Data from the 2021-2022 National Health Interview Survey finds that 88.6% of older adults took a prescription medication (Cohen & Mykyta, 2024). Additionally, from 2017-2020 more than four out of every ten older adults reported using five or more prescription medications, known as polypharmacy (Harris, 2024). With the abundant amount of older adults that take medications and engage in polypharmacy, this highlights the importance of managing medications in a vulnerable population. Medication engagement, or medication adherence is the ability of patients to manage and use medicines prescribed by a healthcare professional that has deemed that the potential benefits outweigh the risks (Aremu et al., 2022). Medication engagement has been shown to improve patient outcomes and have positive effects on overall wellbeing making this an important aspect of patient health (Aremu et al., 2022). However in aging adults, medication engagement becomes increasingly more difficult as this population deals with higher prevalence of chronic diseases, cognitive decline and functional limitations that require caution with medication usage (Centers for Disease Control and Prevention, 2025a). Alongside the physical and cognitive barriers of medication engagement, there are other challenges to attitudes and perceptions that must be addressed

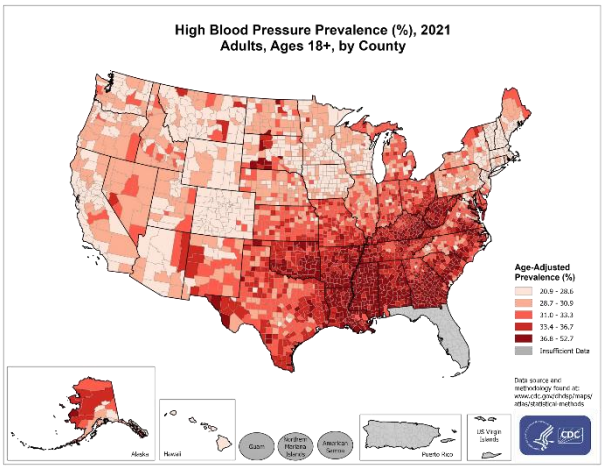
for older adults to see positive outcomes from their medications to improve their health and wellbeing.

For example, in a focus group from a rural community of older adults in Korea, researchers identified two types of nonadherences as intentional and unintentional. Intentional nonadherence involved the patient's knowledge, motivation, or beliefs about illness or treatment, while unintentional nonadherence related to demographic factors like age (Bae et al., 2020). Results showed that self-efficacy, the personal confidence in one's ability, was significantly related to medication adherence, with nonadherence groups having lower self-efficacy scores (Bae et al., 2020). In a secondary analysis of Cohort Study of Medication Adherence among Older Adults (CoSMO) data, researchers investigated factors associated with antihypertensive medication adherence in older adults and discovered that implicit attitudes had a significant correlation to adherence (Krousel-Wood et al., 2021). Implicit attitudes are those unconscious behaviors that are not explicitly rationalized and when in discordance with explicit attitudes, this lowers adherence to medication (Krousel-Wood et al., 2021). Beliefs and attitudes are especially important to consider in medication engagement because they are the basis for patients believing that they needs medications in order to improve their health. Specifically, within older women with hypertension this is essential to their care considering their elevated risk of hypertension and CVD events. Programs to promote self-efficacy and education of medication engagement may be useful for this population as they struggle with attitudes and beliefs that may in turn reflect to poorer health.

Older adults may also face barriers to medication engagement due to physician-patient interactions and relationships that construe their beliefs of medication needs. In a 2007 Medicare Current Beneficiary Survey study of older adults' perceptions of their physicians, researchers measured the perceptions of physicians with a scoring system in which a score of 37 or higher represented favorable perceptions. Results concluded that those patients with higher scores above 37 were likely to be adherent to their antihypertensive medication than those with a lower score, or less favorable perceptions (Ward & ThomasIii, 2018). A similar study on provider-patient dynamics, included 434 participants from rural Alabama and concluded that around 70% of participants felt uncomfortable asking questions and more than 20% found appointments to be stressful (Martin et al., 2010). This highlights a need for changes in communication needs of patients and physicians' execution of information. Perceptions are another important aspect of medication engagement because older adults must feel validation and trust from providers in order to reap the benefits of taking medications to improve their health. Overall, these relationships are important to build and mend with older adults as their perceptions of physicians and their medication

adherence are directly related to health outcomes. Programs for physicians and older patients may be beneficial as education, relationship building, and communication skills are vital to efficient medication engagement.

These specific perceptions and attitudes may be reflected in more vulnerable populations, specifically those places that are medically underserved and rural such as Albany, Georgia. In a broad sense, rural communities experience many health disparities such as higher incidence disease, mortality, and lower life expectancies (RHIHub, 2024). These areas may also deal with higher health risk behaviors and comorbidities along with lower socioeconomic status, and limited access to healthcare (RHIHub, 2024). Many social determinants of health such as income, education, health literacy, and the environment play a role in the ability of people to access care and can ultimately influence their medication engagement (RHIHub, 2024). Additionally, a medically underserved area (MUA) is considered to have a shortage of healthcare services and lacks access to primary care (HPSA). In the context of hypertension, rural areas of Georgia have a 44% prevalence while urban areas have a 35% prevalence, highlighting a discrepancy that lies within rural communities that must be addressed (Kuehn, 2020). In this case, there is a need for care within rural areas as the hypertension rates are higher, which can explain lower life expectancies and premature deaths. See Figure 1 for a visual representation of hypertension rates in rural Georgia compared to the rest of the country (Centers for Disease Control and Prevention, 2025a). Along with social determinants of health, access to resources, and high mortality rates, rural areas may differ from other areas in their culture.



A study examining medication adherence and systolic blood pressure in the rural southeast investigated the impact of social standing on adherence in primary care clinics. (Cummings et al., 2016) Researchers defined social standing as the perceived position in the community's social hierarchy and measured this along with socioeconomic variables. Of the 495 African American and white participants, 40% were nonadherent to their medications, this consequently being correlated to a lower perceived social standing. Even more, researchers identified perceived social standing to be more indicative of medication adherence, highlighting the importance of understanding social and cultural aspects of rural areas (Cummings et al., 2016). While rural areas face many challenges, there is potential for

these communities to improve their medication engagement when focusing on perceptions and attitudes. With programs that target education, self-efficacy, and resources, there can be adequate solutions for rural areas to improve hypertension and medication engagement.

Overall, there is a need for improvements to lower hypertension in older women, who are seen to have a higher risk due to nonmodifiable risk factors such as age, gender, and biological hormones. Many hypertension risks can be alleviated by lifestyle changes, but often medications are the solution to challenging diseases, however medications are difficult to prescribe for older populations due to their limited functional and cognitive abilities. This makes it important to stress the significance of efficient medication engagement. Since the prevalence of hypertension is higher in rural areas, the targeted population for these interventions will take place in a medically underserved, rural community that may lack the education, resources, and skills to improve their medication adherence and ultimately lower hypertension rates.

Theory of Behavior Change

The Information-Motivation-Behavior Skills IMB) Model was first introduced in a study attempting to understand the psychological determinants of HIV risk and preventative behavior (Fisher et al., 2003). The model consists of three comprehensive concepts, including information, motivation, and behavioral skills that are related to a behavior change (Fisher et al., 2003). The overall goal of the IMB model is to ensure that individuals are well-informed, motivated to act, and have the behavioral skills to carry out a behavior change that has a positive impact on health outcomes (Fisher et al., 2003). However, a lack of information, motivation, and behavioral skills contrasts with these outcomes, as individuals are more likely to engage in health risk behaviors and have negative health outcomes (Fisher et al., 2003). For the Smart Heart GA Project, the IMB model can be used to assess medication adherence in older women with hypertension in rural Georgia. This community most likely lacks essential information, has negative attitudes, perceptions and motivation, as well as little to no healthy medication adherence skills that exacerbate their hypertension and CVD risks. Incorporating adequate information, motivation, and behavioral skills into this program is relevant to reducing hypertension and CVD risks through consistent and appropriate medication engagement.

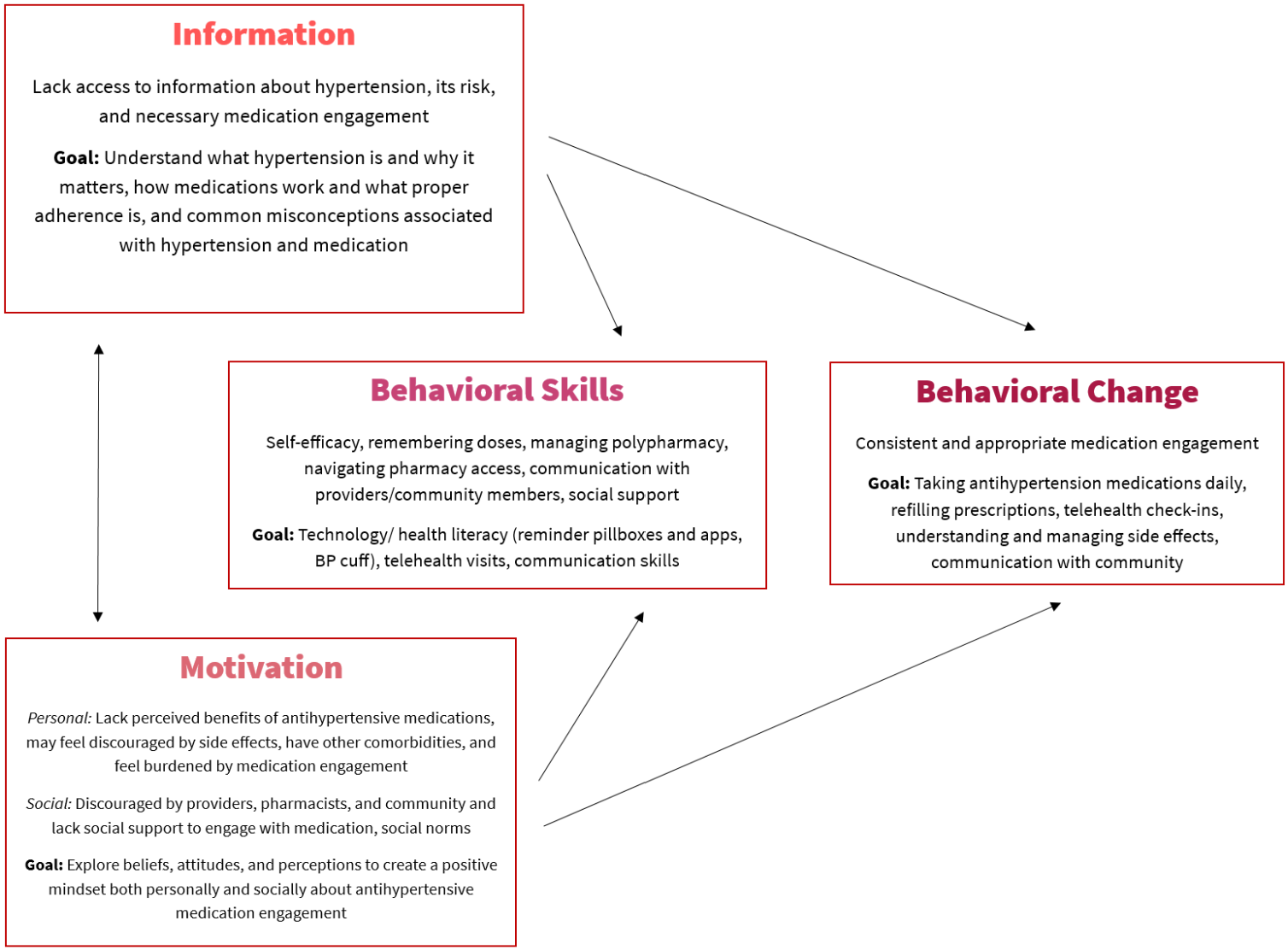
In the IMB model, information is a key determinant of health behaviors when it is directly relevant within an individual's social context. Information can take the form of specific facts, simple heuristics, or complex implicit theories, with each influencing decisions about health behaviors (Fisher et al., 2003). In the context of the Heart Smart GA Project, older women may lack access or have misconceptions about hypertension, its risks, and how to correctly engage with their antihypertensive medication. For individuals to appropriately manage their hypertension with medication, they must be given correct and simple information that addresses their misconceptions and concerns.

Motivation is referred to as an additional key factor that determines whether an individual will perform a health-related behavior with consideration of their knowledge about the health topic. This determinant is defined by personal motivation and social motivation. Personal motivation refers to an individual's own attitudes and beliefs about the behavior while social motivation involves the support and encouragement of received from others (Fisher et al., 2003). Through the Heart Smart GA Project, older women may lack motivation due to their personal perceptions about antihypertensive medications while socially, they may be discouraged through providers, pharmacists, and social norms.

Behavioral skills are the third key role that influence an individual's success in health behaviors. These skills can range from their actual abilities to self-efficacy, and the resources

that they may use to their advantage. For the current project, older women may lack self-efficacy, management of their medications and potential comorbidities, communication skills, and physical resources that may help them to have appropriate and consistent medication engagement.

Figure of Information-Motivation-Behavior Skills Model



Description of Program

The Smart Heart GA Project is aimed to lower hypertension and CVD risks in older women of a rural clinic in Albany, Georgia through consistent and appropriate medication engagement. The program's components, activities, and development are based on the Information-Motivation-Behavioral Skills Model. The model has been deemed successful in a similar population and with a similar health problem about medication adherence for multimorbidity in older people from community health centers in Changsha, China (Yang et al., 2023). The 254 participants completed surveys on their perceptions and beliefs of medications, social support, treatment, self-efficacy, and personal and social motivation. Through several data analysis techniques to determine extended models and model fit, researchers found that 52% of the variance in medication adherence could be explained through the IMB model. Results identified information, social motivation, and personal motivation to have a significant effect on behavioral skills related to medication adherence. While information and social motivation where not directly linked to adherence, they indirectly affected adherence through behavioral skills, highlighting the importance of each component within the model (Yang et al., 2023).

The Smart Heart GA Project aims to have around 50 older women recruited through a rural clinic in Albany, GA. The program will take place in-person, with a combination of individual, small group, and classroom activities based on the learning objectives specified for the session. The projected time needed to recruit and train volunteers, establish partnerships, and recruit participants for the program is about 6 months. The program itself will take place once a week for 6 weeks after participants are given a baseline assessment of their current knowledge, motivations, and behavioral skills to properly curate the program towards participants.

Activities included within the program involve educational sessions that are around 3-4 hours long and are focused on changing or correcting information, motivation, and behavioral skills that hinder appropriate health related behaviors relevant to medication engagement. Session activities range from lecture-based informational sessions, practicing self-readings of blood pressure, ensuring adequate technology literacy and practice for messaging and reminder apps, and focus groups with participants, providers/pharmacists, and family to promote social support. There will also be partnerships with a local pharmacy and local clinic to distribute resources and providers will be encouraged to attend sessions to develop behavioral skills.

A program coordinator is required to oversee the program planning process, ensure set goals are met, and develop and initiate the program timeline as well as train volunteers. A health promotion educator is required to lead information sessions, focus groups, and address individual concerns. Volunteers are needed to ensure that participants are recruited for the program by administering surveys as well as for setting up sessions with supplies (snacks, beverages, resources) and cleaning up after sessions end. Before, during and after the program, data analysis specialists are needed to monitor progress, evaluate assessments and outcomes and suggest program improvements.

Curriculum Table

Session	Module	IMB Focus	Learning Objectives	Activities
1	Understanding Hypertension (3 hours)	Information	• Define hypertension • Describe modifiable and non-modifiable risk factors for hypertension and their management • Explain risks and complications of hypertension	• Welcome activities with health promotion educator and participants • Presentation from health promotion educator • Initial BP cuff reading and assessment of medication engagement with informational pamphlet pass out
2	Why Medication Matters (3 hours)	Information and Motivation	• Describe antihypertensive medication side effects and mitigation techniques • Address medication and hypertension outcomes • Educate on misconceptions and fears	• Misconception myth buster quiz • Presentation from health promotion educator • Q&A session about misconceptions and fears
3	Building Motivation and Support (4 hours)	Motivation	• Explore personal beliefs, attitudes, and perceptions • Identify social support • Build communication and trust-building skills in providers, pharmacists, and participant	• Focus groups with participants • Focus groups with pharmacists and physicians • Family involvement lunch • Mock appointments
4	Medication Management Skills (3-4 hours)	Behavioral Skills	• Practice using electronic pillboxes, reminder apps, and BP cuff • Create a routine guide • Develop polypharmacy management skills	• Hands on training and practice • Create reminder planner • Individual-focused aid on polypharmacy
5	Navigating Access and Resources (3 hours)	Behavioral Skills	• Understand pharmacy insurance • Locate and map transportation to local pharmacy and discuss delivery options • Deliver pharmacy discounts, electronic pillboxes, refill reminders	• Presentation from local pharmacy about refills and delivery • Hand out pharmacy discounts (incentive for program)
6	Staying on Track (2-3 hours)	Information, Motivation, and Behavioral Skills	• Troubleshoot barriers • Reinforce commitment • Review progress	• Set up telehealth appointments • Set up follow-up appointments • Post-program assessment survey

Implementation Plan

In year one before the program begins, from January to April, staff will be hired, and data will be obtained from local clinics to assess the prevalence of hypertension in older women. The clinic with the highest prevalence will be targeted for the intervention. Once volunteers are hired and trained, they will go to the local clinic and recruit qualified patients to be a part of the program. While participants are recruited, partnerships will be acquired with the targeted clinic and its providers as well as a local pharmacy and its pharmacists. This partnership will aid in resources (pamphlets, pill boxes, prescription discounts) that are to be distributed during the program.

Around May and/or when at least 50 participants are enrolled in the program and the resources are acquired, Session 1 will take place where participants are welcomed, given a program session outline, and the first learning objectives are addressed through a presentation by the health promotion educator about hypertension (information). An initial survey will be administered at this session to assess initial information, motivation, and behavioral skills as well as a blood pressure reading, and data analysts will aid in describing this data. The next week, Session 2 will focus on the importance of medication and medication adherence (information and motivation). The session will start with participants engaging in a myth-buster quiz and then given an informational session over the quiz, followed by a Q&A session for any remaining questions.

Session 3 is focused on motivation and building support (motivation). Within this session, participants will be asked to bring a caregiver or family member. This session, providers and pharmacists will be asked to participate in focus groups with participants and family members to engage in communication and trust-building skills. Focus groups will offer time for hearing experiences and struggles, asking questions, and engaging with local partnerships to build community.

Session 4 will focus on behavioral skills, specifically practicing technology literacy such as with messaging and reminder apps, electronic pill boxes, and self-reading blood pressure measurements. This session will also give time for individual participants to address concerns with managing polypharmacy and/or comorbidities. Session 5 is also aimed at behavioral skills, specifically targeting navigation of insurance, transportation, and resources. This session will also allow participants to hear from their local pharmacists about how to navigate prescriptions (refills and deliveries). Prescription discounts will also be distributed to participants as an incentive for joining program and staying through the end.

Week 6 will conclude the program with Session 6 where information, motivation, and behavioral skills will be targeted through participants staying on track with their medication engagement and hypertension risks. At this session, participants will be able to set up telehealth appointments with the health promotion educator and/or provider. This will also be a time to set up follow up appointments with their provider. A post-assessment survey will also be conducted.

After the program ends, in September (3 months) and December (6 months) focus groups will be held in-person with program participants to assess their progress, concerns, and questions. At these focus groups, participants will hand in blood pressure reading sheets, as well as given any resources that they may need replenished. Surveys will also be administered to assess current information, motivation, and behavioral skills.

The next year of the program will be comprised of telehealth appointments, focus groups, and data collection and analysis of surveys to assess progress of the program and participants.

Program Evaluation

Table 1: Evaluation Data Collection Overview				
Indicators/Variables	Source	Collection Overview		
		Staff	Time Period	Methods
Formative Evaluation				
Physician training quality and medication treatment rates, hypertension prevalence, pre-intervention survey, pharmacist knowledge of adherence barriers	Needs assessment	Program Director and program coordinator	January-April	Surveys, clinical records, and interviews
Stakeholder feedback on materials/tools	Interview	Program coordinator	January-April	Interview
Baseline BP, pre-intervention survey of participants	Patient survey & BP monitor	Volunteers	January-April	Survey and BP measurement
Process Evaluation				
Attendance	Sign-in sheet	Volunteers	May	Attendance tracking
Incentive uptake	Program logs	Program coordinator	May	Incentive tracking
Fidelity to IMB Model	Weekly surveys	Program coordinator	May	Survey administration
After session feedback	Open-ended survey responses	Program coordinator	May	Qualitative feedback
Participant engagement with technology	App usage logs	Data analyst	Session 4	App data analysis
Focus group insights (participants)	Focus group transcripts	Health promotion educator/counselor	Session 3	Facilitated focus groups
Focus group insights (providers)	Focus group transcripts	Health promotion educator/counselor	Session 3	Facilitated focus groups
Summative Evaluation				
Changes in knowledge, attitudes, beliefs, and self-efficacy	Pre/post survey	Data analyst	Post program (3 & 6 months)	Survey comparison from before, during and after program
Participants reflections on program	Focus group transcripts	Health promotion educator/counselor	Post program (3 & 6 months)	BP comparison pre- and post-intervention
Change in systolic BP	BP log tracker	Data analyst	Post program (3 & 6 months)	Self-reported tracking
Medication adherence	Surveys and app data	Data analyst	Post program (3 & 6 months)	Self-reported adherence and data analysis from reminder app
Cultural/social barriers	Focus group transcripts	Data analyst	Post program (3 & 6 months)	Qualitative analysis

The Smart Heart Project is a program designed to increase effective medication engagement by prioritizing education and access to resources that ultimately lower cardiovascular (CVD) risks of older women in rural, medically underserved Albany, GA. The goal of this evaluation is to assess the effectiveness of the program as it relates to increased medication adherence and lowered blood pressure readings. The program coordinator and health promotion educator will be in charge of conducting focus groups during and after the program. They will also be responsible for distributing questionnaires before, during, and after the program. The data analyst will be responsible for transcribing data from focus groups and entering all results and data from questionnaires. The data analyst and program director will work together to conduct the final program evaluation and disseminate results to the community.

Formative evaluation will be conducted before the program begins to improve the quality of the program and its components in terms of development and implementation. Process evaluation will take place each week of the 6-week program to measure the fidelity of implementation as it occurs. Summative evaluation will be done after the program ends to assess the effectiveness of the program, describing both impact evaluation, or short term goals, and outcome evaluation, or long term goals.

Formative Evaluation Plan

The formative evaluation will take place during the preparatory stages of the program. The evaluation will include a needs assessment, where the chosen clinic's physicians will be asked several questions about their diagnosis and treatment of hypertension, specifically in older women and this will be used to assess the quality of physician training. There will also be an assessment of the prevalence of hypertension within the clinic and associated amount of antihypertensive medication treatment. Older women with hypertension being treated at clinic will also be surveyed on their health literacy levels, technology literacy and access, self-efficacy, and general medication adherence. Pharmacists from a local pharmacy will also be surveyed to assess their knowledge and understanding of medication adherence in older women with hypertension. Previous research has indicates that respectful and amiable interpersonal communication increases medication adherence while stress and discomfort provides an interference to care so the quality of communication from providers will be evaluated before and after the program (Hong, 2019; Martin et al., 2010). The needs assessment will identify barriers in physicians, pharmacists, and patients that prevents effective medication engagement.

The formative evaluation will also include a partnership and feedback from stakeholders, such as physicians and pharmacists about the educational materials and tools

that will be used in the program to ensure that the program's components are feasible (Objective 2.3). Once completed and confirmed with stakeholders, volunteers will begin to assess eligibility of patients within the clinic and those that are willing and able to participate will have their baseline measurements taken for blood pressure as well as the same survey as mentioned before. This baseline data will be useful for the summative assessment of the program to compare results.

Process Evaluation Plan

Process evaluation takes place from the start of the six-week program and lasts through the duration of the program. Through process evaluation, this allows all of the staff to understand the current strengths and weaknesses of the program and how they may be improved. An important aspect of the program's effectiveness is participant attendance. Once enrolled into the program, participants are given the incentive of prescription discount cards if they attend all six meetings during the six-week period. Additionally, the program will come at no expense to participants, and they will receive all resources for free and will be allowed to keep them. Attendance is also incentivized by transportation, in that participants will be given free bus rides to and from the program if needed. With all of these factors combined, attendance will be evaluated to ensure that these components are worthy of consideration and have actual effects on attendance (Objective 2.4). However, if a participant must skip a class, they forfeit their right to incentives, unless there is a case of an emergency.

The program's framework is based on the Information-Motivation-Behavior Skills Model, and it is important that the fidelity of this model is assessed throughout the program. Many activities and educational components of the program are targeted at each component of the model, and it is important that results of each session and its learning objectives are measured based on effectiveness. To do this, the same survey that participants were given before the study to measure knowledge, attitudes, and beliefs will be administered each week. There will also be additional open-ended responses for any unique feedback on the session or overall program. Ideally, the survey's responses would more strongly correlate to the goals of the IMB Model each week as participants become more engaged. The survey allows participants to actively recall previous sessions and the current session they attend, which can help to strengthen the fidelity of the program and model.

Focus groups are a form of qualitative data that can be useful to understand participants outside of surveys and measurements. For the purposes of this program, focus groups are a time to foster support and motivation (Objective 3.1). The goal of these focus groups are to explore personal beliefs and attitudes while also creating social support, and when combined with health education, focus groups built on motivation have been shown to improve

medication adherence (Kolcu & Ergun, 2020). Participants will also have a session dedicated to working with technology, such as pillboxes and digital health reminder apps that have been shown to significantly improve medication adherence in other programs (Kolcu & Ergun, 2020; Moorhead et al., 2017). Through reminder apps, participants will be able to monitor their medication adherence through tracking missed or late doses (Objective 2.5). This information will be sent to the data analyst to evaluate medication adherence during and after the program. Additionally, participants will be taught how to use digital blood pressure monitors and will be able to track their blood pressure during and after the program that will be used to monitor progress for evaluation. During one session, focus groups will be conducted with physicians and pharmacists to hear from participants as well as to give them feedback on communication and trust-building skills (Objective 2.1 & 3.2).

Summative Evaluation Plan

Summative evaluation takes place after the program has ended and allows for overall analysis of the program. There is two kinds of summative evaluation, including impact evaluation that focuses on short-term goals related to attitudes, beliefs, and perceptions, as well as outcome evaluation that focuses on long-term goals, such as health and quality of life outcomes.

Impact Evaluation

As previously described, the program is derived from the IMB Model. In this program, participants will be able to understand hypertension, medication adherence, CVD risks, and common misconceptions that relate to medications. This goal allows participants to have better education about medication engagement and management of their hypertension to ultimately lead to consistent and appropriate medication engagement (Objective 1.2 & 2.2). The program also targets motivation, by exploring and changing the beliefs, attitudes, and perceptions of participants to create a positive mindset personally and socially about their medication engagement. Last, the program aims to change behavior skills such as self-efficacy, technology literacy, and communication skills that lead to the desired behavior change (Objective 1.1). A similar program evaluation found that compared to a control group and groups that only have education, having education combined with technology aid can effectively enhance medication adherence in older adults with hypertension (Solmaz & Altay, 2024). To evaluate that self-efficacy, attitudes, beliefs, perceptions, and behavioral skills have adequately changed, the program will analyze post-intervention surveys that mirror the pre-intervention surveys. Additionally, the health promotion educator and counselor will hold focus groups at 3 and 6 months post-intervention where participants can share any thoughts and feelings that have changed or stayed the same.

Outcome Evaluation

Before the start of the program, participants' baseline health measurements were recorded, and outcome evaluation is the point at which these results will be compared and interpreted in terms of effectiveness of the program. The primary goal of the program is to reduce the risk of cardiovascular disease in older women in a rural clinic through improved attitudes and beliefs of antihypertensive medications. Through these improved attitudes and beliefs, participants will ultimately have decreases in their systolic blood pressure (Objective 1.3). Blood pressure measurements are to be documented and submitted by participants to staff members at their follow-up focus group meetings.

Marketing Plan

Inclusion and Exclusion Criteria

To be considered for this program, participants must be women that are 65 years of age or older. They must also be experiencing hypertension (140/90 mmHg) and have low score for self-reported medication engagement. They must also be a patient within the specified clinic in Albany, GA. The exclusion criteria includes women over 65 years of age that are self-reportedly taking their medications for hypertension or have controlled hypertension (120/80 mmHg).

Recruitment

The program plans to have a maximum of 50 participants recruited for intervention. The program has allotted $8,000 for recruitment incentives in the budget. With this money, participants will be given discount cards to use for prescriptions at the local pharmacy that the program has partnered with. Since uncovered antihypertensive medications can cost over $300, the goal for this incentive is for participants to receive up to a 50% deduction in the prescription. Another $500 has been allotted for marketing and printing purposes. The program will not be marketed to the public but instead will be marketed towards those participants that qualify for the program once they have completed the questionnaire that volunteers will administer throughout the clinic. The program director and coordinator will ensure the production of pamphlets and volunteers will be tasked with handing out those pamphlets to qualifying participants. The marketing within the pamphlet will help qualifying participants to understand the goals of the program, the incentives, and proposed health outcomes from participating. Physicians can also recommend patients that qualify for the study. Since physicians have adequate access to patient health records, they can more effectively refer patients to the program. If patients are referred by their physician, volunteers can then administer the questionnaire and distribute pamphlets.

Retaining the Population

Retaining the population involves keeping members actively involved in the program, participating in all six sessions, and attending in 3 and 6 month follow-up meetings. The six sessions included in the program will be mandatory in order to receive the incentive of prescription discounts. If participants cannot attend a session, they must submit a reasonable excuse to be considered to keep the incentive. If a participant cannot attend all six sessions with a valid excuse, they will not be considered for the prescription discount. If a participant wishes to discontinue the program, they must inform the program coordinator and will receive a survey for their feedback on the program and why they chose to discontinue the

program. The 3 and 6 month follow-up sessions will not be mandatory, as participants will have already received their incentives, however there will be an option to do an in-person focus group or individual telehealth meeting with the counselor and health education specialist. Participants will be asked to track their medication adherence and blood pressure readings, so it is encouraged to attend the sessions for social support and data evaluation. Participants will also be given the option to receive free transportation to the program and from the program, and this incentive should encourage individuals to attend even with extenuating circumstances.

Special Considerations

Participants will receive an informed consent form before the intervention begins in order to gain their complete approval and understanding of the program. Participants will also sign a waiver to inform them of transportation risk and liability concerns, as well as information about where they live so that transportation can have an accurate route. They will also be given a form to sign for tracking and collection of their health information, including their blood pressure and medication tracking that will be used for data evaluation.

Budget Spreadsheet

Personnel	Salary		% effort	Calendar Months	Year 1	Year 2	Total
Project coordinator	50,000		25%	3.0	12,500	12,875	25,375
	benefits @	40%			5,000	5,150	10,150
Health Promotion Educator	45,000		25%	3.0	11,250	11,588	22,838
	benefits @	40%			4,500	4,635	9,135
Counselor	40,000		20%	2.4	8,000	8,240	16,240
	benefits @	40%			3,200	3,296	6,496
Data Analyst	55,000		10%	1.2	5,500	5,665	11,165
	benefits @	40%			2,200	2,266	4,466
Project Director	55,000		10%	1.2	5,500	5,665	11,165
	benefits @	40%			2,200	2,266	4,466
				0.0	-	-	-
	benefits @				-	-	-
Total Personnel					**59,850**	**61,646**	**121,496**
Equipment					**3,000**	**-**	**3,000**
Bus					3,000		
Travel					**1,000**	**-**	**1,000**
Foreign							
Domestic							
Gas for bus					1000		
Supplies					**15,000**	**-**	**15,000**
BP Monitors (50)					2,500		
Electronic pillboxes (50)					4,000		
Reminder calendars/printing (50)					500		
Prescription discounts (50)					8,000		
Other Expenses						**6,950**	**6,950**
Rent						3000	
Bus driver						450	
Volunteer training space						1500	
Snacks and beverages						2000	
Total Direct Costs					**78,850**	**68,596**	**147,446**
Indirect Costs @	33%				26,021	22,637	48,657
Total Costs					**104,871**	**91,232**	**196,103**

Budget Justification

Personnel

Max Mayfield, MPH Project Director – 1.2 calendar months (10% effort) in Years 1-2

Mrs. Mayfield has a Master's Degree in Public Health. Mrs. Mayfield has over five years of experience working to fill gaps in health education for older adults within rural areas of southern Georgia. Mrs. Mayfield has led two health promotion programs in rural Georgia focused on management of noncommunicable diseases in older adults. During her time orchestrating programs, Mrs. Mayfield has successfully connected with local community members, physicians, and policymakers.

Through her previous accomplishments of planning, implementing, and evaluating programs along with forming meaningful connections with community members, Mrs. Mayfield has the qualifications and expertise to lead the proposed project.

Mrs. Mayfield will perform the following duties on the proposed project:

- Year 1: Mrs. Mayfield will connect with physicians at a local clinic and pharmacists at a local pharmacy to promote the project and request resources and their active participation in the program. She will purchase blood pressure monitors and electronic pillboxes and will work with Mr. Harrington to compose tracking sheets for data collection. Mrs. Mayfield will also collaborate with Mr. Harrington to develop and administer questionnaires to eligible participants as well as providing training in data collection and management for the evaluation process. Mrs. Mayfield will train Mr. Byers to supervise Mrs. Buckley, Mr. Henderson, and volunteers for proper implementation of the program. She will also work with Mr. Byers to distribute resources, pamphlets, and tracking sheets. Mrs. Mayfield will also obtain IRB approval for evaluation activities.
- Year 2: Mrs. Mayfield will continue to supervise the team, connect with local partnerships to replenish any needed resources, and ensure that focus groups are taking place during program evaluation. She will continue to work with Mr. Harrington in collecting and management data for project evaluation as well as beginning to prepare results for dissemination.

Jonathan Byers, Name: MPH, Project Coordinator – 3 calendar months (25% effort) in Years 1-2

Mr. Byers has a Master's degree in Public Health with a focus in the health and wellbeing of older adults with disabilities. He has specifically worked on projects targeting the physical

and mental health of older persons with disabilities to implement healthy behaviors and social support. As Project Coordinator, Mr. Byers will be responsible for overseeing the week-to-week program activities, ensuring learning objectives are met, and creating criteria for eligible participants to engage in the program. Mr. Byers will also supervise the health promotion educator, counselor, and volunteers throughout implementation of the program.

Mr. Byers will carry out the following duties on the proposed project:

- Year 1: Mr. Byers will work with Mrs. Mayfield to implement the health promotion program, supervise Mrs. Buckley and Mr. Henderson, and oversee the week-to-week activities of the program. He will hire and train volunteers to recruit participants and work during the sessions. Mr. Byers will conduct data checks to ensure that data is collected and managed as planned. He will also advise focus groups and telehealth appointments are properly upheld by Mrs. Buckley and Mr. Henderson. Mr. Byers will be responsible for resource distribution, transportation for participants, and will engage in weekly sessions to ensure proper implementation.
- Year 2: Mr. Byers will work with Mrs. Buckley and Mr. Henderson to ensure that post-program focus groups and telehealth appointments are held and data collection is taking place for project evaluation. He will work with Mr. Harrington and Mrs. Mayfield in analysis of the evaluation data and work to disseminate results.

Robin Buckley, MPH Health Promotion Educator – 3 calendar months (25% effort) in Years 1-2

Mrs. Buckley has a Master's in Public Health and is a certified health promotion specialist with a concentration in the medication engagement of rural older adults with comorbidities. Mrs. Buckley has three years of experience within rural South Georgia, collaborating with physicians, pharmacists, and community council members. Mrs. Buckley has been trained in leading focus groups and has extensive knowledge of common noncommunicable diseases including diabetes and cardiovascular diseases. She also has certification in digital literacy.

Robin Buckley will carry out the following duties on the proposed project:

- Year 1: Mrs. Buckley will complete training on project procedure and intervention delivery and assist in training volunteers and recruiting participants. She will primarily be responsible for educational sessions throughout the program sessions specifically focusing on information, motivation, and behavioral skills. In addition, she will assist in digital literacy, focus groups with Mr. Henderson, and ensure proper data collection.

- Year 2: Mrs. Buckley will continue to work with Mr. Henderson to hold focus groups and telehealth appointments post-program. During this time, Mrs. Buckley will ensure proper data collection.

Dustin Henderson, M.Ed. Counselor – 2.4 calendar months (20% effort) in Years 1-2

Mr. Henderson has a Master's in Education and experience working in health education for older adults. He has received training in conducting and collecting data from focus groups. Mr. Henderson will serve as a counselor and lead focus groups through the program and during the evaluation process. He will schedule focus groups, telehealth appointments, and assist in recruiting eligible participants.

Mr. Henderson will carry out the following duties on the proposed project:

- Year 1: Mr. Henderson will complete training on project procedure and intervention delivery and will assist in focus groups during the program to ensure proper health education. He will primarily work with Mrs. Buckley to hold focus groups during program sessions and ensure proper data collection.
- Year 2: Mr. Henderson will continue to collaborate with Mrs. Buckley to hold focus groups and telehealth appointments post-program. During this time, he will also ensure proper data collection for evaluation.

Steve Harrington, MPH Data Analyst – 1.2 calendar months (10% effort) in Years 1-2

Mr. Harrington has a Master's degree in Public Health with a focus in Biostatistics. He has worked on multiple health promotion programs within rural South Georgia and is familiar with data evaluation in these communities. Mr. Harrington will serve as the data analyst on this project and will assist in the creation and implementation of questionnaires, tracking sheets, and focus group data. He will monitor the progress of the program, as well as evaluate assessments and outcomes to suggest program improvements and successes.

Mr. Harrington will carry out the following duties on the proposed project:

- Year 1: Mr. Harrington will assist Mrs. Mayfield and Mr. Byers in creation of project databases, preparing material for IRB, and developing questionnaires and tracking sheets. He will assist the entire program with data management and conducting data checks.
- Year 2: Mr. Harrington will lead the team in data collection and management for program evaluation. He will also assist in disseminating results, outcomes, and improvements.

Equipment & Supplies

Prescription discounts ($8,000, Year 1)

- We request $8,000 to cover the costs of prescription discounts for antihypertensive medications for 50 participants. The goal is for uncovered prescriptions to be deducted at least 50% off. These funds ensure that participants are able to pay for a duration of their prescription for proper medication adherence.

Electronic pillboxes ($4,000, Year 1)

- We request up to $4,000 to cover the cost of 50 electronic pillboxes, each at an approximate price of $80. Electronic pillboxes are necessary to ensure efficient tracking of medication adherence, allowing individuals to be alerted with a noise at specific times to take medications. Participants will be given proper training and practices with the technology before using it at home. Participants will also be allowed to monitor their medication adherence for the next year of the program which will be recorded and entered into data analysis for program evaluation.

Charter bus ($3,000, Year 1)

- We request a charter bus that can fit up to 50 people and transport them once a week for six weeks to and from program meetings. The charter bus will be used for up to 3 hours maximum per week with a route to multiple designated meeting areas for members, to the program session, and back to the meeting areas. The average hourly cost for a charter bus is around $150 for a total cost of $3,000 in Year 1.

Digital blood pressure monitor ($2,500, Year 1)

- We request funds of up to $2,500 to cover the cost of digital blood pressure monitors for all 50 participants. The individual cost of a digital blood pressure monitor is approximately $50 each. Participants will be given proper training and practice with machines before self-monitoring blood pressure at home. Participants will also be allowed to monitor their blood pressure for the next year of the program which will be recorded and entered into data analysis for program evaluation.

Printing costs ($500, Year 1)

- We request $500 to cover the costs of printing reminder calendars, informational pamphlets, tracking sheets, etc. Printed items will be distributed to participants for the duration of the program for tracking and information purposes.

Other Expenses

Rent ($3,000 each year, Year 1-2)

- The estimated cost of a rented space once a week for the six weeks is $3,000. The space will be at a centralized location in Albany, GA for staff, volunteers, and participants to conveniently reach either by walking, driving, or utilizing the charter bus.

Bus driver ($500, Year 1)

- A bus driver is necessary to facilitate transportation of participants to and from the program once a week for six weeks. The bus driver will drive three hours maximum at an hourly rate of $25, totaling $450.

Training space for volunteers ($1,500, Year 1)

- A rented space is required to hold two training sessions for volunteers to learn data collection, communication with eligible participants, HIPPA training, and week-to-week tasks.

Snacks/beverages ($2,000, Year 1)

- We request funds to provide light snacks and beverages for participants and staff for six weekly meetings. One session invites physicians, pharmacists, and family members to join in which funds are requested to cover the costs of a large quantity of food for 50 or more people.

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