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Hypertension Self-Management Perspectives from African American Older Adults

Karen O. Moss, PhD, RN, CNL [Post-Doctoral Fellow],

Frances Payne Bolton School of Nursing, Case Western Reserve University, 2120 Cornell Road, Cleveland, OH 44106-4904

Carolyn H. Still, PhD, MSM, AGPCNP-BC, CCRP [Assistant Professor],

Frances Payne Bolton School of Nursing, Case Western Reserve University, 2120 Cornell Road, Cleveland, OH 44106-4904

Lenette M. Jones, PhD, RN, ACNS-BC [Assistant Professor],

University of Michigan School of Nursing, Department of Health Behavior and Biological Sciences, 400 N. Ingalls, Room 2180, Ann Arbor, MI 48109

Gabrielle Blackshire [Undergraduate Student], and

College of Arts and Sciences, Case Western Reserve University, 10900 Euclid Avenue, Cleveland, OH 44106-4904

Kathy D. Wright, PhD, RN, GCNS-BC, PMHCNS-BC [Assistant Professor]

Chief Diversity Officer College of Nursing, Discovery Theme-Chronic Brain Injury, The Ohio State University, 585 Neil Avenue, Columbus, OH 43210

Abstract

African Americans are disproportionately impacted by hypertension, suffering earlier onset and greater severity of the disease, and premature cardiovascular mortality, than the general population. Managing hypertension is an unending concern for African American older adults. A better understanding of the self-management preferences of this vulnerable population will lead to the enhanced design of culturally acceptable interventions. This descriptive study examined focus group participants' perspectives on engaging in hypertension self-management activities with the goal of developing a co-created intervention. The study was part of a mixed methods study for which audio- and graphically-recorded focus groups were conducted with community-dwelling African American older adults ($N = 31$) diagnosed with hypertension. The majority of the participants were women (87%); the mean age was 72 years ($SD = 7.53$). Themes derived from data analyses centered on primary stressors of communication, healthy eating, and sleep related to blood pressure self-management. Based on these, the researchers co-created educational interventions.

Karen O. Moss, Office: 216-368-0510 (Office), Phone: 407-765-2416 (Mobile), kxm519@case.edu.

Conflict of Interest:

The authors declare that there is no conflict of interest.

Hypertension is a major cause of the disproportionately high rates of coronary heart disease, stroke, heart failure, and chronic kidney disease (Benjamin et al., 2017; Nwankwo & National Center for Health Statistics, 2013). Heart disease remains the number one cause of death in the United States (Benjamin et al., 2017). Compared to other racial and ethnic groups, African Americans are disproportionately impacted by hypertension, suffering earlier onset and greater severity of the disease, and premature cardiovascular mortality, than the general population (Benjamin et al., 2017; Nwankwo & National Center for Health Statistics, 2013). The prevalence of the disease among African Americans increases markedly with age, as two-thirds of those over 60 years of age have a diagnosis of hypertension (Benjamin et al., 2017). Many factors contribute to the prevalence of hypertension, such as a lack of physical activity, an unhealthy diet (especially one high in sodium), being overweight or obese, and psychosocial stress (Borrell & Crawford, 2008). Moreover, hypertension continues to pose challenges in health care, and this, in turn, levies a huge economic burden (Benjamin et al., 2018; Chobanian et al., 2003; James et al., 2014). Failure to adequately manage this disease among African American older adults will result in further increases in morbidity and mortality rates in a population already negatively impacted by the effects of other co-existing conditions (Elperin, Pelter, Deamer, & Burchette, 2014)

Self-Management of Hypertension

Hypertension management and outcomes are dependent on the effectiveness of self-management with regard to follow-through of care plans established with healthcare providers (Chobanian et al., 2003). Important components of hypertension self-management are patient lifestyle modification (diet and physical activity) and adherence to prescribed antihypertensive medications (Chobanian et al., 2003). Among lifestyle factors, accumulating evidence indicates that stress is an important contributor to hypertension, especially in African Americans (American Psychological Association, 2012; Pavlik et al., 2015). African Americans that perceive stress as the cause of their hypertension are less likely to engage in healthy self-management behaviors as compared to those that do not (James et al., 2014). Despite numerous guidelines available to manage hypertension, current US guidelines do not recommend stress reduction interventions for hypertension self-management (James et al., 2014). Moreover, systematic reviews of stress reduction approaches for hypertension self-management are limited, and have not been explored in African American older adults. The purpose of this study was to examine older African American participants' perspectives on engaging in hypertension self-management activities toward co-creation of an intervention.

Method

Design

This descriptive qualitative analysis is derived from a mixed methods study that examined stress and self-management behaviors in African American older adults diagnosed with hypertension ($N=31$). For this analysis, four focus groups were selected as the method of data collection to give voice to a group often marginalized within larger society (Patton,

2015). Bringing together this group of African American older adults who shared these commonalities and were managing the same chronic disease was intentional. We aimed to capture first-hand perspectives from these conversations on a topic we sought to better understand. Institutional Review Board (IRB) approval was obtained prior to beginning the research procedures. We also received permission from a local community center for face-to-face recruitment of participants and posting of study fliers that included information on whom to contact to participate in the study. We recruited from the principal investigator's registry of older adults who had previously agreed to be contacted to participate in future research studies.

Sample

Participants were eligible to participate in this study if they (1) were English-speaking, (2) self-identified as African American, (3) were aged 60 years or older, and (4) were diagnosed with hypertension. Participants who indicated a diagnosis of cognitive impairment or resided outside of the community (e.g., a skilled nursing facility) were ineligible to participate. A total of 49 individuals were invited to participate in the study, and of these, 18 were eligible but did not want to participate due to lack of interest or previous time commitments. The total study sample was $N=31$. Eighteen participants belonged to the Focus Group 1 (Wednesday group) and thirteen belonged to Focus Group 2 (Saturday group). Thirty participants participated in Session 1 and 28 participated in Session 2.

Data Collection

Study participants were divided into the two groups (a Wednesday group and a Saturday group) based on their availability to attend the focus group sessions. Each group met twice. The focus groups were led by the principal investigator (KW), while other members of the research team (co-investigators, research assistants, and graduate student assistants) assisted during the sessions. The researcher opened each session with a scripted introduction, followed by an agenda of activities for the session, and then shared tips for effective communication to use during the session. Research assistants were on hand at each session to assist participants as needed. A member of the research team recorded field notes, which included graphically tracking the number of times each participant spoke in order to ensure that each participant received optimal opportunities to share their perspectives with the group. Names and other identifiers were not used, and the recordings were kept on a password-protected, secure server. Each focus group session lasted between 90 and 120 minutes and was audio-recorded.

We used a technique known as *co-creation* to gather data from participants to create an intervention. *Co-creation* is a form of community-based participatory research that uses a small number of stakeholders, such as the researcher and the older adults, to solve a problem with a participant-feasible solution (Jackson & Greenhalgh, 2015). The process of co-creation has been conducted in businesses to improve processes with input from stakeholders (Greenhalgh, Jackson, Shaw, & Janamian, 2016; Jackson & Greenhalgh, 2015, Wright, Harmon Still, Jones, & Moss, 2018).

Session 1—Prior to any data collection, informed consent was obtained. Participants completed demographic forms and other measures related to the quantitative arm of this study, the results of which are reported in another paper (Wright et al., 2018). An interview guide comprised of semi-structured questions was used to ask questions related to self-management of hypertension, including stress management. These included questions regarding personal practices or routines that have worked well for them, as well as preferred ways to manage their blood pressure. The following probing questions/statements were asked: 1) How does managing your blood pressure cause stress? 2) Tell me about how you manage stress. 3) Tell me about how effective is your own way of managing stress. 4) How does a person develop hypertension? and 5) If you had to put together an intervention to treat stress with, what would that look like, and what are some of the things that you think should be in it?

Session 2—Two to three weeks following the two initial focus groups, both of the Session 2 group meetings were held. Based on information provided and participant suggestions during the initial meetings, role play was used to describe a stressful telephone communication between two friends. A participant provided a scenario of poor communication as a stressor and provided permission for it to be used for the discussion. Based on this, a discussion format was used to debrief using the scenario during which participants shared data regarding their personal viewpoints from the conversation. Participants also provided details on their preferences for an intervention that would emerge from these focus groups.

A graphic recorder was present at one of the initial focus groups. Based on data shared by the participants, the graphic recorder verbally and pictorially captured and summarized the thoughts and feelings expressed by the participants in real-time. This graphic was recorded onto a large white board (see Figure 1). This, as well as the researchers' assessments via analysis of the audio recording, were combined to interpret the results presented in this manuscript.

Refreshments were available for participants at each of the focus group sessions. Each participant was given a \$50 gift card and provided taxicab transportation service or a \$10 gas card for each of the two focus group sessions they attended. At the close of the study, participants were each mailed a personal-sized copy of the graphic recording image along with a thank-you note for participating.

As part of a follow-up intervention study, interested participants were invited to participate in the intervention beginning three weeks after the second session was completed. The intervention is described in the results section of this paper, and the results of the intervention will be reported in a future publication.

Data Analysis

Demographic data were analyzed using SPSS software (Version 24). Transcribed audio recordings were verified independently by members of the research team. Co-investigator and lead author (KM), led these data analyses. The lead author and two other research team members independently conducted coding before coming together to resolve conflicts in

coding. Coding results were mutually agreed upon by the research team. Main themes were clarified by research team members checking with the study participants after the focus group sessions to ensure that the research findings agreed with the participants' views (Lincoln & Guba, 1985; Pyett, 2003). Content analysis was conducted using Miles and Huberman's methods of data analysis (Miles, Huberman, & Saldana, 2014). Both inductive (predetermined) and deductive (emerging from data) coding were used for this analysis. Three rounds of independent data analyses were conducted by three members of the research team (Miles et al., 2014). Dedoose software (SocioCultural Research Consultants, 2017), as well as manual notes (paper and pencil) were used for coding. Final themes, categories, and codes were mutually agreed upon by the research team.

Results

Focus group participants were mostly female (87%), and mean age was 72 years (range: 62-91 years). Demographic characteristics of Focus Group 1 participants were similar to participants in Focus Group 2. Table 1 contains participant demographic information by focus groups.

Based on data provided by participants during the initial focus groups, the graphic depicted in Figure 1 was developed by the graphic recorder in real time, providing a visual image of information shared by the participants. Three major themes emerged from these data as primary stressors related to hypertension self-management: communication, healthy eating, and sleep. This image is the graphic recorder's interpretation of the findings. These, as well as the researchers' assessments via analysis of the audio recordings and field notes documented during the focus group sessions, were combined to interpret the findings presented in this manuscript. From left to right of Figure 1 the participants identified communication, sleep (noise, pain during the night) and diet as stressors related to self-managing their blood pressure.

Communication

Participants described the communication theme as it relates to coping with hypertension and thus provided advice for doing this, such as prayer. This communication theme was also related to stress management with hypertension. Communication was viewed as a significant stressor that when not adequately addressed, resulted in elevated blood pressure. Verbal and nonverbal communication were described as major stressors that influence blood pressure management. "Communication is the most important thing," said one participant, and went on to say, "That's what we lack." One participant shared a scenario that demonstrated poor communication as a stressor provided and permission for it to be used for further the discussion. The researcher (focus group facilitator) sought permission to brainstorm on a communication scenario used in the role play. In discussing it, one participant said, "Sometimes it's not what you say, it's the way you say it." Most participants agreed, indicating this to be true based on their personal experience, and was affirmed during the communication role play discussion when a participant became emotional as she related the scenario to her personal experiences. This was an example of the degree of emotional distress that can be elicited when communication breakdowns occur. It was established that

the lack of nonverbal cues (i.e., text messaging and telephone (audio) conversations) can lead to misinterpretations of tone or voice. These misinterpretations could result in unnecessary stress, leading to elevated blood pressure.

Age was considered to be a barrier to communication when generational differences existed. One participant said that her younger, out-of-town friends continued to expect her to cook, clean, and host them the same as she had done when she was younger. This caused her emotional stress. In response to input from group members, one participant said, "I'm going to change my thinking now that I am getting older." This indicated that she was willing to consider the diversity of thought among her group of friends based on the age differences that existed. All study participants agreed that negotiating a compromise was conducive to good communication. It was also suggested that "Sometimes you just have to let go. Consider yourself. Just let go and consider yourself first." Another participant advised the group to "Just say a prayer. That's what you need. Put it in the hand of God. He'll handle it." Yet another suggested writing a letter to communicate thoughts and feelings to others that were difficult to express face-to-face or via telephone. The groups agreed that the individual at the center of the role play was getting older this should be welcomed and interpreted this reality as positive to her not being able to entertain her younger friends as she had done in previous years. Both groups agreed that the individual faced with a stressful communication scenario needs to put his or her self first. Communication discussions also included the use of technology. Those results are presented in another paper (Harmon Still, Jones, Moss, Variath, & Wright, in press).

Healthy Eating

Several participants stressed that the topic of diet had to be addressed, because it's important, regardless of whether individuals chose to follow a diet. The term *diet* was described overall as unfavorable. One participant said, "I don't think it should be called a *diet* ...because the first three letters in *diet* are *die*, and I don't use no diet pop, no diet nothing. I think it should be called *healthy eating*..." Many of the participants agreed. She continued, "...because if you say *diet*, I'm not going to do it, and it's just a mind-set." Her focus group then agreed that "healthy eating and portion control" is a preferred way to refer to following a meal plan that is conducive to blood pressure control and a healthy lifestyle. One participant described a personal experience regarding her ability to observe positive changes in her body after making dietary changes towards healthier eating. This testimonial was well received by the group.

Grocery shopping was considered a significant stressor that provoked anxiety. Causes for this were related to large crowd sizes, not enough cashiers, sale items being sold out at the grocery store, and insufficient funds. Participants shared advice towards making this experience more enjoyable by planning ahead, making a list, gathering coupons, choosing an appropriate store (based on location, quality and selection of food), avoiding the impulsivity of grocery shopping while hungry, wearing comfortable clothing and shoes, and selecting a day of the week/month and time of day when crowds are likely to be smaller. Participants advised each other on the importance of having a positive attitude and being patient as it relates to grocery shopping.

Sleep

The participants described a lack of sleep and a reduction in the quality of their sleep (due to barriers such as light, noise, and the inability to turn off their thought processes) as a stressor that contributed to elevated blood pressure. Sleep, or the lack thereof, also emerged as a cause of a substantial amount of stress. Focus group participants provided suggestions on what enhances as well as hinders the quality of their sleep. A potential solution such as taking a nap during the day was also seen as a barrier. As one participant said, “When you take a nap during the day, then you don’t sleep good at night.” Participants also spoke of outside noises such as a dog barking, loud music, thunder, and the sound of a fire engine, as disruptive to good sleep hygiene. Some barriers to restful sleep discussed were associated with internal, physiological processes such as nerves, hyperactivity, hot flashes, hunger, a need to use the restroom, and a diagnosis of insomnia.

Pain was also described as contributing to sleep disturbances. Focus group participants also discussed pain as it relates to maintaining quality of life. One participant described use of prescribed narcotic pain medications to obtain relief. Other solutions discussed for pain management included engaging in crossword puzzles, reading, use of sleeping pills, getting a massage, aromatherapy (e.g., lavender), sound therapy (e.g., rushing water), an alcoholic beverage, and watching television.

Participants were receptive to the focus group experience as a means to share their knowledge and strategies for stress and blood pressure management. Some of them said they wished they had received such valuable information earlier in life in order to take advantage of the time to make lifestyle adjustments such as healthier eating. One participant summed up the conversation in this way, “Well, we’re dealing with adults, so that’s kind of hard, you know. It’s their health, and they have to take their own health in their own hands.” Another participant said, “But really, a program like this should start with someone in their late 40s, early 50s.” Table 2 contains additional responses provided by participants under the larger themes, categories, and excerpts derived.

Co-Created Intervention

Based on the themes presented in Table 2, the focus groups lead to the development of interventions to (1) cope with reducing stress of managing a chronic condition such as hypertension; (2) engage in self-management activities such as proper sleep hygiene, exercise, diet, meditation, prayer, and use of communication technology (such as smart phones or tablets), and other participant-generated stress reduction activities; and (3) promote healthy self-management behaviors. Topical ideas shared by the participants during the focus groups were used to develop the intervention. This included the researcher specifically asking about preferences for timing, duration, and format of the intervention. For example, they were asked: 1) Would you prefer to do this in a group setting or one-on-one? 2) How many sessions are needed to learn the intervention that we created together? Participants co-developed interventions for stress and hypertension self-management and this approach was titled “Team Learning to Take Control” (TLC). This intervention was delivered over four biweekly registered nurse- or dietitian-led group sessions that addressed (1) blood pressure monitoring, (2) communication, (3) sleep and pain, and (4) healthy eating

and portion control. Three of the four sessions were led by members of the research team. We obtained IRB approval and re-consented participants so that they could engage in the co-created 4-week intervention prototype.

Week one: TLC - monitoring your blood pressure—This educational meeting was included as the first session based on the consensus from participants that there was a need for more general education on blood pressure monitoring. This educational meeting covered diagnosis, causes, risk factors, symptoms, interventions, and how to safely monitor one's blood pressure. The first hour was an interactive didactic lecture and slide presentation where participants asked questions of the geriatric nurse practitioner. During the second half, participants were divided into small groups and practiced what they learned. After each session, participants were given a nutrition record and sleep diary to complete as homework for review at the following session. Participants brought in their blood pressure monitors and volunteer graduate nursing students worked in small groups (3-4 people) to demonstrate proper use of the home blood pressure monitor. The participants brought in their monitors at each session until they felt confident in taking their own blood pressure.

Week two: TLC – communication—Similar to the format of Session 1, the nurse provided didactic instruction on the *10 Tips on Being Assertive*, which included helpful advice on effective communication, thinking, nonverbal communication, listening, and speaking (State Government of Victoria, 2012). They also learned about communication breakdown and the effects that stressful communication can have on your physiological response, particularly, increased heart rate and breathing (Heffner, Devereux, Ng, Borchardt, & Quigley, 2013). During this session, participants were encouraged to talk about their own positive and negative experiences communicating with family and friends. They provided each other with solutions for breakdown in communication. The participants were divided into small groups and given a communication scenario to practice what they learned. The entire group was debriefed by the nurse, then given a homework assignment to complete a 7-day Sleep Diary (National Sleep Foundation, n.d.).

Week three: TLC - sleep and pain—Sleep and pain management were described by participants as potential contributors to elevated blood pressure if they are not adequately moderated or controlled. During this session, the nurse reviewed the importance of sleep, including barriers and facilitators to optimal sleep, such as noise and light, sleep management practices, and relaxation before bedtime. In particular, alcohol use was discouraged as a remedy for disturbed sleep. The group practiced a 10-minute mindfulness body scan. Next, the nurse discussed pain assessment and nonpharmacological control strategies such as physical activity, massage, and mindfulness meditation (Palta et al., 2012). The nurse taught participants how to determine if the pain required emergency treatment, as in the case of chest pain. Throughout the session, the nurse stressed to participants the importance of collaborating with their healthcare providers and to seek treatment for unrelieved sleep and pain concerns. At the end of the session, participants reviewed their sleep diaries previously completed, and shared strategies for maintaining optimal sleep. As an assignment, participants were given a food diary to complete—a visual depiction of a healthy plate from ChooseMyPlate.gov (United States Department of Agriculture, 2018).

They were also encouraged to bring in a favorite recipe for the group to make suggestions on how to prepare it in a healthier way.

Week four: TLC - healthy eating and learning portions (HELP)—This session, specifically titled by the participants during the initial focus groups, was led by a registered dietitian. Each participant received educational handouts from the American Heart Association on lowering blood pressure. This included information on the Dietary Approaches to Stop Hypertension (DASH) diet, which provided information about portion sizes and ingredient substitutions to add flavor without the salt (American Heart Association, 2018a). The dietitian gave the group a salt quiz that compared sodium in common foods like dairy, breads, and pasta (American Heart Association, 2018b). This was followed by a question and answer session about heart-healthy eating. The dietitian gave a slide presentation using the Portion Distortion II Interactive Quiz from the U. S. Department of Health and Human Services that demonstrates the changes in serving sizes over the past 20 years (United States Department of Health and Human Services, 2015). This included examples of the amount of exercise you would have to do to burn large amounts of calories. At the end of the session, participants volunteered to review their food diary, which was previously completed as homework with the dietitian and the group. They worked with the dietitian to identify healthy substitutes for cooking favorite ethnic meals, such as using olive oil, celery, and spices to season collard greens instead of fatty pork.

Discussion

As mentioned previously, this study used graphic recording during focus groups to capture data from African American community-dwelling older adults with hypertension for the purpose of developing a co-created intervention. This process is in agreement with the 2003 National Academies of Science, Engineering, and Medicine's report on participant-centered clinical research in the community (National Academies of Sciences, Engineering, and Medicine, 2003). To this end, a strength of the study was that the principal investigator either had an established relationship with the participants or took the time to develop this relationship with them. Congruence of the racial background of the research team may also have fostered a trusting relationship between the team and study participants (Luebbert & Perez, 2016). This led to a high level of participation and comfort, allowing participants to openly share information and ask questions to seek clarification as needed. Group dynamics were influential to the sharing of ideas and information exchanges among study participants. They were open to each other's perspectives, which appeared to influence their own thinking regarding strategies for stress management while living with hypertension. Group interactions observed by the researchers were beneficial to the study and helped add to the quality of data obtained. The participants shared openly with each other, acknowledging similar experiences and respectfully disagreeing when appropriate.

These focus group findings should be interpreted within the limitations of the study. As with focus groups in general, there is dependence on group dynamics to foster the discussions. While this was an apparent overall benefit to the process, the large size of the focus groups (greater than eight per group) may have limited the ability of some members of the groups to participate fully. To counteract this, the researcher (facilitator) and team members present

were intentional about tracking the number of times participants spoke and provided additional time to answer outstanding questions. Also, the gender makeup of the focus groups was not representative of African American male older adults in the city where this study took place. Male participants were underrepresented, though not intentionally. This dynamic was representative of the convenience sample of participants who typically use the community center from where study participants were primarily recruited. This resulted in more female perspectives being reflected in this analysis, and also could have limited the degree to which the male participants were comfortable in expressing their views within the groups. The researchers attempted to overcome this by over-recruiting for male participants, including a male research team member, and being intentional to include male participants' perspectives in the conversation. Despite these limitations, this study has value because it gives voice and authority to a vulnerable population contributing to the solution of blood pressure self-management and stress.

Co-creation requires a system perspective and encourages local adaptation as the program unfolds (Greenhalgh et al., 2016). It was based on this premise that we decided to conduct the intervention in the same sample of participants that helped to co-create it in order to demonstrate how the community-based participatory tenet of trust-building over time may work in this sample of older adults with hypertension from conception through to implementation. Therefore, it was important for the authors to be able to seek feedback from the group that helped to design the intervention based on their needs. It is recognized that while this is a strength of this study, it is also a limitation that may have resulted in threats to fidelity of the intervention. Additionally, study participants were adamant that they wanted to be able to try out/test the intervention. Therefore, we were able to make this request to retain the same participants to the Institutional Review Board (IRB) via an addendum to the original protocol allowing us to re-consent them using a new IRB approved consent form.

This nurse-led study provided valuable data to support the benefits of focus group settings to elicit information from a group of community-dwelling African American older adults self-managing hypertension. It laid the foundation for the development of a hypertension self-management intervention that was subsequently tested in this same population. As a result, buy-in was sought from the group, and IRB approval obtained to move into the next phase of the program of research. Additional details and results of the testing of this intervention will be presented in a future publication. This study and its outcomes support research priorities of the National Institutes of Nursing Research that target patient-focused self-management programs in order to engage individuals living with chronic conditions in maintaining and improving their quality of life (National Institutes of Nursing Research, 2016). Future research to extend this work should use this approach to foster familial education across generations focused on health-related topics. This would allow opportunities for sharing of health information and self-management strategies that was alluded to by study participants to occur earlier in the lifespan (Jones, Moss, Wright, Rosenberg, & Killion, 2018). Continued work in this area may provide opportunities for community health nurses to tailor education approaches in this population to more precisely meet the needs of this population that is at high risk to suffer from the complications of hypertension.

This study presented a novel approach to a community-based, co-created education program implemented in the same group of African American older adults with hypertension that co-designed the education intervention. Data provided by participants highlighted their desire for education on communication, healthy eating, and sleep for the self-management of hypertension. Based on this, the researchers co-created a set of education interventions. This model has the potential to influence how self-management education is delivered in community-based settings with the use of community health nurses as key change agents towards improving hypertension outcomes among African American older adults.

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Dr. Moss is a post-doctoral fellow in the Frances Payne Bolton School of Nursing at Case Western Reserve University (T32 NR014213) and Jonas Nurse Scholar Alumni (2014-2016).

Dr. Still is an Assistant Professor in the Frances Payne Bolton School of Nursing at Case Western Reserve University.

Dr. Jones is an Assistant Professor in the School of Nursing at the University of Michigan.

Ms. Blackshire is an undergraduate nutrition student in the College of Arts and Sciences at Case Western Reserve University.

Dr. Wright is an Assistant Professor and Chief Diversity Officer in the College of Nursing at The Ohio State University.

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Figure 1.
Graphic Recorder Depiction of Focus Group Findings

Table 1

Demographics

Characteristics	N=31	Focus Group 1 (n=18)	Focus Group 2 (n=13)
Gender			
Male	4 (12.9 %)	1 (5.6 %)	3 (23.1 %)
Female	27 (87.1 %)	17 (94.4 %)	10 (76.9 %)
Age (years): Mean (SD)	72.1 (7.53)	71.8 (8.7)	72.5 (5.9)
60-69	13 (41.9 %)	9 (50.0 %)	4 (30.8 %)
70-79	12 (38.7 %)	5 (27.8 %)	7 (53.8 %)
80-89	5 (16.1 %)	3 (16.7 %)	2 (15.4 %)
90-99	1 (3.2 %)	1 (5.6 %)	—
Ethnicity			
Non-Hispanic or Latino	23 (74.2%)	14 (77.8 %)	9 (69.2 %)
Hispanic or Latino	8 (25.8%)	4 (22.2 %)	4 (30.8 %)

Table 2

Derived Themes, Categories/Codes, and Excerpts

Theme	Category	Excerpt
Communication	Barriers	<ul style="list-style-type: none"> • <i>"I understand communication is a wonderful thing; you got to let people know, but there's a lot of people who misconstrue tone of voice in your communication as being stressful."</i> • <i>"...a lot of people are stressed out on their jobs because of how people talk to them."</i> • <i>"The stressful part for me in communication is texting...I want to know how you're saying it...so I'd rather hear your voice."</i> • <i>"Some people are just blunt...some people cannot stand to be talked to blunt[ly], so it means you got to baby them."</i> • <i>"Well, like your age difference, they may not really see you as having gotten older. That might be a problem with them, that they feel that you're still the same old girl. They don't see that you've gotten tired."</i> • <i>"Sometimes they [healthcare providers] tell you one thing, and then there's something totally different."</i>
	Solutions	<ul style="list-style-type: none"> • <i>"...[if] we talk too long on the phone, I'll say, 'Excuse me. Another call [is] coming in.'"</i> • <i>"I mean, it's best to be honest."</i> • <i>"But another thing too is body language. I prefer talking face-to-face."</i>
Healthy Eating	Barriers	<ul style="list-style-type: none"> • <i>"Not being able to eat what you want."</i> • <i>"Not being able to go by the guidelines of what you're supposed to eat."</i> • <i>"Having enough money to buy what I need... because being on a fixed income, you can only afford certain things."</i> • <i>"...going to the grocery store will stress you out..."</i>
	Changes in quality	<ul style="list-style-type: none"> • <i>"...it's not the food we're eating. It's what they're putting in it...there's a lot of GMOs,... because our parents didn't have this problem, and they ate lard, pork, and everything, and they lived to be a hundred and something; but now, all of a sudden, we're dying in our 30,40,50s."</i> • <i>"[In the past,] foods were different... they didn't have all this, and I was raised in the country, so there was not a lot of pollution...[now] foods are different, which is going to affect your health."</i>
	Benefits	<ul style="list-style-type: none"> • <i>"...something about a diet that lets people live longer."</i> • <i>"I think if we're going to talk about diet, we need to talk about heart-healthy foods, the correct way to prepare heart-healthy foods, because as long as your heart is working right, then your blood pressure is right."</i> • <i>"After I stopped eating potato chips and drinking that [soda]...I wasn't itching, because I'm drinking more water and more cranberry juice."</i> • <i>"I noticed since I'm not eating red meat and pork, I don't get that twisting, and the gripping in my colon hasn't been as spastic."</i> • <i>"... they start these kids in kindergarten and preschool, teaching them about foods right now, [about] making [healthy] choices."</i>
Sleep	Disturbances	<ul style="list-style-type: none"> • <i>"Sometimes, I get to the point where my brain [is] moving so I can't shut it off...I mean, I'm not thinking about anything, but it's going."</i> • <i>"I had a bad cold and I couldn't sleep because I coughed all night."</i> • <i>"Pain can also stop you from sleeping."</i>
	Solutions	<ul style="list-style-type: none"> • <i>"If my brain is running like that...I will wake up, but I have a notepad by the bed and I'll write whatever message I'm getting. I'll write it down and then get that, and then I'll go back to sleep."</i> • <i>"I know it doesn't sound right, but they said exercise helps you to sleep."</i>