Heart Health: A Case-Based Approach to Improving Preventative Care at Health Centers

Julian Dormitzer, AGNP-C

04/14/2026

NATIONAL LGBTQIA+ HEALTH EDUCATION CENTER

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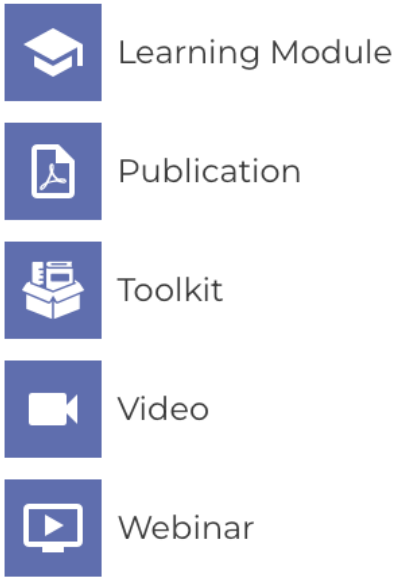

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Disclosures

- None

Learning Objectives

- Identify common barriers to preventative cardiovascular care.
- Evaluate psychologically-informed approaches to heart health.
- Explore strategies to enhance patient engagement in preventative cardiovascular care through a strengths-based, whole-person approach.
- Explain how health centers can apply psychologically-informed strategies to address barriers to preventative cardiovascular care.

Urgency of Cardiovascular Prevention

- Cardiovascular disease (CVD) is the leading cause of death in the U.S.
- Nearly half of U.S. adults have at least one major cardiovascular risk factor.
- Hypertension and diabetes remain leading modifiable drivers of morbidity.
- Prevention reduces likelihood of stroke, myocardial infarction, and long-term disability.
- Between 2021 and 2023, 48.9% of U.S. adults had some form of CVD.

American Heart Association, 2026

The Role of Health Centers in Prevention

- Health Centers serve 30+ million patients nationwide.
  - Approximately 90% of patients are low income.
  - Nearly half are Medicaid beneficiaries.
- Health centers are best positioned to meet groups at highest risk for CVD.
- A 2019 study revealed that health centers that screened for factors (e.g., housing, food access, and transportation) had higher % of patients with adequately controlled diabetes and hypertension.

(Davlyatov et al., 2024)

Individual Barriers to Cardiovascular Prevention

- **Health literacy** can limit understanding of risk and prevention strategies.
- **Medication concerns** (side effects, mistrust, cost) reduce adherence.
- **Psychological stress & depression** impair self-management capacity.
- **Competing life priorities** (work, caregiving) delay preventative care.
- **Ambivalence about lifestyle change** is common and normal.

Why This Matters:

Sustained behavior change (diet, exercise, medication adherence) requires cognitive bandwidth, emotional readiness, and adequate support.

(DiMatteo, 2004; Miller & Rollnick, 2013; Centers for Disease Control and Prevention, 2024)

Systemic Barriers

- **Transportation barriers** limit access to follow-up and monitoring.
- **Financial constraints & insurance instability** interrupt care continuity.
- **Food insecurity** hinders heart-healthy diet adherence.
- **Housing instability** reduces care prioritization.
- **Limited appointment access** fragments care coordination.
- **Limited English proficiency** affects communication and trust.

(Davlyatov et al., 2024; Health Resources and Services Administration, 2024; World Health Organization, 2008)

Why Preventative Cardiovascular Care Matters

- Early management improves quality of life.
- Prevention reduces mortality and long-term disability.
- Health centers play a key role in prevention.
- Despite serving groups with higher risk burdens, Health Centers often perform as well or better than national averages and demonstrate comparable quality benchmarks for hypertension control.
  - This suggests that health center–based, person-focused care models contribute positively to chronic disease management even in less served communities.

American Heart Association, 2026
Health Resources and Services Administration, 2024

Core Principles of a Whole-Person Approach to Cardiovascular Health

- Behavior change is a process.
- Use motivational and collaborative communication.
- Address stress and emotional factors.
- Recognize social context.
- Reinforce patient strengths and self-efficacy.

Case Introduction: Meet Angela

- 56-year-old woman
- Recently diagnosed with **hypertension**
- Repeated primary care visits for minor concerns (headaches, fatigue, sinus symptoms)
- Blood pressure consistently **150–160/90–95**

Summary of Recent Visits

- Provider has recommended medication several times
- Patient remains hesitant to start treatment, sharing a fear of "being on pills forever"
- "I've always just powered through things in life; I haven't needed long-term medication in the past."
- She is concerned about medication side effects
- “I feel nervous at the doctor’s office which makes my blood pressure go up”

Key Challenge

Frequent visits create opportunities for prevention, but directive medication recommendations alone have not led to treatment uptake.

Questions for Angela

- You see Angela on your clinic schedule for the day. How would you approach Angela during this visit if her blood pressure is again elevated?
- What kind of information would you share with her regarding her hypertension diagnosis?

Exploring Goals and Building Trust

Provider:

"I notice your blood pressure has been high at several visits. Can you tell me how you're feeling about the idea of starting medication?

Angela:

"I just don’t want to rely on pills if I can avoid it."

Provider:

"It sounds like you're worried about becoming dependent on medication. Many patients share similar worries about starting long-term medication."

Angela also shares:

- High stress caring for her mother
- Limited time for exercise
- Poor sleep

Next Steps with Angela:

- Instead of an immediate medication decision, the provider and Angela agree to:
  - **Short-term strategies**
    - Home blood pressure monitoring
    - Walking **20 minutes three times per week**
    - Stress management strategies
  - **Education**
    - Review how untreated hypertension increases long-term heart risk
  - **Follow up**
    - Revisit medication discussion in **4–6 weeks**

Spotlight: Home Blood Pressure Monitoring

- A 2023 study equipped 180 hypertensive patients with a home blood pressure cuff free of charge. It led to a significant improvement (5.4 mm Hg systolic, 2.7 mm Hg diastolic) in BP and the majority of participants reported feeling more active in their healthcare.
- Counsel patients on purchasing a validated home BP device for the upper arm. Ask leadership about any available funding to offer patients a cuff at no cost.

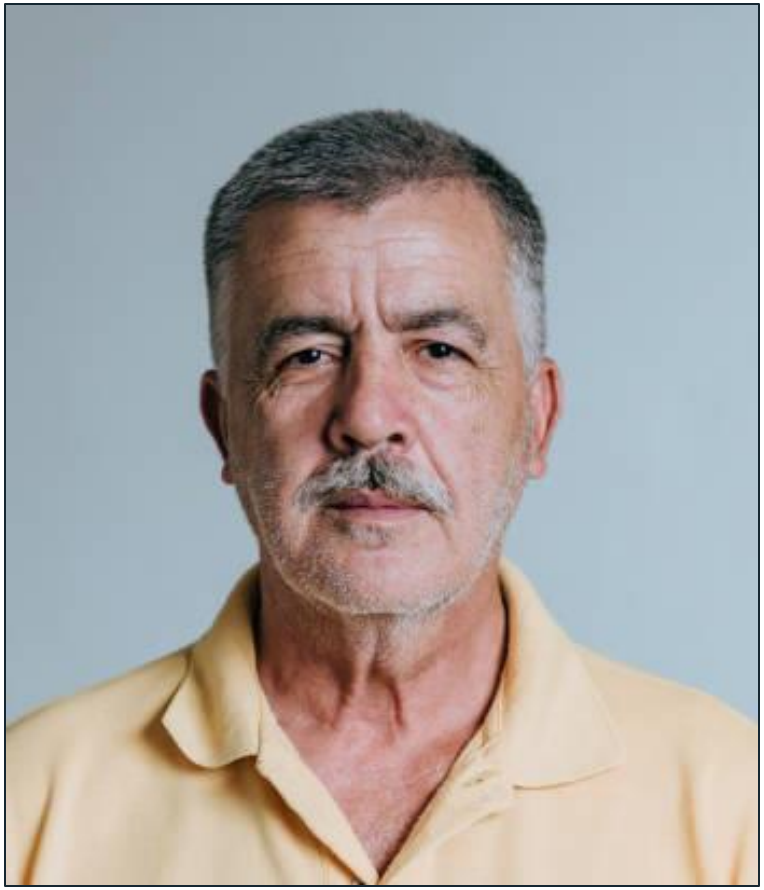
(Deshpande et al., 2023)

Follow-up Visit 5 Weeks Later:

- Angela reports tracking BP at home.
  - Readings remain elevated (152/90, 160/98)
- She expresses greater openness to medication.
  - **Angela**: *"Seeing the numbers at home helped me understand why you were concerned. I also experience frequent headaches and didn't realize this could be my blood pressure before our last visit."*

- Patient-focused conversations can transform **resistance into readiness**, supporting more effective cardiovascular prevention.

Case Introduction: Meet Louis



- 58 years old
- Hispanic man, lives with adult son
- Works as a delivery driver
- Medical history includes hypertension, prediabetes, mild hyperlipidemia
- Social factors: transportation challenges, variable work hours, high stress, limited English proficiency

Case Study: Louis

- What barriers to preventative cardiovascular care do you notice in Louis's situation?

    - What individual factors might affect his ability to manage his hypertension?
    - What social or structural barriers might be influencing his health behaviors?
    - Are these barriers common among patients in your health center?

Case Study: Applying Psychologically Informed Care

Follow-up appointment focused on cardiovascular risk prevention and blood pressure management

Provider Approach

- Begin with collaborative agenda setting.
- Invite the patient to describe their experiences.
- Focus on understanding barriers and motivations.

Provider:

"Before we review your numbers, I'd like to hear how things have been going for you managing your heart health."

Louis:

"Honestly, it's tough with my work schedule. I forget my medication sometimes and grab fast food on the road."

Psychological Principle

Patient-driven communication builds trust and engagement.

(Miller & Rollnick, 2013)

Understanding Motivation and Social Context

Motivational Interviewing

- Open-ended questions
- Reflective listening
- Exploring readiness for change

Provider:

"On a scale from 1 to 10, how important is improving your heart health right now?"

Louis:

"Probably a 7. My dad had a heart attack around my age."

Provider:

"A 7 is pretty high. What makes it that important to you?"

Understanding Motivation and Social Context

Addressing Social Context

- Louis describes:
  - Long work hours driving
  - Limited healthy food options
  - Stress from delivery quotas
  - Difficulty attending appointments
- Provider response:
  - *"Your job makes healthy routines challenging. Let's find options that fit into your day."*

Collaborative Goal Setting for Heart Health

Small, Achievable Goals

- Together, Louis and the provider agree to:
  - Take medication **with morning coffee as a reminder**
  - Walk **10–15 minutes during work breaks**
  - Bring **one healthier snack** during delivery shifts

Provider:

"These are small changes, but they can make a big difference for your blood pressure."

Follow-Up Support

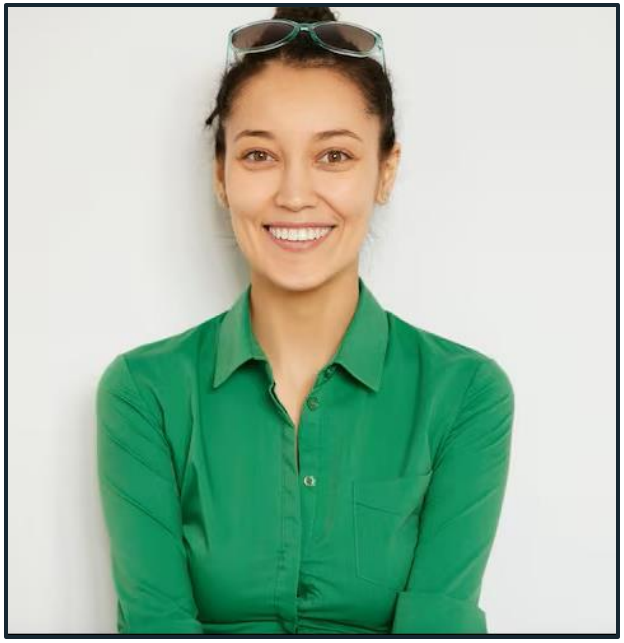
- Care plan includes:
  - Nutrition counseling referral
  - Transportation support for labs
  - Follow-up visit in **6 weeks**

Reflecting on the Visit with Louis

- Which communication techniques helped build trust?
- How did the provider address Louis's real-world challenges?
- What strengths did the provider identify in Louis?

Case Introduction: Ellen

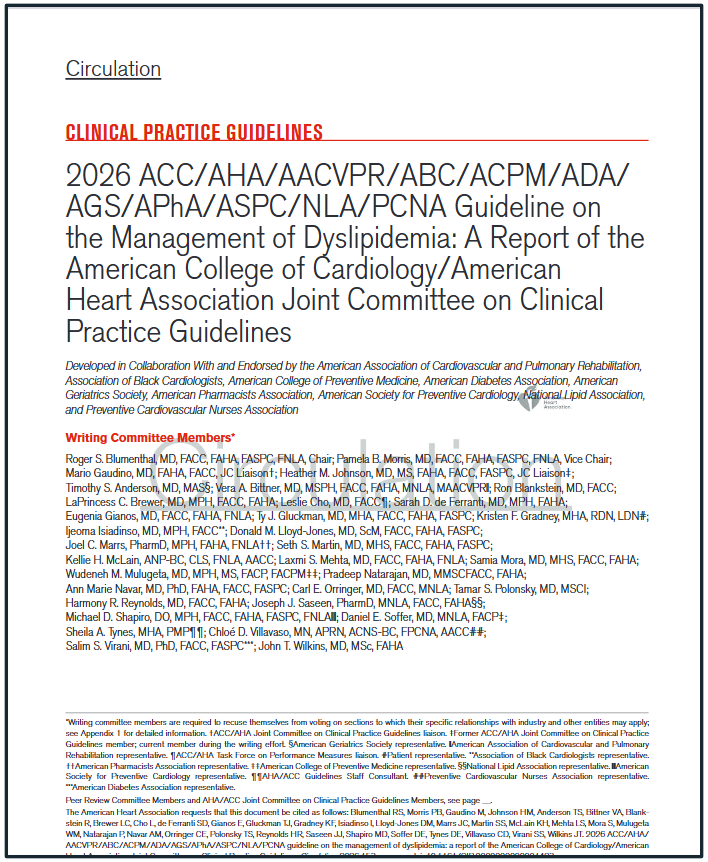
- 38-year-old Asian American woman
- In clinic for annual physical
- Current medications
  - Metformin 1000 mg BID (twice a day)
  - Lisinopril 10 mg daily
  - No statin therapy
- Relevant Medical History
  - Type 2 diabetes (diagnosed 2 years ago, A1C 7.2%)
  - Chronic Kidney disease stage 3a (eGFR 52 ml/Min/1.73)
  - Hypertension well controlled (on lisinopril 10 mg daily)
  - No prior cardiovascular events



Case Study Continued: Ellen

- Vitals Signs & Lab Work:
  - BP: 128/78 mmHg
  - Total cholesterol: 215 mg/dL
  - LDL-C: 135 mg/dL
  - HDL-C: 48 mg/dL
  - Non-smoker
  - BMI: 28 kg/m²

Should Ellen's PCP recommend that she start lipid lowering medication?



Circulation

CLINICAL PRACTICE GUIDELINES

2026 ACC/AHA/AACVPR/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Dyslipidemia: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines

Developed in Collaboration With and Endorsed by the American Association of Cardiovascular and Pulmonary Rehabilitation, Association of Black Cardiologists, American College of Preventive Medicine, American Diabetes Association, American Geriatrics Society, American Pharmacists Association, American Society for Preventive Cardiology, National Lipid Association, and Preventive Cardiovascular Nurses Association

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2026 American College of Cardiology (ACC)/American Health Association (AHA) Dyslipidemia Guidelines

Key Shifts from 2018 guidelines:

- Language change from “cholesterol” to “dyslipidemia”
- Treat to Target: Specific LDL-C goals, not % reduction
- Recommendation to use AHA PREVENT Equations in estimating atherosclerotic cardiovascular disease (ASCVD) risk in adults 30-79 years old

Patient Group	LDL-C Target
Primary prevention (high risk, ≥10%)	70 mg/dL
Primary prevention (moderate risk)	100 mg/dL
ASCVD (standard)	70 mg/dL
ASCVD (very high risk)	55 mg/dL
Severe hypercholesterolemia (LDL ≥190)	100 mg/dL (or 55 if ASCVD)
Diabetes with multiple risk factors	70 mg/dL

Case Study Continued: Ellen

- Risk Assessment using PREVENT Equations:

  •**10-year ASCVD risk: 4.2%**

  •**30-year ASCVD risk: 18%**

  •The PREVENT equation incorporates Ellen's age (30-79 years accepted), diabetes, reduced eGFR, and other risk factors

  •**Recommendation: Statin therapy indicated** based on the 2026 ACC/AHA Dyslipidemia Guidelines, which recommend considering lipid-lowering therapy at ≥3% 10-year risk

Moving from Individual Encounters to Wider Change

- Psychologically-informed care must be embedded in workflows, not dependent on individual clinicians.
- Health centers can integrate behavioral strategies into:
  - Team-based care models
  - Case management programs
- Incorporating behavioral health integration improves management of hypertension, diabetes, and lifestyle risk factors.
- Community health approaches allow health centers to proactively identify patients needing preventative cardiovascular care.

(HRSA, 2024; De Marchis et al., 2019)

Leveraging Health Center Data and Technology

- Electronic health record (EHR) prompts
  - Flag patients due for blood pressure screening, lipid panels, or lifestyle counseling.
- Patient registries
  - Identify high-risk groups for outreach.
- Remote monitoring
  - Home blood pressure monitoring programs improve hypertension control.
- Patient portals and text messaging
  - Reinforce medication adherence and lifestyle goals.
- Community health dashboards
  - Track prevention metrics across patient populations.

Key Takeaways

1. Prevention requires addressing real-world barriers.

- Patients served by health centers often face **social, structural, and behavioral barriers** to cardiovascular prevention.
- Factors such as **transportation, food insecurity, financial stress, and competing priorities** directly influence heart health behaviors.

2. Communication and engagement matter.

- Traditional directive medical models often lead to **limited patient engagement and lower adherence**.
- **Psychologically-informed approaches**—including motivational interviewing, shared decision-making, and strengths-based communication—help patients feel heard and supported.

Key Takeaways cont.

3. Whole-person, patient-driven care improves prevention.

- Effective prevention considers the **patient's lived context**, not just clinical risk factors.
- Integrating **behavioral health, social factors screening, and care navigation** can improve engagement and long-term cardiovascular outcomes.

4. Health centers are critical drivers of prevention.

- FQHCs provide **accessible, community-based care** for groups at high cardiovascular risk.
- Through **team-based care, community health tools, and community partnerships**, health centers can scale effective prevention strategies.

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