



MOBILIZING AFRICAN  
AMERICAN COMMUNITIES  
TO ADDRESS DISPARITIES  
IN CARDIOVASCULAR  
HEALTH

THE BALTIMORE CITY  
CARDIOVASCULAR  
HEALTH PARTNERSHIP  
STRATEGY DEVELOPMENT  
WORKSHOP  
SUMMARY REPORT





One of the comments made during the Baltimore City Cardiovascular Health Strategy Development Workshop was that involving and engaging children and youth in an effort to address a chronic disease, such as cardiovascular disease, is essential to the goal of sustaining the cardiovascular health of communities. The Baltimore City Cardiovascular Health Partnership recognized this need early during its partnership discussions and conducted a youth heart health poster contest among Housing Authority of Baltimore City (HABC) day care and youth development center participants as a way to introduce young people to the importance of cardiovascular health. The artwork (pictured above) demonstrates the creativity and inspiration that young people can bring to health education.

**The photograph collage on the cover of this report** depicts the tapestry of people, places, and culture that exist in Baltimore African American communities. The collage includes photographs of the HABC resident and staff leaders, a youth resident, and an aerial view of the HOPE VI public housing development—Pleasant View Gardens. Also included are the cross street sign, McCulloh and W. Madison, and a building mural artwork (Gary Mullen 1999) that was created on McCulloh street. The collage background is an afrocentric print fabric.

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SUMMARY REPORT

National Institutes of Health  
National Heart, Lung, and  
Blood Institute

Office of Prevention,  
Education, and Control

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# CONTENTS

<b>Acknowledgements</b> .....	<b>ii</b>
<b>Introduction</b> .....	<b>1</b>
<b>Workshop Goals and Structure</b> .....	<b>2</b>
<b>Workshop Agenda</b> .....	<b>3</b>
<b>Workshop Participants</b> .....	<b>5</b>
<b>Breakout Discussions:</b>	
<b>Executive Summary</b> .....	<b>11</b>
<b>Background: Cardiovascular Health and Baltimore African American Communities</b> .....	<b>17</b>
<b>Presentations</b> .....	<b>19</b>
Impact of Cardiovascular Disease in African American Communities – <i>Dr. Wallace Johnson</i> .....	19
Recreation and Park Association: Promoting Cardiovascular Health – <i>Marvin F. Billups, Jr.</i> .....	22
Real-Life Effects of Cardiovascular Disease on African American Families: Testimonials – <i>Carol Payne and Andrew Walker</i> .....	25
A Community Outreach and Education Cardiovascular Health Framework – <i>Lenee Simon</i> .....	28
Students in Action to Promote Cardiovascular Health – <i>Dr. Yvonne Bronner</i> .....	31
U.S. Department of Housing and Urban Development and Community Health Workers – <i>Carol Payne</i> .....	33
Housing Developments Embrace Cardiovascular Health Opportunities – <i>Dr. Samuel B. Little</i> .....	36
<b>Youth Poster Contest</b> .....	<b>38</b>
<b>Breakout Group Discussions Summaries</b> .....	<b>40</b>
Public Education and Media .....	40
Public Housing Community .....	43
Training Community Health Workers To Promote Cardiovascular Health .....	48
Integrating Public Health Students in Community-Wide Cardiovascular Health Promotion Activities .....	52
Building and Sustaining Collaborative Partnerships for Cardiovascular Health Education and Outreach .....	58
<b>Next Steps</b> .....	<b>62</b>
<b>Appendix: Breakout Group Discussion Questions</b> .....	<b>63</b>





Tom Miller, 1998, Cherry Hill Shopping Center, 600 Cherry Hill Rd. Photo courtesy of Baltimore Office of Promotion and the Arts.

The mural artwork above and those shown throughout this report are courtesy of the Baltimore Office of Promotion and the Arts and are part of its City Murals Project. The National Heart, Lung, and Blood Institute would like to thank the Baltimore Office of Promotion and the Arts and Mr. Gary Kachadourian for use of the photos in this report. The mural captions indicate the artist, year made, and street location.

## INTRODUCTION

**A**s part of its commitment to the Healthy People 2010 (HP2010) national health agenda, the National Heart, Lung, and Blood Institute (NHLBI) is working with groups in communities at high risk for cardiovascular disease (CVD) to address the two overarching goals of the agenda—eliminate disparities in health (in particular cardiovascular health [CVH]) and increase the quality and years of healthy life. The Baltimore City Cardiovascular Health Partnership (BCCHP) is an initiative to promote CVH in African Americans in Baltimore City, primarily targeting public housing residents. The NHLBI and the BCCHP presented a community-based CVH workshop in Baltimore City on September 24, 2001, 8 a.m. – 4 p.m. At the time of the workshop, the core partner institutions that comprised the BCCHP were the Morgan State University Public Health Program, the Housing Authority of Baltimore City (HABC), and the Baltimore Field Office of the U.S. Department of Housing and Urban Development (HUD). During the workshop, the Baltimore City Department of Recreation and Parks (BCDRP) stated its commitment to the BCCHP’s efforts and has since joined the group.



The purpose of the workshop was to bring together a cadre of Baltimore residents and service providers to begin a dialogue about opportunities to integrate CVH outreach and education activities into existing programs and activities targeting Baltimore City African Americans, particularly African American residents living in Baltimore public housing developments. More than 70 representatives from Baltimore health and social service agencies, HABC staff, and Baltimore public housing residents attended the event and advised how the cosponsors could capitalize on existing programs and outreach channels, especially programs in public housing developments, and use them for CVH. The workshop participants also discussed communication channels and strategies to promote a community-wide CVH campaign. The workshop was an important step for the BCCHP to assess the communities’ readiness to plan, develop, and implement activities to improve CVH.

The purpose of the workshop was to bring together a cadre of Baltimore residents and service providers to begin a dialogue about opportunities to integrate CVH outreach and education activities into existing programs.

## WORKSHOP GOALS AND STRUCTURE

**A**s demonstrated by the coronary heart disease (CHD) and stroke death rates for African Americans living in Baltimore City, and the national CVD risk factor data for African Americans outlined in the background section of this report, the African American community in Baltimore could benefit from CVH education and outreach activities. The goals of the BCCHP Strategy Development Workshop were to provide participants with an opportunity to:

- Increase their understanding of and knowledge about the context for implementing heart health awareness and education activities in Baltimore City.
- Provide recommendations on effective strategies to promote and reinforce improved heart health behaviors.

The workshop was structured as an interactive event. During the morning sessions, participants heard the latest data on CVD in African Americans and the concepts that BCCHP would use to improve CVH in Baltimore City. In addition, a family told their story of the real-life impacts of CVD. In the afternoon, participants were divided into five discussion groups to discuss topics related to developing a well-informed and well-considered heart health promotion strategy. The following were the breakout group discussion topics:

### Breakout Group I:

#### **Public Education and Media**

### Breakout Group II:

#### **Public Housing Community**

### Breakout Group III:

#### **Training Community Health Workers To Promote Cardiovascular Health**

### Breakout Group IV:

#### **Integrating Public Health Students in Community-Wide Cardiovascular Health Promotion Activities**

### Breakout Group V:

#### **Building and Sustaining Collaborative Partnerships for Cardiovascular Health Education and Outreach**

## WORKSHOP AGENDA

8:00 a.m. Registration

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**Session I Facilitator:**  
**Dr. Yvonne Bronner,**  
**Morgan State University**

8:30 a.m. Welcome  
Invocation

Dr. Yvonne Bronner

Minister Douglas Wilson,  
Clergy United for the Redevelopment  
of East Baltimore

Opening Remarks

Dr. Claude Lenfant, Director,  
National Heart, Lung, and Blood Institute

8:45 a.m. Introduction of Speaker  
Impact of Cardiovascular Disease  
in African American  
Communities

Dr. Bronner

Dr. Wallace Johnson  
Assistant Clinical Professor of Medicine  
Department of Medicine,  
Hypertension Section  
University of Maryland School of  
Medicine-Baltimore

9:30 a.m. Recreation and Park Association:  
Promoting Cardiovascular  
Health

Mr. Marvin Billups  
President, National Recreation and  
Park Association

9:45 a.m. Real-Life Effects of Cardiovascular  
Disease on African American  
Families: Testimonials

Ms. Carol Payne  
Mr. Andrew “Drew” Walker

10:15 a.m. Questions & Answers

10:30am BREAK

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**Session II Facilitator:**  
**Ms. Carol Payne,**  
**Baltimore Field Office,**  
**U.S. Department of Housing and**  
**Urban Development (HUD)**

10:45 a.m.	A Vision of CVH for Baltimore City African Americans	
	<ul style="list-style-type: none"><li>• A Community Outreach and Education CVH Framework</li><li>• Students in Action to Promote CVH</li><li>• HUD and Community Health Workers</li><li>• Housing Developments Embrace CVH Opportunities</li></ul>	Ms. Lenee Simon, NHLBI Dr. Bronner Ms. Payne Dr. Samuel B. Little, Housing Authority of Baltimore City
11:45 a.m.	Questions & Answers	
12:00 p.m.	Youth Poster Contest Presentation Luncheon	Presented by Mr. Harold Young, Field Office Director, Baltimore Field Office of HUD  and Mr. Paul T. Graziano Executive Director, HABC

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**Session III Facilitator:**  
**Dr. Samuel B. Little, HABC**

1:15 p.m.	Charge to Breakout Groups	Dr. Little
	<ul style="list-style-type: none"><li>• Format and Content</li><li>• Facilitation</li><li>• Recording Outcomes</li></ul>	
1:30 p.m.	Breakout Group Sessions	Breakout Group Leaders (I, II, III, IV, V)
2:30 p.m.	Stretch/Break Continue Breakout Discussions	
3:15 p.m.	Summarize Breakout Group Discussions	
3:30 p.m.	Reports from Breakout Group Leaders	Breakout Group Leaders (I, II, III, IV, V)
4:15 p.m.	<ul style="list-style-type: none"><li>• Summary Remarks and Discussion</li><li>• Next Steps</li></ul>	Dr. Bronner Ms. Simon
4:30 p.m.	Adjourn	

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Main meeting room - September 24, 2001  
Strategy Development Workshop



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## BREAKOUT DISCUSSIONS: EXECUTIVE SUMMARY

**T**he BCCHP and NHLBI designed the breakout discussions at the Strategy Development Workshop to elicit ideas from participants for a CVH public education and outreach strategy in Baltimore City African American communities, with an emphasis on targeting public housing residents. We developed a group of issues to look at core elements of public health programming: 1) the target audience; 2) communication channels; 3) health messengers and messages; 4) incentives, motivators, and barriers to reaching desired objectives; 5) educational activities; and 6) monitoring and evaluation.

The NHLBI uses a model of health education outreach that assesses the environment to identify existing programs and areas where CVH messages and education could be integrated. Therefore, groups were asked to assess their community for opportunities to integrate CVH education. The crosscutting recommendations that follow resulted from two or more of the five breakout groups.

### Crosscutting Recommendations

Participants selected three primary target audiences—women, youth, and family. The rationale for selecting women is their role in communities and families as “gatekeepers” to changing family behaviors. Also with regards to public housing, often women are the head of the household. The youth audience was described as one where the primary prevention message could be most effective. Participants commented that behaviors are more easily modified at younger ages and the BCCHP could target this audience to form positive health behaviors before they can

develop poor health behaviors as adults. Youth are also seen as an appropriate target because they can serve as role models for their peers as well as adults in their family. Participants also noted that by targeting the entire family an intergenerational CVH message can be developed. Women and youth can serve as role models to other members of the family. Therefore, by targeting youth and women the family can be targeted indirectly.

Channels to reach the above audiences:

- 1) radio, television, and print media;
- 2) a membership card modeled after a successful promotional marketing strategy used by a Baltimore City commercial radio station; and 3) Internet and computer-based tools (e.g., a partnership Web site, CVH educational software).

Recommended CVH messages for the BCCHP included slogans with the words “keep” and “beat” (e.g., “The Beat Goes On,” “Keep the Beat Going”). Participants recommended a CVH theme that addresses the role of nutrition and diets in African American culture. A message about the effects of CVD on the lives of everyday people was also suggested. Celebrities, peers, youths, and Community Health Workers (CHWs) were recommended as behavior change agents, to deliver these messages to the Baltimore community and public housing residents.

Participants identified activities to promote CVH awareness and improve lifestyles. They recommended training CHWs—adults and youths using a train-the-trainer or modeling approach. Line dancing and hand dancing are popular Baltimore social activities that are relevant to CVH promotion as a form of physical activity and can also



## Cross-Cutting Recommendations

- Target population: women, youth, and family.
- Communication channels: cardiovascular health membership card, Radio One, and local cable stations.
- CVH themes/messages: slogans with the words “keep” and “beat,” the effect of CVD on the lives of “everyday” people, and the relationship between diet/nutrition and the burden of CVD in African American populations.
- CVH messengers: celebrities, everyday people, youth, and community health workers.
- Existing public housing programs to integrate CVH activities: youth development centers, tenant counsel programs, BCDRP, and programs sponsored by local community and civic organizations.
- Educational activities: CVH training, support groups, line and hand dancing, fairs and health screenings, and heart health games.
- Incentives and motivators: award service learning hours, certificates, CVH survivors as role models, and promotional items (water bottles, T-shirts).
- Policy change/advocacy: improving school nutrition and increasing physical activity, increasing availability of heart healthy food choices, spearheading a heart health political agenda in Baltimore City, and improving access to quality CVH preventive care.
- Challenges: funding, competing priorities and needs in communities (i.e., unemployment, substance abuse), uninsured and underinsured, and health beliefs and perceptions.
- Potential partners: supermarkets, churches, schools, hospitals, public housing tenant counsel, and elected officials.
- Monitoring and evaluation: periodic clinical and behavioral health assessment (i.e., blood pressure, smoking habits, weight), and monitoring a BCCHP Web site.

be used as an opportunity for CVH education. Other activities recommended included support groups, health fairs and screenings, and heart health games and competitions. The existing public housing infrastructure offers opportunities to engage residents on CVH. Participants recommended conducting CVH activities during tenant counsel meetings, at youth development centers, and as a part of after-school programs.

In order to encourage participation in CVH activities, participants suggested incentives and motivators. “Service-learning” is a community service requirement for graduation from public schools in Baltimore, so awarding service learning hours for youth participation was recommended. Linking CVH activities with this requirement could have health and educational benefits for youth. Other recommended incentives included, certificates and shopping discounts and promotional items (e.g., water bottles, T-shirts). In addition to providing incentives and motivators, a strategy to engage Baltimore African American communities about CVH must recognize and address the barriers that may impede the success of public health objectives. Participants discussed these barriers to participation and interest in the BCCHP activity, identifying lack of funding, competing priorities, low availability of heart healthy food choices, limited access to care, and preexisting health beliefs and perceptions.

Participants recommended a monitoring and evaluation strategy that periodically assess health indices in the targeted population, including blood pressure, weight, physical activity, and customer satisfaction.

Participants identified policy changes, advocacy, and partnerships that would help to address barriers. To improve the availability of heart healthy food choices, participants recommended soliciting supermarkets and grocery stores to become members of the BCCHP. Elected officials were seen as important persons to target for membership in the BCCHP to effect city policy changes to encourage heart healthy lifestyles and create a city-wide heart health agenda. School representatives should also be invited to participate in activities and become members of the partnership, to improve school nutrition and physical activity policy. They also stated that hospitals and health providers should also be targeted to improve Baltimore City’s quality of cardiovascular preventive care.

Participants recommended a monitoring and evaluation strategy that periodically assess health indices in the targeted population, including blood pressure, weight, physical activity, and customer satisfaction (as related to CHW activities). Other partnership evaluation measures recommended by participants included partnership Web site “hits,” attendance at activities, and participation in a members’ club using a card that could electronically monitor the consumption of heart healthy products.



Pontella Mason, 1997, 2117 E. North Ave. Photo courtesy of Baltimore Office of Promotion and the Arts.

### Special Issues by Breakout Discussion Session

In addition to the crosscutting recommendations made during two or more discussion sessions, certain issues and recommendations arose during individual sessions.

#### **Public Education and Media**

Participants in the public education and media session recommended targeting African Americans with the highest CVD rate. They also recommended targeting African Americans 35 years and older, based on the success of a commercial marketing campaign that has targeted this segment of Baltimore's African American population. Participants recommended tracking activities using a formal database. Participants familiar with the public housing community recommended using public housing computer learning centers to conduct CVH Web-based and computer software educational programs.

#### **Public Housing Community**

Participants of the public housing community session recommended targeting elderly, disabled, and homeless persons (people who do not reside in public housing but use public housing facilities and programs). Challenges to engaging members of the public housing community identified by participants included scheduling activities on inappropriate days (e.g., "check day") and treating all public housing developments as if they were the same. For example, not all public housing developments offer the same services to residents. An important policy activity that could impact the CVH of public housing residents would improve residents' voter registration. Participants believed that this would provide residents with more clout when advocating heart healthy policy changes to improve their community's health.

#### **Training CHWs to Promote Cardiovascular Health**

This session identified CHW characteristics. CHWs should be informal community leaders who are able to develop one-on-one relationships and serve as role models for a particular health issue. When selecting CHWs, the participants recommended looking beyond traditional criteria, such as educational attainment, and focus on the characteristics described above. Recruiting public housing residents, identifying people who are actively involved with local schools, churches, community associations, and the HABC Resident Advisory Board, and seeking referrals from HABC family support counselors, were recommended strategies for identifying potential CHWs.

BCCHP CHWs should be trained in core CHW competencies such as ethics, assessment, and crisis intervention, as well as core CVH content (e.g., nutrition, heredity, physical activity, lifestyle). The materials for training should be visual and not text-heavy and the training structure should include mock home visits; "shadowing" experienced CHWs; and in-class, clinic-based, and in-the-field practice. The instructors conducting CHW training should themselves be experienced CHWs and CVH professionals.

Participants believed that people will be motivated to become a CHW if it is paid employment and if there will be possibilities for professional development, such as opportunities to write and present on health topics with other health professionals. Other incentives identified included health and childcare benefits and personal development opportunities (e.g., financial planning, improving one's own health). A barrier to one's becoming a CHW would be practicing a negative health behavior (e.g., substance abuse). Public housing income limits might also be a disincentive to participating in CHW activities. Persons with a criminal record might be prevented from participating, and low-literacy persons might find CHW activities to be a challenge.

### **Integrating Public Health Students to Community-Wide Cardiovascular Health Promotion**

Participants of the student-focused discussion session agreed to broaden the targeted student population to include elementary, middle, and high schools; college students; and graduate students in the Morgan State University public health program. They also recommended collaborating with Baltimore City educational institutions that serve large African American student bodies (e.g., Coppin State College, Sojourner Douglas College, and Baltimore City Community College). A strategy that will engage students in public health education activity must first prepare students with training in both the health topic area and contextual information about the population targeted. Participants recommended using a train-the-trainer model in which youth would serve as peer educators. The youths targeted to participate in these activities would be public housing residents, as well as involving youths who are involved with the criminal justice system or not currently in school. Trained youths would target their peers, family members, and the larger community. Outlets recommended for youth CVH education include the summer youth employment program, collaborating with the University of Maryland Cooperative Extension program, and youth dissemination of CVH information packets in public housing developments.



Pontella Mason, 1997, 2125 E. North Ave. Photo courtesy of Baltimore Office of Promotion and the Arts.

### **Building and Sustaining Collaborative Partnerships for Cardiovascular Health Education and Outreach**

Participants of the partnership sustainability discussion session recommended expanding the BCCHP organization base to include the private sector (commercial businesses), philanthropic organizations, youth organizations (e.g., the YMCA, Boys and Girls Clubs), City Government (Mass Transit), and small grassroots and social organizations (e.g., hand-dance groups). To expand the organization base, participants recommended a communication and promotion strategy that would include the development of an information packet about the BCCHP, soliciting meetings with potential partner organizations, and involving local media to promote the BCCHP message. In addition to promoting the CVH message to the public and to Baltimore City organizations, participants recommended advocating policy to make environmental changes for CVH. The recommendations included collaborating with Maryland State and Baltimore City government-funded programs that provide food assistance to residents to develop a heart healthy food consumption incentive program, targeting food vouchers recipients. The group also recommended alliances with the U.S. Department of Agriculture and African American farming groups in Maryland to promote the consumption of the heart healthy products they produce. The group also recommended developing a policy-advocacy tool to be called a Baltimore City CVD Hotspots Map. Participants envisioned a map that would identify geographic areas of Baltimore City with high morbidity and mortality due to CVD. The maps would be shared with city officials responsible for “hotspot” neighborhoods to spur their accountability and encourage their active involvement in the BCCHP.

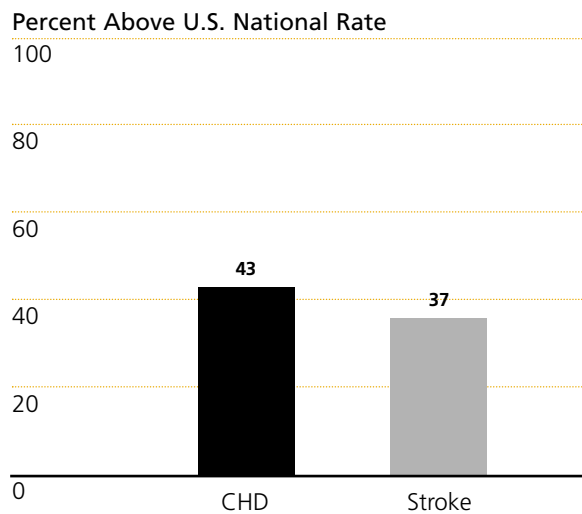


## BACKGROUND: CARDIOVASCULAR HEALTH AND BALTIMORE AFRICAN AMERICAN COMMUNITIES

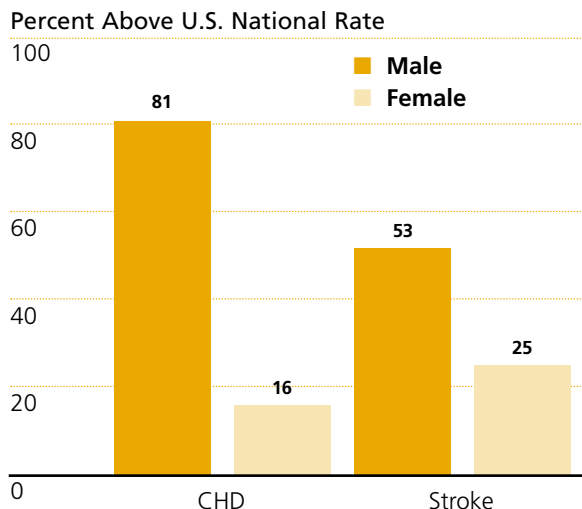
**A**frican Americans in the Baltimore metropolitan area suffer disproportionately from CHD and stroke mortality and associated risk factors. This situation calls for immediate and aggressive action. Based on 1996–98 data, the age-adjusted death rate for CHD was 43 percent higher for African Americans living in Baltimore City than the national rate;<sup>1,2</sup> the rate of stroke death was 37 percent higher than the national rate (Figure 1).<sup>1,2</sup> This translates into more than 3,600 Baltimore City African Americans who died of CHD and stroke during this period.<sup>1</sup> Furthermore, CHD and stroke death rates for Baltimore African American males were 81 percent and 53 percent higher than the national rates, respectively (Figure 2).<sup>1,2</sup> For African American Females, the rates were 16 percent and 25 percent higher than the national rates (Figure 2). There have been declines overall in the U.S. prevalence of heart disease, but African Americans have not seen the same rates of decline as whites. Between 1988 and 1998, the percentage declines in CHD mortality were the lowest among African American females and the highest among white males.<sup>3</sup>

In addition to disparities in heart disease and stroke, the major forms of CVD, risk factors that can lead to heart disease and stroke are also disparately higher in the African American community. The following information on national CVD risk factors prevalence for African Americans is being used as a proxy for the Baltimore City African American population. Forty percent of African Americans aged 20 years and

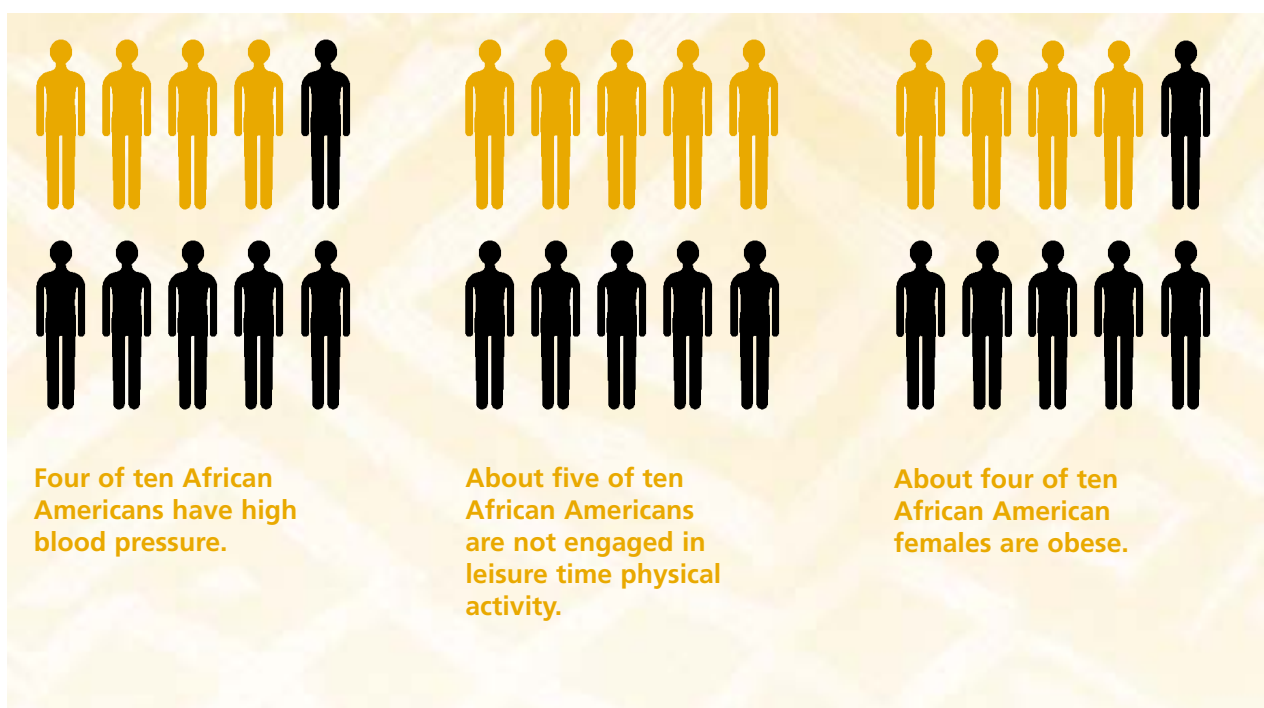
**Figure 1: Baltimore City African American Coronary Heart Disease and Stroke Mortality Compared to U.S. National Rates (1996-98)**



**Figure 2: Baltimore City African American Coronary Heart Disease and Stroke Mortality By Sex Compared to U.S. National Rates (1996-98)**



**Figure 3: Selected CVD Risk Factors for African Americans**



older have high blood pressure (white 27 percent; Mexican American 29 percent) (Figure 3).<sup>4</sup> Fifty-two percent of African Americans engage in no leisure time physical activity (white 38 percent).<sup>5</sup> Thirty-eight percent of African American females are obese—the highest percentage of obesity exhibited in any U.S. ethnic or racial subgroup (Figure 3).<sup>6</sup> Only 19 percent of African Americans with high blood pressure have it controlled—this is 31 percentage points below the HP2010 objective target of 50 percent.<sup>7</sup>

**REFERENCES:**

- 1) Data calculated by the National Heart, Lung, and Blood Institute, National Institutes of Health. Mortality data from CDC National Center for Health Statistics' 1996-98 Mortality Multiple Cause of Death Files. Population data are from U.S. Bureau of the Census and National Center for Health Statistics, Population Estimates by age, race, sex, and Hispanic origin 1990-1999.
- (2) National Vital Statistics System (NVSS), CDC, NCHS (1998).
- (3) Vital statistics of the United States, NCHS (data for 1988-1998).
- (4) National Health and Nutrition Examination Survey (NHANES), CDC, NCHS. (data for 1988-94).
- (5) National Health Interview Survey (NHIS), CDC, NCHS. (data for 1997).
- (6) National Health and Nutrition Examination Survey (NHANES), CDC, NCHS. (data for 1988-94).
- (7) National Health and Nutrition Examination Survey (NHANES), CDC, NCHS (1988-94).

## PRESENTATIONS

### Impact of Cardiovascular Disease in African American Communities



**C**VD is the leading cause of death in the United States. Most of these deaths are preventable and premature (occurring in persons under age 65). CVD-related death rates are higher in the African American population than in the white population, and persons of lower socioeconomic status (SES) suffer higher CVD incidence and mortality rates than those of higher SES. High cholesterol, hypertension, and diabetes account for 43 percent, 29 percent, and 13 percent of CHD deaths respectively.

**Dr. Wallace Johnson**  
Assistant Clinical Professor of Medicine  
University of Maryland School of Medicine



CVD is not just a disease of the elderly. It is apparent at young ages. Autopsies have shown the presence of one type of CVD—atherosclerotic lesion—as early as age 15. These lesions were more severe in African Americans. A factor that may be related to higher CVD rates in African Americans is the greater clustering of risk factors (i.e. a person having multiple risk factors, such as cigarette smoking, hypertension, obesity, or diabetes at the same time). End-stage renal disease is several fold higher among African Americans than among white Americans. There is also a higher prevalence of left ventricular hypertrophy (thickening of the heart muscle) in African Americans, which increases the risk of sudden cardiac death.

Hypertension is a major risk factor for CHD and stroke in African Americans. It is still the “silent killer”—not only because of patients lack knowledge about the disease, but also, due to apathy, by physicians in particular. The following anecdotal example illustrates the need for physicians to address hypertension in young African American patients. In a review of blood pressure readings of high school students, African American students, both those with hypertension and those with readings within the normal range, had higher blood pressure readings as compared to their white peers. Factors contributing to hypertension in African Americans are salt sensitivity, earlier disease onset, and higher levels of stage 3 hypertension requiring multiple medications. Hypertension control rates remain at less than 50 percent. There is a need for continued education and advocacy for CVD and its risk factors, such as hypertension, which is now considered a common disease, and does not receive the public’s attention, as do health issues such as human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) and homicide.



Gary Mullen, 1999, *Arena Players*, 801 McCulloh St. Photo courtesy of Baltimore Office of Promotion and the Arts.

Barriers to patient care also affect African Americans. The Center for Studying Health System Change noted in their (1998-1999) Physician Survey that about one in four African American physicians (35.9 percent) surveyed, most of whom treat African American patients, have difficulty in getting their patients admitted to hospitals, as compared to white physicians. Reasons cited include poor physician clout, poor proximity to hospitals and specialists, and discrimination. In addition, African American physicians have greater difficulty than white physicians in securing specialty care referrals for their patients. These differences remain constant, even when factors such as physician experience, training, practice size, and managed care participation are controlled. The lead investigator for the study, J. Lee Hargraves, states “The inability of doctors to get hospital and specialty care contributes to documented health disparities among African Americans.” Other health disparities that may contribute to poor health outcomes in some African Americans are:

- African Americans receive less diabetes care than whites.
- African Americans are less likely to receive cardiac surgery than whites.
- Minority physicians provide a disproportionate amount of care to underserved minority communities.

The Meharry-Hopkins Cohort study illustrates the health disparity that exists in CVD between whites and African Americans.<sup>1</sup> The purpose of the study was to determine, if any, differences in CVD risk factors existed between a cohort of male African American medical students at Meharry Medical College (1958-1965), and a cohort of male white medical students at Johns Hopkins University (1957-1964) (female study participants were excluded from analysis due to statistical soundness). Followup data were collected from the participants at 22.5, between 25 and 30, and 35 years after the initiation of the study. The study was significant because both medical student groups had similar educational, professional, and socioeconomic status, and avoided confounding variables seen in prior studies.

About one in four African American physicians (35.9 percent) surveyed, most of whom treat African American patients, have difficulty in getting their patients admitted to hospitals, as compared to white physicians. Reasons cited include poor physician clout, poor proximity to hospitals and specialists, and discrimination.

The results of the study found several disparities in health.

- African American physicians were noted to have higher excess risk of diabetes compared to whites, and this could only be explained partly by racial differences in adiposity (fat distribution).
- African American men participating in this study had a higher-than-expected risk of CVD, premature death, and hypertension. In fact, the hypertension prevalence rate in this group was greater than that of the African American population at large.

The study concluded that education and affluence provided the Meharry cohort with little protection from health problems that affect the African American community at large. African American physicians are therefore falling prey to the same diseases that strike down their patients. In summary, when both the physician and patient have excess risk of CVD the African American community is in danger of going from underserved to unserved.

Let us work and pray that the hearts and minds of the African American community are not disproportionately affected by CVD.

1. Thomas J., Thomas D.J., Klag M., et.al. Cardiovascular disease in African American and white physicians: the Meharry Cohort and Meharry-Hopkins Cohort studies. *Journal of Health Care for Poor and Underserved*. 1997;8:270-83.

## Recreation and Park Association: Promoting Cardiovascular Health



The field of recreation and park activities is larger than just “fun and games,” and the BCDRP believes that people can lead healthier lives if they engage in physical activity. The BCDRP offers prevention activities as well as activities to address the needs of people who have diseases. The availability of recreation and park facilities throughout the Nation can have an impact on CVD, by reducing risk factors of the disease through physical activity. The National Recreation and Park Association (NRPA) is working with NHLBI to implement Hearts N’ Parks, a community-based program in 50 sites across the United States, to encourage physical activity and heart healthy nutrition practices among children participating in park and recreation programs. NRPA is also working with the Centers for Disease Control and Prevention (CDC) to evaluate the impact of its members’ facilities on health. One of the goals of the collaborative

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Baltimore City  
Department of  
Recreation and  
Parks

is to develop a database of activities offered by facilities nationwide. Currently, there is no central database of recreational activities across the country.

NRPA plans to secure a grant from the CDC to develop this “Active Parks” database and will advocate that all its member organizations across the country submit their program information to Active Parks.



Information will include the types of facilities and what activities they offer. The intermediate goal is to share this information with the

public and help them identify the many activities available through their local parks and recreation department of interest to them.

The ultimate goal is increased public physical activity (At the September 2001 NRPA meeting in Denver, CO, Marvin Billups was appointed the new president of NRPA.).

Baltimore City has about 5,700 acres of parkland within its boundaries. Many BCDRP activities are designed to provide outlets for youth. Some of the youth activities are little league baseball, football, and basketball, and soon volleyball will be added. Last summer, the BCDRP implemented a youth gymnastics program. A youth golf program is ongoing. This will give youth a lifetime physical activity skill. The department runs 3 pools year-round, and 19 pools that are open during the summer months. Park and recreational facilities are available in Baltimore City, but if the public is not aware of them, they will not be used. The goal of the BCDRP is to create a climate in communities where people are engaged in more physical activities, not only among the City's youth population, but the population's entire age spectrum.

Soon the BCDRP will have a trail, 14 miles long, that will stretch from Baltimore's northwest side (Gwynns Falls/Leakin Park) to the harbor. Some portions of the trail are useable now. The facility will be a walking path of gorgeous woodland. Another Baltimore park site available for public use now is Lake Montebello. The BCDRP recognizes that recreation and park programming are generally targeted to males. The department is making an effort to encourage participation by Baltimore City females through the development of programs targeted to this population. Next summer and fall, the BCDRP will offer programs specifically for women. One program that is under consideration is a Baltimore Olympics for women, from toddlers to seniors.

The goal of the BCDRP is to create a climate in communities where people are engaged in more physical activities, not only among the City's youth population, but the population's entire age spectrum.

The BCDRP also has approximately 95 senior citizen clubs and plans to enhance club agendas to promote health and physical activity. Next spring the department will kick off a program called "Come Out and Play Baltimore." The concept is to teach people how to play again. Many rules of sports engagement set standards that eliminate people who cannot play well. In the past, all that was required to participate in games was one's willingness to play. Anyone could get a "chance at bat." Now, if you don't play well enough, you are not on the team—at the elementary, middle, or high school levels. People therefore don't play anything that they are not "good at." This system of elimination builds a pyramid, with a small group of players at the top and a large group of people not participating in physical activity. The BCDRP "Come Out and Play Baltimore" message will challenge this system. The department will promote a message that everyone can engage in wholesome recreational activities—regardless of skill level, and that it is all right if you are not "good"—it is all right to go out just for the fun of the game. The department's goal is to develop another reason for being involved in physical activity other than competition and ranking—improved health. The BCDRP will send a message early to youth about the benefits of good health choices and the implications of poor health choices.

Many adults make the mistake of believing that being busy is the same as being active. They go to work, and then are off to a meeting—only having a "quick" bite for lunch. These adults are not taking care of their bodies, their temples. Sooner or later, because of stress, poor nutrition, and inactivity, adults allow their bodies to become a candidate for hardened arteries. Some smoke cigarettes. Adults may not be aware of it, but they set examples for their children—by what they eat and how they take care of their bodies. Families probably spend more time at fast food restaurants than at their dinner tables. They have become too busy

to prepare a nutritious meal at home. Each one of us is a role model to our families, children, and friends. Each one of us must ask ourselves, what are we doing with our lives that continue to put us in harm's way?" Community service providers must ask themselves the question, "What am I doing as a provider to set an example to the public?" Providers of services in communities must internalize a healthy lifestyle. Providers in communities cannot be inactive and believe that they can successfully promote a message of physical activity. It only takes 30 minutes a day. You can walk around your neighborhood right now, and you don't need new clothing—unless you want to look stylish. You don't need to join a new health club. Collectively, we need to change how we live.

The department wants to promote the use of recreation and parks—low-or-no cost resources, to develop comprehensive health programs that would help keep people healthy and reduce their need for chronic disease care by health professionals. The BCCHP activities along with the efforts that the BCDRP will be instituting can make an important difference in health outcomes of residents of Baltimore. At the national level, NRPA will collect data to track activities and to show statistically that its efforts can make a difference—that physical activity leads to healthy lifestyles and outcomes. It's nice to see people engaged in physical activity, but when linked to health outcomes, it has even more meaning. The BCCHP can be on the cutting edge by working with the BCDRP to develop a system in Baltimore that measures health outcomes and park and recreation activities, which can result in a healthier Baltimore.



Lyle Kissack & Gerald Ross, 1997, 1000 N. Patterson Park Ave. Photo courtesy of Baltimore Office of Promotion and the Arts.

## Real-Life Effects of Cardiovascular Disease on African American Families: Testimonials

(The following are paraphrased remarks)



### Carol Payne

In 1999, I had the misfortune of losing my husband to CVD. It was the most devastating moment in my life. I was not prepared for his death or the impact of CVD on my life. He was my friend, my confidant—the other side of me, and I miss him terribly.

### Carol Payne and Andrew "Drew" Walker

Our family experienced the concerns Dr. Wallace Johnson spoke about in his discussion on the impact of CVD in the African American population. My late husband, William, had a long history of cigarette smoking and developed diabetes when he was in his forties. As his wife and a nurse, I tried desperately to educate him. He was non-compliant. When it became clear that we might not win the battle, William insisted that I educate everyone in our family—about the effects of CVD. In response to his wish and as a tribute to his remembrance, I became involved with cardiovascular community projects. In 1999, I served as cochair of the Walk-for-Wellness, a community event designed to raise awareness of CVD, its risk factors, and the importance of physical activity to CVH. That year, my colleagues, as a touching salute to his memory, dedicated the Walk-for-Wellness to my late husband.

I did not know in 1999 that I would be here today participating in the BCCHP. This is God's miracle. I was put in place to do his work, wherever I am. I must do His work. I'd like to pause for one moment so everyone can think about how heart disease, stroke, or diabetes has touched you, a family member, a coworker, a member of your community, or a member of your church—by a death or in suffering the side effects of a cardiovascular

event. It can happen to anyone of us participating in this workshop today. You don't want to miss the opportunity to prevent it from happening to you, or someone dear to your heart.

This year while traveling in Egypt, Dr. Elmer Martin, founder of the Great Blacks in Wax Museum had a heart attack and did not recover. The death of Dr. Martin was the loss of a community hero—someone who made our community better. I know if he were here today, he would say that we must do something—we must take action. The other person I want to mention is Ella Thompson. If you read the book or saw the movie “The Corner,” you are aware of her work and efforts to improve the quality of life in the Franklin Square Community, especially for young children. Quite by accident, I was introduced to Ella in my infant mortality work and in my working with young mothers.

The day after traveling to Washington, DC to pickup donated computers for her community (donated by Ted Koppel), she suffered a heart attack. Ella smoked cigarettes for many years. The Franklin Square Community is not the same without her. We all know Ray Haysbert of Park Sausage. While attending a party, he had a heart attack. He survived and is doing well. The persons I mentioned are recognized leaders who are important to our community. So when you think about heart disease, stroke, and hypertension, take a moment to look in the mirror. It could happen to anyone of you.

This time last year, my first-born son had a stroke at 31, and I had a serious conversation with God. I said to Him, “Now God, in 1999, I survived the death of my husband. I'm not sure I can survive this one. So you must step in . . . and take care of him.” I am so pleased to introduce my son—my heart, who will share his story—Andrew.

### Andrew “Drew” Walker

It is an honor to be here today. My mother spoke to me about today's event and asked me to participate. Given my experience a year ago, I agreed to tell my personal story of dealing with CVD. Last June, I suffered a mild stroke. It was caused by a defect in my heart. My heart had a small hole.

I never knew what a stroke was until that day. I was taken to the emergency room and given several diagnostic tests. Although I had the signs and symptoms of a stroke, because I was only 31 years old, the physicians did not believe it could be a stroke. In our community (the African American community) people have strokes at an early age, but not at 31 years. The experience of having a stroke was weird. I lost the ability to move on the left side of my body. I couldn't speak well. Imagine speaking with a mouth full of food. My speech was slurred. I sounded like a “drunk.” The motor skills on my left-hand side were “shot.” I recall being asked by doctors to move my left hand. In my mind I was moving my hand, but physically there was no movement. While in the hospital, I felt as if I was being used as a “guinea pig,” to teach medical students. I did not like this aspect of hospital care.

When we lost my stepfather, my mother made sure that members of our family had their health assessed. Prior to my stroke, I was the picture of perfect health. I played basketball religiously. I played football. When I had the stroke, I asked myself, “What did I do wrong?” I was told that I had a heart defect, which I had lived with for 31 years, by the grace of God. It was time for it [the stroke] to happen. As part of my care, I went into rehab at Kernan Rehabilitation Hospital. During my first day there, I went to the cafeteria and immediately went back to my room and asked for my meals to be served in my room. Everyone in the hospital was older (seniors) than me. I thought, “Whatever it takes for me to get out of here, I am willing to do it because I want to do it.” Because of my willingness and eagerness to get better,

the staff tried new exercises to speed up my recovery. I didn't like being at the rehabilitation facility because it reminded me of when William, my stepfather, passed away, and his experience in the hospital. I remember his condition before he passed away and how hard he fought to get better, but we caught it too late. My condition was diagnosed early, and I was committed to do whatever was necessary to get better. I didn't even mind working with the medical students, testing rehabilitation therapies. I developed a connection with one of the therapists.

Once I left rehabilitation, there was another health care decision I needed to make. Should I have open-heart surgery or stay on medication (Coumadin) for the rest of my life? I did not want to be on Coumadin, because I love okra. I would not be able to eat okra while taking Coumadin. I also love playing basketball and I couldn't imagine being on a blood thinner, and not being able to play basketball as I had before. My mother, father, and I got together and decided what to do. We decided that I would have open-heart surgery. But before finalizing this decision, I would take several tests to make sure that it was the right decision for me. The test confirmed that I had a hole in my heart about the size of a dime and that I needed surgery.

I was presented with two surgery options. I opted for open-heart surgery—the gold standard. I had to go through all these steps before my first consultation with Dr. Levi Watkins, the surgeon who finally performed my surgery.

I thank God for my mom arranging for me to see Dr. Watkins. As Dr. Wallace Johnson said in his presentation, it is very important that our community (the African American community) have access to state-of-the-art medical care. There is a great disparity between Caucasians and African Americans with regard to receiving proper medical care.

The surgery was scheduled for the Monday after Thanksgiving. When I awoke after surgery, I was in an intensive care unit. I had a breathing tube in my throat and a tube in my neck and chest. My chest was “killing” me. The pain was awful. I tell most people that what I've gone through I wouldn't wish on my worst enemy. It's something that you just don't want to go through if you don't have to. I was slated to go to a recovery room the Wednesday after my surgery. But the Tuesday before the scheduled surgery date, we had a problem. I suffered a small stroke. During recovery, the way my mother could tell I was doing fine was by the smile on my face. That Tuesday morning, my mother came in my room, and I had a blank look—like something was wrong. My mother told the attending nurse that something was wrong because she didn't see my smile. I had several mini-seizures. The doctors concluded that these were residual effects. I had to stay in the intensive care unit a little longer.

I was thankful that prior to my stroke and surgery, I was healthy. I ate right. I exercised. The surgery was on a Monday, and I was sent home that Friday. I was thankful for that. Now, I really must maintain my lifestyle. I try to watch what I eat. Every now and then I splurge. I cannot stress the fact that we—our community—need to take care of ourselves. We must go to the doctor regularly. I'm scheduled to go in November.

We need to take care of ourselves—individually and collectively. If you've got an uncle, or grandfather, and you know they are up in years, there is a chance that they may have CVD. You need to ask them, “Have you been to the doctor?” or take them if they have not. Find out if they are okay. We are losing far too many African American males. We really have to do it for ourselves. Now, I'm more cautious, and conscious of what's going on in my body. I know we all should do the same thing. If not, we will not be here much longer. I thank you.

## A Community Outreach and Education Cardiovascular Health Framework



The NHLBI is involved in community activities to address the national health agenda called, HP2010. The two HP2010 overarching goals are to: (1) increase the quality and years of healthy life of all Americans and (2) eliminate disparities in health. The BCCHP is a program being developed in response to the HP2010 challenge.

The community outreach and education CVH approach being considered by the BCCHP is guided by three principles. These are: (1) partnership; (2) local context; and (3) lifestyle and health recommendations that are relevant and applicable in real life. The first principle of partnership involves the collaborative efforts of organizations, community members, and leaders to take action to improve CVH. The second principle, local context, and in particular the Baltimore City African American community context, is defined by gathering information from the partners described above, through informal meetings and formal meetings, such as the BCCHP

**Lenee Simon**  
NHLBI

Strategy Development Workshop. The third principle, making relevant lifestyle and health recommendations, involves conducting formative research with community residents to gather information on their current behaviors and what would motivate them to make changes in their lives. This information is then used to identify lifestyle and behavioral approaches and strategies that will be relevant and applicable in the everyday lives of the Baltimore City African American community.



The NHLBI is supporting community outreach and education to reduce CVD because of its devastating impact on the Nation. Heart disease is the number one cause of death in the United States regardless of one's gender or race, and stroke is the third cause of death. Since the 1950s there have been declines in CVD, particularly CHD death rates. This is a consequence of the advent of new medical technologies, as well as the knowledge of how lifestyle behaviors can impact CVD occurrence. The declines in CVD have not been proportional in U.S. racial and ethnic groups. African Americans die from heart disease and stroke at a higher rate than any other racial or ethnic group in the United States.

There are also geographic disparities in CVD mortality rates. The health service area that includes Baltimore City has higher CHD mortality rates than the Washington, DC metropolitan health service area. When one compares CHD mortality rates within Baltimore's health service area, African Americans have higher rates of death than whites residing in this same health service area. CVD risk factors and lifestyles can contribute to the rates of CVD death. Some national CVD risk factor rates for African Americans are:

- Four of 10 African American adults has high blood pressure.
- Two of three African American adults are not at a healthy weight.
- One of four African American adults smokes cigarettes.

The declines in CVD have not been proportional in U.S. racial and ethnic groups. African Americans die from heart disease and stroke at a higher rate than any other racial or ethnic group in the United States.

These risk factors can be reduced or reversed by changing lifestyle behaviors. The BCCHP's goals and corresponding activities of the BCCHP will address these risk factors. The first goal is to prevent the development of CVD risk factors, such as high blood pressure, smoking and obesity, through public education awareness activities that will promote the adoption of heart healthy behaviors. The second goal is to detect and treat CVD risk factors by informing the Baltimore City community about the importance of knowing whether they have risk factors and how they can reduce and control these.

The BCCHP is considering a two-pronged strategy for engaging African Americans about CVH-promoting lifestyles. The first component being discussed is a CVH public education awareness campaign targeting Baltimore City African Americans. The second component is intense outreach and education activities targeting African Americans who reside in Baltimore City public housing. Some of the community systems that are sought to participate in this initiative are:

- Public housing
- CHWs
- Local government
- Churches
- Schools/historically black colleges and universities (HBCU)
- The BCDRP
- Health care
- Business and media
- Community-based organizations (CBOs).

The partnership team includes Morgan State University, the HABC, The Baltimore Field Office of HUD, and the BCDRP. The partnership will also seek advise from leading African American CVD physicians in the Baltimore City area.

The NHLBI plans to conduct assessments to develop heart health educational tools for African Americans. The BCCHP goal is to develop education and outreach activities for public housing residents that encourage and reinforce CVH promoting lifestyles and behaviors. To facilitate outreach and education activities in public housing developments, CHWs—persons from the Baltimore City and HABC public housing community—will be recruited and trained to act as CVH information disseminators and role models.

The initiative began in December 2000, with partnership development activities. Partnership development is an ongoing activity. The Strategy Development Workshop (September 2001) is a milestone in the initiative's development and implementation. Specifically, the breakout sessions are an important step in gathering input from community leaders, service providers, and residents. Community assessment, following the workshop, will provide the context and content for developing activities and materials. The BCCHP reconvened a meeting in January 2002 to discuss the results of the Strategy Development Workshop and the assessments conducted to date.



Pleasant View Gardens, Housing Authority of Baltimore City

## Students in Action to Promote Cardiovascular Health



An observation by Pope Pius XII states, “The direction that society will take tomorrow depends on the minds and hearts of today’s. . . students.” Students can contribute in important ways to the BCCHP because they are our future. The posters promoting CVH placed around the meeting room are examples of the contribution of student residents of the HABC. In order for a student to participate in a poster contest to promote heart health, they must have knowledge of this topic. We see symbols, such as the heart, depicted in the posters, and in some posters the role of diet is highlighted. Students need a base of knowledge to participate in CVH promotion activities. A comprehensive student involvement approach to the BCCHP will facilitate knowledge acquisition by youth and young people.

**Dr. Yvonne Bronner**  
Morgan State  
University Public  
Health Program

Programs, heretofore, have been targeted to students, like those of the BCDRP discussed by Mr. Marvin Billups, director of the BCDRP. However, as the department has recognized, adults need these programs as well. Students can lead adults toward participation in activities to promote heart health throughout their lifetime. Activities to promote a heart healthy diet and physical activity are important components of an effort for CVH. The benefit of utilizing students is their ability to change their behaviors



more quickly than older adults, and to act as role models. It is important that students are made aware of their ability to make important contributions to improve health because sometimes the potential for their contribution is undervalued.

Participation by students in health education and promotion should start early, even at the elementary school level. It should not be put off until they have completed college. Student participation requires that the students be organized and contribute. We must make students aware that we value them and their abilities. Valuing students is one goal of student involvement by the BCCHP.

The BCCHP must embrace a concept of the long view of aging and health. Drew Walker's testimony is an example of this concept. Drew believed he was an invincible young person, and then something happened to him. The myth of youth invincibility and the real health concerns of young people are seen in autopsy reports of Vietnam veterans. The reports showed that these young men already had CVD in their blood vessels at ages between 18 and 20. The factors of poor diet, lack of exercise, and in some cases smoking, formed a pattern leading to unhealthy outcomes in these young men. This example supports an approach that starts early in life—as early as Head Start—and the need to partner with groups such as the Women, Infants, and Children programs. Even starting at the educable moment of pregnancy is important, in order to help families develop healthy habits instead of needing to change poor health behaviors. A study implemented in churches by Johns Hopkins University supports this view. Women in the study stated that while they may not have been able to make behavioral changes, they were very interested in seeing that their grandchildren not take the same health path

they did. They described this as a path that leads to hypertension, diabetes, and needing to take medication.

Obesity is an epidemic in our community. When comparing 1990 rates of obesity to 2000 rates, in some cases, there were increases between 50 and 75 percent in the rate of obesity (data from the CDC). These percentage increases in obesity were disproportionate, not only in adults and women, but also in teenagers. Obesity is epidemic in children as well. This is a pathway leading to CVH destruction for the next generation. Good food habits are needed, such as diets that are low in fat, high in fiber, and have the appropriate amount of caloric intake. Diets of fried foods, frequent eating at fast food restaurants, and eating large quantities are not healthy. In addition, physical activity is needed at all ages. In your 50s, 60s, and 70s, you can get started. The body is designed to do exactly what you ask it to do. If you ask it to do nothing, it will do nothing. But if you ask it to do 10 minutes, 3 times a day, it will, and you can build up to an hour.

A vision for student activities to support the BCCHP is one that involves students at the primary and secondary school levels (elementary, middle, and high schools). Once these students are organized, college and graduate students can lead the activities of students at all levels. Students involved in the BCCHP will learn about CVD risk factors and prevention and advocate knowing blood pressure and cholesterol numbers. Students will be involved in developing, implementing, and evaluating the plans for the initiative. The goal of student participation is to develop a winning CVH outreach and education model that can be replicated in other urban areas and among historically black colleges and universities. The students at Morgan State University are in training to develop these models and to evaluate the efforts of the BCCHP.

It is important that students are made aware of their ability to make important contributions to improve health because sometimes the potential for their contribution is undervalued.

## U.S. Department of Housing and Urban Development and Community Health Workers



**Carol Payne**  
Baltimore Field  
Office of HUD



**H**UD’s primary mission is to provide a decent, safe, and sanitary living environment for every American. In 1965, the U.S. Department of Housing and Urban Development (HUD) was created, as part of President Johnson’s War on Poverty. But its history extends back to the National Housing Act of 1934 and the 1937 amendment that created the United States Housing Authority for low-rent housing. HUD is responsible for national policy and programs that address the Nation’s housing needs, that improve and develop the Nation’s communities and enforce the fair housing laws—that is, creating opportunities for people to have a better quality of life. HUD programs that support community needs fall into the following categories: (1) community planning and development, (2) mortgage and loan insurance through the Federal Housing Administration (FHA), (3) public or subsidized housing for low-income families, (4) fair housing public education and enforcement, and (5) homeless assistance through local communities.

HUD’s core business is housing and creating opportunities for people to have a better quality of life. Implementation of HUD’s mission includes the following examples. Over 67 million American families own their homes through the FHA mortgage insurance program. Empower Baltimore is a HUD Community Planning and Development initiative (empowerment zones) designed to facilitate job training and other economic development activities at the community level in Baltimore City. The Office of Fair Housing and Equal Opportunity seeks to expand housing choice by responding to hate crime assessments and investigating other acts of discrimination.

Locally, the Baltimore Field Office of HUD coordinated the development of the Faith Academy, which was designed to expand the role of Baltimore's faith community in capacity building and community and economic development. Thousands of communities and tens of millions of Americans have benefited from HUD's housing and community development programs.

In 1998, under the leadership of Secretary Andrew Cuomo, the U.S. Department of Housing and Urban Development launched the Community Builder Fellowship Program. Community Builders serve as the first point of contact for HUD "customers" who need help: homebuyers, tenants, community leaders, nonprofits, public officials, business owners, and many others. Community Builders actively work to integrate HUD programs where it matters most in the community, by providing information and access to HUD's programs and services and fostering partnerships. Community Builders come from various backgrounds and use their expertise and professional experiences to further HUD's mission and empower communities. In the Baltimore Field Office of HUD, one approach has been recognizing and promoting the link between health and housing and the critical role health plays in moving families toward self-sufficiency and greater economic opportunity.

The BCCHP is an example of an integrated health and housing approach designed specifically to address the cardiovascular health of public housing residents. The organizations involved in the partnership have a common interest—a desire to address CVD and broadly disseminate a cardiovascular health message targeting African Americans.

The BCCHP will incorporate the CHW model in the implementation of the cardiovascular health project. The CHW model combines health promotion and awareness while providing economic opportunity through employment and training. CHWs help individuals and groups take greater control over their health and their lives. They promote healthy living by teaching how to prevent disease and injury, helping community residents understand their right to quality health and human services and how to navigate the formal health care system.

CHWs are known by several titles, community health worker, community outreach worker, community health advisor, lay health worker, and promotora. The important characteristic of CHWs is that they have roots in the community they serve. They are credible, trusted, and respected in communities. CHWs can identify barriers to behavior change that other health providers, such as a nurse or doctor, might not understand and help residents to move beyond the barriers.

HUD is responsible for national policy and programs that address the Nation's housing needs, that improve and develop the Nation's communities and enforce the fair housing laws—that is, creating opportunities for people to have a better quality of life.

CHWs have several core roles. They serve as cultural mediators and translate health messages for the lay public. The health and human services system can be intimidating to some—CHWs can serve as the mediator. They provide informal counseling, and social support, and a one-on-one relationship—allowing residents to open up and share their health issues. CHWs provide culturally appropriate health education and advocate for individuals while looking broadly at the community’s needs to assure the delivery of services. They also accompany clients to medical visits, facilitate transportation, and provide incentives to improve treatment compliance such as (medications and doctor’s visits). CHWs build individual and community capacity by assuming leadership in addressing community issues of public safety, voter registration, and other community building initiatives.

CHWs are trained in the competencies and skills of community outreach. Their skill set is different from that of a nurse or a doctor but just as critical to the healthcare team. These are: communication, a knowledge base, capacity-building, interpersonal skills, advocacy, service coordination, organization, and teaching ability. The last skill, teaching, is critical to their ability to translate information for the community’s consumption. Other qualities of CHWs are community trust, desire to help the community, empathy, persistence, respectfulness, personal strength and courage, creativity, and resourcefulness.

The BCCHP is an example of an integrated health and housing approach designed specifically to address the cardiovascular health of public housing residents.

There are several beneficial outcomes when CHWs provide preventive services. Access to health care increases. Quality of care improves. Health care costs are reduced. Families and communities are strengthened. New training and employment opportunities and a healthy workforce can invigorate local economies.

CHWs have been part of health and human services systems in the United States since the 1950s. The CDC estimates there are over 12,500 CHWs in more than 200 programs, providing a wide range of services as volunteers or paid staff. Successful models of CHW programs in Baltimore are:

- Baltimore City Healthy Start
- Baltimore City Healthcare Access
- The Young Black Male High Blood Pressure Study
- Heart, Body, and Soul (Faith-Based)
- Project Sugar—Two (Diabetes)
- Project Enable (Chronic Diseases).

The BCCHP will build on the success of these programs.

Community building through health promotion offers the chance to improve the quality of life and provide economic opportunities to community residents. The key to health promotion and disease prevention in the 21st century lies in lifestyle modification and creating more health-promoting program and policies at the community level. One of the goals of the BCCHP is to utilize the CHW model and work with the Baltimore public housing community to tailor the program to meet the needs of their community. The goal is to create a model that has been developed for and designed by and will benefit African Americans and one that can be replicated in public housing communities nationally and globally.

## Housing Developments Embrace Cardiovascular Health Opportunities



**P**ublic housing authorities that are effective do three things exceedingly well:

- Rebuild obsolete communities that no longer are in demand—in Baltimore this is evidenced by the Hope VI program.
- Manage their current inventory of housing stock—performing housing management tasks (e.g., collection of rents).
- Provide necessary supportive services to families that live in public housing—in Baltimore City this is facilitated by the Office of Resident Services (ORS).

**Dr. Samuel B. Little**  
Housing Authority  
of Baltimore City

The ORS of the HABC provides a plethora of supportive services and economic development activities for public housing residents. The goal of providing these services is to move residents towards self-sufficiency and living healthier lifestyles. The following is an overview of the HABC community, including a description of residents and the services that are offered to them by the ORS.



### Resident Characteristics

Thousands of the more than 50,000 people who reside in public housing in Baltimore City receive Temporary Cash Assistance (TCA) or other forms of public assistance. In public housing communities, there is a high incidence of substance abuse and high unemployment rates. Of the unemployed persons who live in public housing, some 45 percent of them lack a high school diploma or GED. There are also large senior and disabled populations living in public housing.



## YOUTH POSTER CONTEST

### Background

Prior to the Strategy Development Workshop, several preliminary discussions were conducted in Baltimore City with the HABC, Morgan State University Public Health Program, Baltimore Field Office of HUD, and the National Heart, Lung, and Blood Institute. One such meeting was held at the HABC on August 21, 2001 at Pleasant View Gardens Community Center. One of the topics of discussion engaged participants about the opportunities and existing programs and infrastructure that exist in public housing for CVH outreach and education. Several youth programs were mentioned. In order to garner youth interest and participation in these programs, contests and promotional activities were conducted. The participants recommended that a similar activity be implemented to promote the BCCHP and be displayed at the Strategy Development Workshop September 24, 2001.

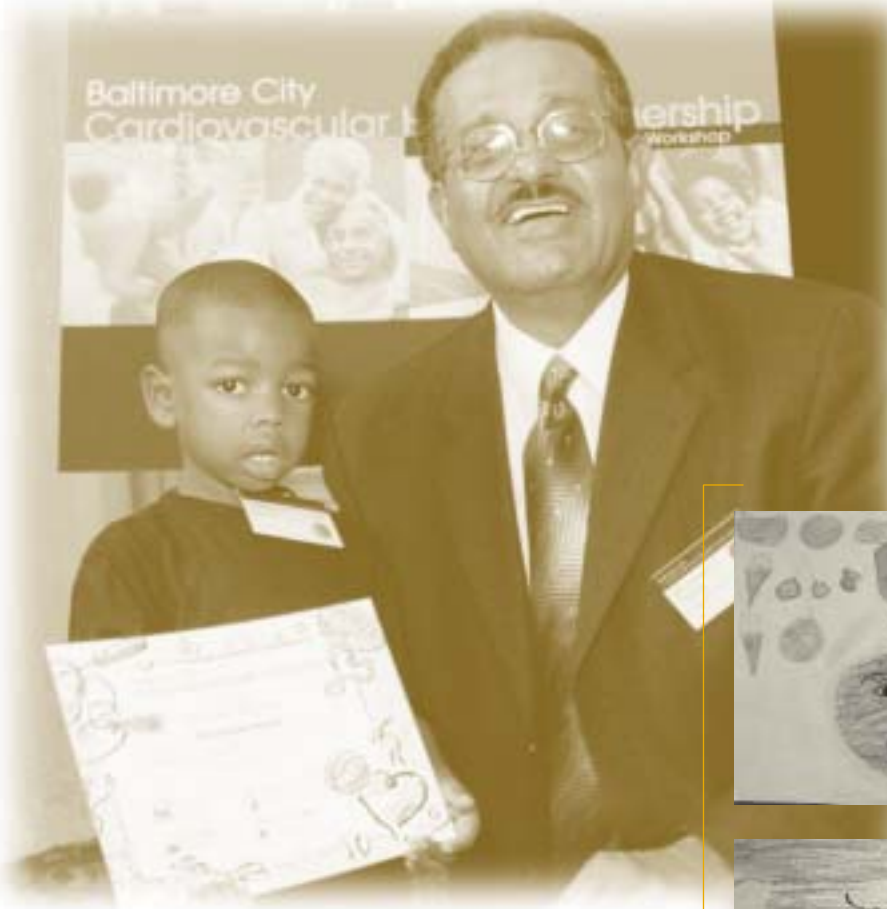


### Contest

The HABC conducted a youth poster contest for the BCCHP Strategy Development Workshop. The purpose of the contest was to begin to foster an interest in, and understanding of the importance of CVH, primarily, and the BCCHP generally, among public housing residents, and particularly youth residents. Children and youths from HABC childcare programs and from youth development centers participated in the contest. Over 200 enrollees from nine of the HABC childcare programs participated. The age ranges of these children are 2 to 5 years in the preschool program and school age participants are between the ages of 6 and 12. Between September 10, 2001 and September 21, 2001, teachers incorporated the CVH theme into the health unit portion of childcare programs. Specifically, teachers guided students through CVH concepts, like nutrition and diet, and maintaining a healthy heart. Students created an artistic interpretation of maintaining healthy hearts. Eight children's posters were selected winners by a three-member committee of judges.

HABC youth poster contest winners from Latrobe Child Development Center and South Baltimore Child Development Center at Cherry Hill. From left to right: Christopher Hunter (age 4); Taja Harper (age 8); Qwashawan Daniels (age 12); and Jasmine Watts (age 11).

From left to right:  
Christopher Hunter  
(age 4), HABC poster  
contest winner and  
Harold Young, Field  
Office Director, Baltimore  
Field Office of U.S.  
Department of Housing  
and Urban Development



### Awards Presentation

During the BCCHP Strategy Development Workshop, youth art depicting CVH scenes and themes were displayed around the main meeting room. At noontime, during the workshop, an awards presentation was held for the winners. Mr. Harold Young, Field Office Director for the Baltimore Field Office of HUD and Mr. John Wesley, Assistant Director of Communications at the HABC presented the youth winners with certificates of award. The following are a list of youth winners:

- Christopher Hunter (age 4)
- Qwashawan Daniels (age 12)
- Jasmine Watts (age 11)
- Taja Harper (age 8)
- Cierra West (age 15)
- Malcolm Levi (age 10)
- Michael Harvey (age 13)
- Myron Higgins (age 11)



## BREAKOUT GROUP DISCUSSIONS SUMMARIES



Strategy Development  
Workshop Participants

### **BREAKOUT GROUP I: Public Education and Media**

Breakout group I discussed public education and media needs to support the goals of the BCCHP. The group was given the charge to identify communication strategies that would engage Baltimore City African American residents and raise awareness about the improvement of CVH. The group was guided by eight questions (see appendix).

#### **Key Recommendations in Brief**

- Target audience: mothers/women, African Americans at highest risk of CVD, African Americans over age 35.
- Outreach channels: radio, membership clubs, health fairs, and public housing computer learning centers.
- Messages: “The Beat Goes On,” “What Are You Doing to Your Heart?,” and What Would Happen If . . . The Family Caretaker Developed CVD?”
- Messengers: celebrities, peers, and health educators.
- Incentives: certificates, tickets to sporting events, CVH related items—exercise equipment, and water bottles.
- Policy: engage supermarket owners to increase heart healthy food availability, legislators to raise awareness about the problem of CVD, city health care professionals, and providers about standardizing preventive care.
- Challenges/barriers: competing issues (substance abuse, homelessness, unemployment), lack of heart healthy food, existing health beliefs, and attitudes (fatalism).
- Monitoring and evaluation: collecting and measuring changes in CVH indicators (changes in risk factors and physical activity).

## Summary Comments

### Target Audiences and Communication Channels

Participants identified adult women of reproductive age as the target audience for the public education and media activities for the initiative. The rationale for this selection was that women have the most impact on the individual members of a family. They care for younger children, older adult parents, husbands, and other family members. This will provide opportunities to further impact the larger population through women's interaction with youth and elderly. In addition, in public housing women are often heads of households. Secondary target audiences included mothers, the segment of the African American population with the highest prevalence of CVD, and African Americans over the age of 35 years. The group believed that overall, healthy women can facilitate healthy communities.

Participants identified several media to reach this target audience. Radio was identified as a source for the Baltimore community, specifically Radio One and its owner Cathy Hughes, who was suggested as a possible partner. Radio One has a membership club called the "30 and Over Club," which could be used to reach the 30 years and older demographic. Participants estimated that there are approximately 80,000 members in the 30 and Over Club. Newspapers, such as the *Baltimore Times* and the *Baltimore City Afro*, were mentioned as other media sources by which to reach the target audience.

An online, Web-based CVH program would be another outlet to reach the targeted population. This medium should be utilized in conjunction with church-based groups and community centers that offer Internet tech-

nology. There was concern, however, about the accessibility of Web-based channels by Baltimore City African Americans and public housing residents. A number of public housing developments have computer learning centers but there is still a digital divide in public housing with regards to Internet access. In addition to Web-based channels, a participant recommended developing heart health software to promote CVH. One housing resident participant identified a person in her community skilled in computer technology as a potential participant in this initiative.

Other avenues suggested included community health fairs, CHWs, the faith community, and celebrity spokespersons. Another participant asked about the use of supermarkets and restaurants as channels for public education to support activities, such as supermarket tours or identifying heart healthy dishes on menus. Some participants mentioned that the target area for the project has mostly fast food restaurants and small grocery stores that lack heart healthy food choices. The major grocers, like the supermarket chain, Giant, that have more heart health food varieties, are not located in the communities targeted for this initiative.

### Communication Messages

Participants next discussed the types of messages that might appeal to the target audience, women of childbearing age, and how these messages should be delivered. Participants stated that any message should be attractive and eye-catching. Some participants suggested celebrity spokespersons while others preferred everyday people, "just like me." Some suggested message themes were:

- "What would happen to your family if. . . the caretaker developed CVD?"
- "The Beat Goes On"
- "Help Your Heart; It's a Good Start"
- "What Are You Doing to Your Heart?"

### **Incentives**

The group suggested incentives such as certificates for shopping in supermarket and mass market stores (Target, Kmart, etc.), and tickets to sporting events, particularly Baltimore Ravens football games to motivate participation in public education activities. Incentives specifically related to CVH behaviors included exercise equipment, stadium water bottles, and stress balls (to manage stress). Participants stated the need for tangible incentives. They suggested that less tangible incentives, such as improving your health and well-being, should be presented in a church or group setting for optimum effectiveness. Health educators were also identified as persons who could provide incentives and motivation for changing health behaviors.

### **Policy**

Participants identified key decisionmakers who should be involved with or informed about the initiative to influence policy. One group, buyers for supermarkets, are key to supplying communities with heart healthy foods. Health care providers and health departments would be instrumental to the success of the initiative as the community's providers of health. Their participation in improving the community's CVH should include guidelines for providing blood pressure readings, referral to additional care and testing, and using family histories to improve patient's knowledge of their CVH. In addition, Baltimore City legislators need to be actively engaged in the initiative's efforts.

### **Media Assets**

The participants identified the assets and resources that media organizations can bring to the BCCHP. These included celebrity spokespersons, airing public service announcements, and WEB-CT (digital signal broadcast).

### **Barriers**

Some barriers to reaching the identified target audience with public education messages and heart health promotion include competing issues and priorities. For instance, some Baltimore African American communities are dealing with substance abuse, homelessness, transportation, employment, and family issues. Also, the places where the targeted community members purchase food often do not have heart healthy items, such as fresh produce. Health beliefs and attitudes about health may serve as barriers. One health attitude, particularly among young people, is the belief that they will die young. One participant described young men buying caskets for themselves in anticipation of their deaths.

### **Monitoring and Evaluation**

Participants identified ways to track the success of the public education and media activities. They stated that establishing baseline data for CVH goals is important. Implementing pre- and postquestionnaires to evaluate changes or improvement related to identified goals will be important to tracking success. Another important evaluation component is collecting data. Participants identified developing a database for this information as key to measuring success. Possible outcomes to track are awareness and knowledge of CVD risk factors and level of participation in physical activity.

Health beliefs and attitudes about health may serve as barriers. One health attitude, particularly among young people, is the belief that they will die young. One participant described young men buying caskets for themselves in anticipation of their deaths.

## BREAKOUT GROUP II:

### Public Housing Community

Breakout group II discussed the needs and opportunities that exist in public housing developments to conduct CVH outreach and education activities. Specifically, the group was charged with identifying current activities and programs in public housing that could be integrated with CVH education and outreach activities. The group addressed 15 questions (see appendix).



From left to right: Lorraine Ledbetter, Dr. Samuel B. Little, and Shirley Jackson – Housing Authority of Baltimore City.

#### Key Recommendations in Brief

- Target audiences: youth and school-aged children, families, elderly, disabled, and homeless.
- Outreach channels in a public housing setting: Resident Advisory Board and Tenant Council, community health clinics, youth centers, and external community services providers (churches, schools, and hospitals).
- Activities: CVH education presentations, cooking demonstrations, social activities and games with a heart health theme (line dancing, heart health bingo).
- Incentives and motivators: awarding youth service learning hours for participation, heart health support groups, and gift certificates.
- Challenges: lack of funding, scheduling activities during inappropriate times (e.g., “Check Day”), apathy, competing priorities, and lack of persons trained to deliver CVH education.
- Monitoring and evaluation: bimonthly followup clinical and behavioral CVH assessments (i.e., physical activity, blood pressure, and cholesterol levels).
- Policy: improve public housing resident voter registration, residents’ testimonials to city officials about the impact of heart health, and engaging city officials and businesses.
- Public housing assets for CVH activities: residents’ knowledge of their community, an infrastructure that can support activities, and an opportunity for a public housing community to serve as a model for best practices in health promotion.

## Summary Comments

### Target Audience

The participants agreed that it is important for all African Americans in the targeted community to receive CVH information because everyone is affected. Participants suggested that a way to consider specific target audiences in public housing is to identify groups that are already in place (e.g., youth development centers, adult medical daycare centers, child daycare centers, congregate housing programs). Within that broad audience, several subgroups were identified to receive CVH outreach and education activities. These were:

- Older women
- Young mothers
- Families
- Elderly
- Youth and young adults
- School-aged children
- Males
- Persons with disabilities
- Homeless
- Middle-aged persons

The rationale for prioritizing these targets is that the African American population has the highest rate of CVD. In addition, diet in African American communities is part of its culture and has been cited as a contributor to increased CVD levels. The disproportionate numbers of uninsured and underinsured persons also impact the public housing community's CVH rates. Youth were suggested because CVD risks are modifiable, especially at the earlier stages of life—youth and children are key audiences for primary prevention. The fact that all these groups reside in public housing, and are captive audiences, can facilitate the outreach and education efforts of this initiative.

### Priority Audiences

Discussion participants further prioritized these identified groups to determine which audiences should be targeted first, second, third, and so forth.

1. Youth and school-aged children
2. Families
3. Elderly
4. Disabled
5. Homeless

Participants were concerned about the ability to target homeless people. Some participants stated that the homeless could not be reached in a public housing setting—particularly because it is an institution whose mission is to provide housing for those in need. However, a public housing resident commented that some homeless people attend HABC tenant meetings. In addition, homeless people can be reached during the distribution of surplus food in public housing. Another issue of concern was defining family. Participants were concerned that specifying the composition of a family would exclude the diversity of household compositions (elderly headed, or single male-headed households). One participant stated in response to the generalization that public housing consists of female-headed households, “I understand that. . .but we have to look at that differently because that was years ago. . .Now you have just as many single men raising children at public housing as you do women.” A participant also mentioned that a single person could constitute a family (head of household). Participants agreed that in addition to targeting specific groups within public housing, all public housing developments should have access to program activities.

### Existing Outlets in Public Housing for Outreach

Participants identified groups in public housing that should be asked to participate in CVH education activities. They include the public housing Resident Advisory Board—elected residents who represent the interest of the entire public housing community—and Tenant Council Leaders who represent the interest of individual housing developments. Health clinics and youth development centers (serving residents ages 7 to 18) are existing channels to engage the public housing community. HABC direct service staff and other external community service providers, such as local churches, schools, and hospitals, could also provide opportunities for CVH education. In the past, these entities have offered health screenings and fairs, health education, prevention, fitness programs, and dissemination of community news and resources, and they address housing residents overall concerns. One participant suggested integrating activities, such as cooking demonstrations, into regularly scheduled resident meetings. Integrating CVH education into ongoing housing programs could help sustain the program and keep the issue of CVH present in public housing.



A housing resident stated her plans to reimplement an activity called “stress night.” On Fridays, public housing residents would gather. Each person would prepare a dish for the potluck meal. The participants would then discuss their life concerns. The discussants agreed that this activity would be relevant to the BCCHP. Participants stated that all available partners should be involved in reaching the public housing community, with the caveat that each public housing development is different and not all services may be provided at all developments. Participants were also concerned about access to programs housed in hospitals because some residents may not have health insurance. This might create a barrier to their participation.

Participants discussed ways that residents who are already actively involved in civic, social, faith-based, and similar activities, could become involved in CVH education and outreach in public housing. They suggested that these residents present at public housing meetings. Some participants suggested having professional athletes give presentations (e.g., Michael Jordan). Participants suggested the following educational activities to promote CVH: (1) heart smart bingo or grocery bingo using healthy foods; (2) line dancing as a form of physical activity; (3) parties with healthy food (e.g., for Halloween); (4) games and raffles; (5) before and after demonstrations using photographs (like Subway spokesperson Jared); (6) heart health fairs; (7) poster or writing contests (8) utilizing nutritionists; and (9) partnering with an existing seasonal small mobile food business that could serve the public housing community during the summer months by selling fresh produce.

Housing Authority of Baltimore  
City Youth Development Center  
Participants

## Barriers

The lack of funding to support activities (materials, staff) was mentioned as a potential barrier to implementing CVH activities in public housing. Activities conducted on “check day” will have low participation. Also, activities that are conducted away from the public housing developments might lessen participation, because transportation could be a barrier. Other barriers mentioned included:

- Fear of the unknown
- Lack of facilities
- Inaccessible location
- Inappropriate time of day
- Lack of interest/apathy
- Lack of participation
- Competes with existing health perceptions
- Competes with existing priorities
- Lack of information and knowledge about CVH
- Lack of trained personnel

The theme “lack of information and knowledge” captured the idea that introductory information about CVH must be given before residents attend activities related to improving CVH—a first activity would be to raise awareness and address perceptions about CVH in public housing. One participant mentioned that tenant council meetings might be a good place to introduce the program and to promote residents’ involvement. Activities that serve refreshments might also see increased participation.

“In order for the youth and different people to get the message, you [the messenger] have to be on an equal level for them to listen.”

## Communication Messages— Themes, Materials, Messengers

Participants suggested themes, messages, and materials that might appeal to targeted audiences in public housing. Some messages included, “Keep the Beat Going” and “And the Beat Goes On.” Television (PSAs), radio, and billboards using celebrity messengers such as hip-hop artists (e.g., Master P) or professional athletes (Ray Lewis, The Rock, Michael Jordan) were cited as means of reaching the housing population. In addition to celebrities, CVH messengers must be on the same level (peers) as the audience being targeted. One participant stated, “In order for the youth and different people to get the message, you [the messenger] have to be on an equal level for them to listen.” Materials for delivering CVH messages included flyers and T-shirts. A youth participant suggested placing advertisements on the Baltimore teen broadcasting station, Channel 1, and City Channel 21. Another suggested paraphernalia for displaying a CVH message was water bottles (squeeze bottles). One participant suggested developing a fictional character like Snoopy. A youth participant commented that the character shouldn’t be a cartoon character, but a real person. In response to an inquiry regarding specific symbols with which African Americans in public housing could identify a youth participant responded, “You can just simply have a person that has been through CVD . . . just sit them down . . . a basic commercial—no music, no celebrity or nothing. . . just a regular person.” Another youth participant suggested a symbol or other representation of a heart. Participants expanded on this image and suggested that the heart be split. On one side—the healthy side—the heart is holding a carrot, and on the other side of the heart—the unhealthy side—is a smoldering cigarette.

### **Motivators and Incentives**

Participants recommended utilizing role models—persons who have survived a CVD event—to motivate housing residents to participate in CVH activities. They believed that showing the real-life effects that CVD can have on one’s health will motivate residents.

Incentives or rewards might also be given to residents, after completing education activities. Awarding “service learning hours” to youths would be an example of using an existing program to promote youth residents’ participation in CVH activities. High school students are required to perform community service hours toward graduation. Other suggested motivators and incentives were food vouchers, gift certificates or stipends, and using community residents already involved in CVH activities, as well as train-the-CVH trainer and support group activities to motivate persons to change behaviors.

### **Monitoring and Evaluation**

Participants discussed ways to track the success of CVH education activities in public housing. They mentioned pre- and postsurveys to collect population baseline information and measure changes after the initiation of activities begin. The process discussed for collecting information included quarterly and bimonthly followup health assessments to measure changes in participants’ cholesterol, glucose, blood pressure, weight levels, and smoking habits. Another suggestion for measuring success, suggested by participants would be to measure changes in physical activity levels by participants over time.

The priority approach is to make sure that all residents are registered to vote and do vote.

### **Policy**

To effect policy change related to CVH, participants in the public housing discussion mentioned several approaches. The priority approach is to make sure that all residents are registered to vote and do vote. Residents can also provide testimonials to policymakers. Participants recommended an overall message for policy decisionmakers as “this could be your child” to impress upon policymakers the impact that CVD is having on families in the public housing community and to demonstrate why they should support the BCCHP. Policymakers should participate in CVH educational activities conducted in public housing. Participants also stated that policymakers may be also unaware of the effects of CVD and should be targeted for educational activities. Participants recommended inviting policymakers to hold positions on the BCCHP advisory board or steering committees of the BCCHP. In addition to policymakers, businesses, such as fast food restaurants, might serve as BCCHP spokespersons to influence policy in their field.

### **Public Housing Community Assets**

Assets in the public housing community are important to improving the health of residents. Participants discussed the assets that residents have for promoting and improving CVH. These include residents’ life experiences and CVH stories. Residents will also bring their personal commitment and interest in improving their health and the health of their community. Residents also will understand their community and the reality of addressing CVH in public housing. Participants believed that residents have the willpower to change their behaviors and a sincere desire to live healthier lives. In addition, public housing has an infrastructure that can accommodate and deliver CVH activities, including staff that can implement CVH educational activities. Overall, public housing can serve as a model for implementing CVH education and outreach in African American communities in Baltimore City and other communities.



## Summary Comments

### CHW Selection

The members of the CHW breakout session began the discussion by determining the criteria for becoming a CHW. Persons sought to become a CHW should already be informal community leaders. They are people who are willing to get health outreach work done and are committed to this work. A CHW must be able to develop one-on-one relationships with community members. They will serve as peer role models to community members—persons who have experienced CVD. Discussants mentioned that it is important to look beyond traditional criteria. One discussant was concerned that some public housing residents might not have a high school diploma. Another discussant stated, “I have found that some people with high school diplomas don’t do as well as those who don’t have [a high school diploma] . . . I found that they [people without high school diplomas] are good communicators, and they can work well with the public.” The participants thought it important that the lack of previous training or education not disqualify an applicant.

### Training Content

The discussants described content areas for CHW training. CHWs need sensitivity and diversity training to address the needs of their population and meet them “where they are.” Training in CVH is necessary so that the CHWs “know their product”—CVH education and outreach. A CHW trainer must be a professional with references. This will ensure that CHWs-in-training receive the necessary training in CVH and general CHW skills. In addition, a professional trainer can provide optimal training for CHWs that will lead to best practices in this area.

The discussants identified “generic” skills that all CHWs should have. CHWs need training in identifying available community resources to inform their clients. In addition, some may need to make behavioral changes in themselves to serve as role models and “to practice what they preach.” They will need

ongoing professional development training, including presentation skills. Another skill area for CHW training is time management. One participant stated, “Some place [during training is needed] to talk about how one manages time. . . both for the job and for themselves, because burnout comes quickly for folks working in the community.” CHWs will need ethics training in personal information and confidentiality in regards to the information their clients will share. Participants suggested that assessment skills training be given to CHWs on how to report their interactions with community members. One participant mentioned that the research literature on the CHW approach identifies assessment as an area needing further development. The BCCHP activities could serve as a model for improved CHW assessment. Finally, crisis intervention training will be an important content area. CHWs need to know when to seek help, to know their limitations, and when to seek assistance for their clients’ well-being.

### Recruitment

Most of the CHWs will be recruited from the public housing community. Discussants described methods for recruiting public housing residents. They suggested surveying schools, churches, and community associations to identify public housing residents who are already volunteers. Referrals from the Department of Social Services, public housing family support counselors, and the Resident Advisory Board were also recommended. Participants suggested recruiting persons at drug counseling centers, and advertising in public housing and church newsletters, as well as the community employment journal, Baltimore Employment Guide. Also, in addition to recruiting, participants mentioned networking through the Community Outreach Worker Association of Maryland (COWAM), an organization that promotes the use, legitimacy, networking, and sponsorship of CHWs’, and identifying programs that are losing funding to recruit persons who may need employment as ways of identifying potential CHWs.

### **Barriers**

Participants discussed barriers to someone becoming a CHW. They noted that potential CHWs might be practicing negative behaviors, such as drug abuse. Some potential CHWs have childcare issues. Potential CHWs might be concerned about confidentiality. Others may not be able to read or write well. Transportation may present a barrier to some potential CHWs. Income level limits may prohibit some public housing residents from becoming CHWs. Finally, some potential CHWs may have a criminal record. One participant stated, “HUD has rules that deal with criminal background checks, and the Housing Authority has its own set of rules [regarding criminal records].”

### **Motivators**

Persons with an existing passion to help others will be motivated to become community health peer educators. Related to this passion is a sense of responsibility for the well-being of their community, and this will serve some as a motivator to become a CHW. The CHW position presents an economic opportunity, as it will be paid employment. If the pay wage is higher than the minimum wage, this can also attract potential CHWs. The opportunity to build a work history can also serve as motivation. Overall, a CHW’s opportunity for economic development through wage earning can be a step toward homeownership. Persons who are interested in learning new skills will be motivated to become a CHW. A CHW program that offers benefits such as transportation and daycare will motivate people who perceive these issues as barriers. Another motivating employment benefit would be health insurance. CHW training that includes life and financial planning skills would also motivate persons looking to improve their skills in these areas. Also, a desire to improve one’s own health will motivate some people to become CHWs. Becoming a CHW may create a sense of self-worth in some participants. This could be a motivator for participation.

### **CHW Trainers**

The discussants identified the characteristics of persons who should deliver training to CHWs. Potential trainers should be top-notch CHWs who are already in the field and CVD health professionals. These professionals could potentially come from hospital settings. Discussants mentioned developing a CHW institute as a place to identify trainers. They also recommended partnering CHWs together as part of this initiative. The proposed CHW institute would serve to organize and certify CHWs working in the Baltimore area. One CHW participant, in support of creating a CHW institute stated, “Our knowledge base is as good as anyone else’s knowledge base. . .we ought not to always consider somebody else’s knowledge base and run with their stuff. . .but [recognize] that we know stuff, and we need to respect what we know.” The participant stated that the CHW knowledge base should be housed in an HBCU, to preserve this knowledge.

### **Training Program**

Once trainers are identified, a training program should be ongoing and include CVH benchmark competencies, as discussed above in the training content. There is also an element of trial and error in the duration of training related to determining an individual’s needs. One participant described a training scenario that would include mock home visits. The trainer will identify the CHW’s readiness based on their ability to successfully complete a mock home visit, for example. In addition, novice CHWs should be partnered with seasoned CHWs during their initial interactions with the community. One participant also divided training between in-class training, clinic-based training (such as in a hospital under the supervision of a nurse), on-the-job training, and finally field training. This would facilitate a structured training program. One participant also mentioned activities that CHWs can execute without previous training, that will yield useful information about the project. She stated, “You can find out where Gilmore Street is. . . you can find out how many houses are board-

ed up in that neighborhood. . .you can find out how many elderly people live in that neighborhood. . .what are the statistics related to cardiovascular disease. . .and you can find that information out yourself.” The specific CVH training content identified by the discussants included lifestyle behaviors, nutrition, exercise, heredity factors, and statistics—giving the community information about the depth of the CVD problem. They also discussed how the content should be presented. The training materials and presentation should not be “wordy” but very visual. They mentioned a program called Neighbor-to-Neighbor as an example of a CHW program. To capture the community’s attention, having local celebrities was suggested as part of the training format. In addition, the training should be presented as leading to job opportunities and educational experiences.

### **Incentives**

Participants recommended incentives to encourage participation in a “train-the-trainer” program to train other CHWs. The first incentive was recognition of being a trainer. The opportunity to receive additional educational training was also cited as an incentive. Financial incentives (wages) would also encourage participation. Professional development—the CHW trainer as an active partner in the outreach and education planning process, participating in writing professional papers and presentations and attending conferences—also would be an incentive.

“Our knowledge base is as good as anyone else’s knowledge base . . . we ought not to always consider somebody else’s knowledge base and run with their stuff . . . but [recognize] that we know stuff, and we need to respect what we know.”

### **Partners**

The discussants identified partners that might participate in CHW training. Federal, public, and private entities, such as the National Institutes of Health, the Black Caucus of Maryland, political leaders, private foundations, community hospitals and agencies, drug companies (as training sponsors), and medical associations are all partners that could add to the success of this effort.

### **Monitoring and Evaluation**

To track the success of the CHW activities, the discussants agreed that the initiative should conduct needs assessments throughout the project. The indices should include process evaluation (short-term goals and objectives), mortality and morbidity rates, and customer satisfaction, and be summative (long-term assessment), to facilitate reevaluation.

### **Policy**

The participants discussed policy and policy decisionmakers that could be influenced by the BCCHP activities. They identified several important policy issues related to public schools—nutrition, health curriculum, and physical education. Access to quality preventive care is another important policy issue.

### **Youth CHWs**

Youth CHWs were discussed. The roles that youth could play include peer counseling. Young people could also participate in media activities to promote CVH. At schools, young people could give presentations on CVH topics.

### **CHW Assets**

The session participants identified assets that CHWs as well as the community would bring to the project. CHW assets include knowledge about their own community, a resource network to impact community members, and ability to serve as a liaison between the community and community service providers. Institutions that are already active in communities including churches, community-based organizations, fraternities, and HBCUs also would be project assets.



## Summary Comments

### The Students

The discussion began by broadening the student population to include other university and college students in the Baltimore City community, especially those with a large African American student body, such as Coppin State College, Sojourner-Douglas College, and community colleges, in addition to Morgan State University students. Students at the secondary, middle, and elementary school levels also should be engaged in the initiative.

### Strategies and Activities

#### Readying Students

The discussants talked about the importance of knowing the culture of each community and doing your homework, not assuming that all African American communities are the same. One participant stated, “It’s different in Sandtown than it is in Brooklyn. . . leaders are not necessarily the president of the community organization. . . it’s Ms. Mary down the street who keeps everybody’s kids . . . you have to tap into people who are respected.” A participant discussed the “stages of change” theory and described it as the various levels of readiness that community members may exhibit in making lifestyle behavior changes. These stages include precontemplative, contemplative, preparation, action, maintenance, and relapse. He underscored the importance of students’ familiarity with these stages when participating in the initiative, to manage the frustration that students may feel when engaging community members who may not make behavioral changes immediately. A participant added to this concept of “readying” students to work in low-income communities, specifically public housing communities, by recommending that they partner with existing programs in these communities. These programs already have a knowledge base and can provide a proper

introduction for working in these communities. She explained the difficulty that one graduate school public health outreach program had with using students who were not knowledgeable about the environmental context of their targeted population. The students experienced resistance from members of the community because of their lack of knowledge about their community. However, once the students worked in conjunction with community outreach workers familiar with and known to the community, the activities were better received. In addition, student and youth peer educators will need effective demonstration materials that are visual, not just flyers.

The approach or model that could be used to implement youth or student participation in the project would be to partner with organizations that have experience in Baltimore City African American communities, working in conjunction with Morgan State University students to develop a curriculum for CVH education and outreach. That curriculum would be used to train middle and high school students. This will ensure that once peer educators go into the community, appropriate information is being developed. This model is also known as train-the-trainer. In addition, students should be involved in all aspects of implementation, including training, data collection, data analysis, and reporting—so that they are involved in work to benefit their own communities. The interaction between graduate students and young people will also present an opportunity for students at the graduate level to serve as role models for the benefits of pursuing higher education. Another training tool described by a participant is a high blood pressure machine, available at Morgan State University, that demonstrates the effect of high blood pressure on one’s body.

The project must take a comprehensive approach, as shown by the diversity of activities suggested by participants. This comprehensive approach must also be specific to the environment, especially utilizing a multimedia and multidimensional approach. A participant mentioned that some senior public housing residents might be offended if youth suggest that they change their behaviors. A more appropriate environment for seniors might be church-based activities utilizing peer change agents to demonstrate how to change behaviors, such as cooking. One participant mentioned the importance of providing students with stipends, especially public housing students.

### **Secondary School Student Involvement**

One avenue for student involvement, especially at the secondary level, is linking participation in the CVH initiative to student service learning hours. Students must earn 75 community service hours to fulfill their high school graduation requirements. University-level graduate students could work with secondary school students to meet this requirement. These secondary school students, particularly in public housing developments, could become CVH peer advocates to disseminate this information in their own developments. The participant discussed the advantage of having public housing youth participants working in their own communities to fulfill this requirement. She stated, “There’s nothing like having someone who looks like you, who lives in the same area you live in. . .who you can identify with, to help you understand the process [of changing health behaviors]. . .as opposed to someone else coming from outside of the community.” One participant described lifestyle and nutrition habits of some young African American males in public housing. She stated, “Even if they have food in the house. . . and someone is preparing the food. . .they are not going home to sit down and eat. . .and this is because no one has really talked to them about how they need to sit down and

eat a meal.” Another benefit of student participation is that public housing high school students will have a secondary audience to impact—their own families. Once they are trained in CVH, they can share this information with their families.

### *Summer Youth Employment*

Another avenue for youth participation would be to create a summer youth employment program around this initiative. A participant noted that during the summer, public housing youth seek jobs, and often they experience problems in finding employment. She suggested a strategy of selecting a group of youths from each public housing development for training, and providing paid employment to youth who participate in CVH outreach and education in their community. In order to facilitate developing what the discussant described as a “summer program site,” the process of developing this activity must start early—February or March prior to the summer of implementation. The organization to implement such a program is the Office of Employment Development—Youth Works, which funds students for a 6-week period. This organization solicits groups to establish “sites,” but they need to be engaged early. Participants suggested integrating summer youth employment activities with summer youth food programs—providing CVH education and nutrition information to this captive audience of youths receiving breakfast and lunch.

“There’s nothing like having someone who looks like you, who lives in the same area you live in . . . who you can identify with, to help you understand the process [of changing health behaviors]. . .

### **Integration into Public Housing**

Public housing developments already have after-school programs, youth development centers, and daycare centers, reaching the entire age spectrum of children and youth. A participant discussed the process through which students can become active in public housing communities. This process would involve engaging tenant council leaders and counselors at each public housing development. These existing activities could be integrated into the initiative's efforts, receiving CVH outreach and education by trained youth. The Cooperative Extension Services of the University of Maryland is also active in public housing developments—providing residents with nutrition information. One participant, who is a HABC staff member, is interested in seeing youth participate in activities to sample healthy foods. Seniors in public housing have already been involved with programming to choose healthy and economical foods through the cooperative extension program.

Public housing features tenant councils, with a proportion of senior women members. A participant saw this as an opportunity for the older generation of public housing residents to share cooking and meal planning skills with younger residents. Another suggested program activity is making CVH information distribution mandatory in public housing. This suggestion was based on the current requirements for lead paint information distribution to all public housing residents. A similarly developed “CVH packet” could be distributed. Students and public housing counselors could help develop these packets and distribute them. Participants reiterated the point that simply distributing literature will not be helpful, but that the literature must be part of comprehensive activities with incentives, such as a cooking demonstration with meals, in which residents can be involved. Public housing already has a workshop series called “Vision Connections,” which provide a meal, health screenings, and education. These workshops occur monthly with approximately 30 residents participating.

The discussant stressed the need to be creative and to plan events that will be appealing to the targeted population. She stated, “We know that traditionally men don't come to workshops. . .so we had to do our men's [programs] in the summer time. . .the flyer said “Men's Day in the Park ”. . .we put the food out there, the speakers out there . . . but the screenings were in doors. . .we had 50 men participate. . .if we had it indoors, we might have only gotten three participants.”

A participant recommended working with the Department of Juvenile Justice (DJJ). She noted that many young children come into contact with the juvenile justice system and partnering with this institution could lead to opportunities to provide constructive activities for these youth. Another participant expanded on this issue, the need to involve youth who are not in school. Other suggested local partners included local stores, especially those that market youth and students, and civic organizations such as, 100 Black Men, sororities, and fraternities.

### **Youth Educating Multiple Audiences**

One participant recommended not only that students provide education and outreach to community residents, but also owners of supermarkets to advocate more heart-healthy foods available in communities. One participant mentioned that the Baltimore City supermarket chain “Stop, Shop, and Save” serves a large proportion of low-income African Americans, especially those receiving public assistance. She also suggested partnering with the Empowerment Zone of Baltimore to develop a kind of voucher system, especially for residents who have hypertension and diabetes, in partnership with supermarkets. Some supermarkets already donate food to public housing residents. However, these foods are not diverse, for example they are carbohydrates. In addition, one participant described the differences in food choice in supermarkets by neighborhoods. Supermarkets in public housing

neighborhoods don't carry ready-to-eat fresh salad bags, for example, that are available in other neighborhoods. The discussant mentioned that this might be caused by the belief that customers in public housing neighborhoods will not purchase these goods. One respondent mentioned that it is important that a demand for these products be created in communities.

Another participant spoke of "underground community doctors." These are people in communities who prescribe home remedies that may not be very effective, such as drinking vinegar, or cooking with onions. Her point was that people are already self-diagnosing or diagnosing each other and the population needs appropriate education on CVD warning signs.

### Existing Outreach Models

Participants discussed some successful nutrition programs that might be of relevance to the proposed Baltimore project. A nutrition program in North Carolina drew upon the church environment and cooking. Another discussant described a Baltimore program called the Gleaning Program, as part of which Baltimore residents, including public housing residents, were allowed to gather produce on farms that had not been picked. However, some public housing residents did not like traveling to the farm, and for some residents traveling was a barrier. A participant suggested younger students, rather than teenagers, might like this type of activity. Other barriers experienced in this program included the difficulty of storing and preserving large quantities of perishable food by



John Ellsberry, 1998, Ramsay & Cross Streets. Photo courtesy of Baltimore Office of Promotion and the Arts.

low-income participants. A participant suggested teaching students skills, such as storing and canning foods, to address some of these barriers, and have students distribute these foods in public housing.

A middle school program in Charles County involved a youth cancer research group. These students worked with the National Cancer Institute to collect data from their community and compare these to national data. This information was posted as a Web site and students are visiting other schools with this information. This program is an example of the impact that young people can have on the health of their community.

A participant mentioned a Coppin State College program that produces videos. This program could be used to develop heart health promotional videos.

### **Motivators**

Participants discussed motivations for youth and student involvement. They suggested contests, such as the poster contest held for the BCCHP Strategy Development Workshop. Other motivators might be a newsletter or posters. Motivators for youth included development of a mascot to promote CVH. Also children and youth must receive praise to encourage their continued participation. Athletic competitions between public housing developments—awarding prizes based on commitment level rather than athletic skills—that is, the amount of time the young people have spent in physical activity—might also serve to motivate youths.

### **Policy**

Participants discussed existing policy and how the project can impact policy in communities to improve CVH. One policy issue discussed was increasing physical activities in schools. The lack of funding and time for new activities, presents barriers to greater stu-

dent activities, in particularly public schools. A participant mentioned the need to demonstrate to schools the relationship between improved health through physical activity and improved grades, to justify increased spending on physical education. Another discussant mentioned the links between physical activity education and childhood injury. That is, a comprehensive approach to physical activity and injury prevention (e.g., bicycle safety, sports injuries) may be useful in this effort. According to the discussant, Baltimore has a high rate of childhood injury. Morgan State has a physical education department, which would be a natural partner to this effort. Another partner to promote this issue would be the BCDPR, which recruits children from school systems. Also, offering aerobics activities in public housing developments would be a means to increase residents' physical activity—and would facilitate a intergenerational approach. Line dancing (with heart healthy cheers) is also a very popular social activity that can be promoted as physical activity. Policy advocacy was recommended regarding the types of foods served in school cafeterias. A participant reported on one occasion that her son bought ice cream and candy for his lunch. The American Heart Association was suggested as a partner on this issue because this group has readily available information on heart health.

On the topics of nutritional education and improved food choice policy, a participant discussed common eating habits of low-income communities. She stated, “We do nutrition classes. . . Oodles of Noodles, tuna fish, canned chicken noodle soup. . . and that’s in the beginning of the month. . . when the food stamps run out and the money starts to dwindle, it’s chicken boxes, it’s cheeseburgers, it’s whatever I can get from the corner store or from fast food [restaurant].”





ket chain, to fill this need. However, the retailer's products lack produce and emphasize largely canned and processed foods. The participants suggested that a campaign to solicit partners should include grocers, such as Fresh Fields, Giant, and smaller food cooperatives. The objective of bringing in these partners would be to create and demonstrate a demand in African American communities for these stores' services and products. A participant commented that healthier foods are more costly, and may create a barrier to people choosing them.

### **Communication, Promotion, and Outreach Strategies**

Workshop participants discussed strategies for informing potential partners about the partnership. A participant mentioned that early on in the project effort, media should be involved to inform the groups discussed above of the BCCHP's existence, prior to developing a broad community campaign. Another participant agreed, and noted that this strategy is a gateway of entry to the community. She mentioned that it is important to have as many points of entry to the community as possible, including through partner organizations. Another suggestion was securing a media sponsor, such as a television station, to continually advertise the initiative's messages via PSAs and community news. A participant stressed that small organizations and companies, in addition to larger ones, have an important role to play. For example, members of a pinocle club could distribute materials and information on a more intimate level.

A participant discussed communication messages. She referred to a public service announcement campaign with the slogan, "Do you know where your child is?" This message diffused throughout the media and became part of the popular culture. Suggested BCCHP slogans included, "What did you eat last night?", "What shape is your heart?," and "How fat is your heart?" Participants suggested marketing CVD issues along the lines of existing campaigns on violence and violence prevention, HIV/AIDS, and cancer.

In addition to public education messages, the discussants identified ways to communicate with partners, especially potential partners. This communication would serve as a way to bring new partners on board and facilitate ongoing dialogue among partners. One discussant suggested holding breakfast or lunch meetings with potential organization partners' because these half-day meetings would be more sensitive to the schedules of organization's representatives. The participants voiced a concern that requesting a full-day meeting for an initial contact might create a barrier to organization responses. Facilitating communication among organizational partners was agreed to be one of the coordinating committee's roles. Face-to-face meetings with organization executive directors were also suggested.

A participant discussed identifying leaders (medical, political, and others) to serve as a liaison with organizations, as they have clout and can help to bring in new partners. These leaders can serve as initiative spokespersons or role models for the initiative, especially if they are known to have survived a CVD event, such as the owner of Park Sausages. One participant suggested drawing on organizations that have already shown their commitment to the partnership, such as sending a representative to the workshop. This reservoir of leaders will have contacts and relationships with other organizations and could serve as personal endorsers of the initiative. Therefore, representatives from current partnership members might be given assignments to do further outreach with organizations. For initial and introductory contacts with potential partners, a discussant suggested that the BCCHP prepare an information package that would include an invitation to participate. Another participant suggested providing the option of levels of participation, such as providing time or financial support. Communication with these organizations might be done by means of an electronic listserve, which could address the problem of organizations being unable to attend in-person meetings.

## **Monitoring and Evaluation**

Discussants identified tools for tracking the success of partnership activities. One such tool, an Initiative telephone hotline, would serve a dual purpose—to provide information to the public about the Initiative and to track public interest. The number could be printed on partnership materials and publicized through radio and television PSAs. Another participant suggested developing a project Web site and assessing numbers and patterns of Web site “hits.” Another means of tracking project success would be for each partner to report on its activities and any feedback collected, compiling this information; developing a computer model of the activities, approaches, and outcomes; and disseminating this on the Internet. Another discussant described a Baltimore radio station promotion item, called the 30 and Older Club, which could be replicated by the BCCHP. The 30 and Older club gives the bearer discounts on purchases in supermarkets and other participating retailers among other benefits. The club’s marketing is saturated throughout Baltimore. A BCCHP card of this type could symbolize members’ commitment to living a heart healthy lifestyle, and the reward for this lifestyle, in addition to improved health, might be discounts, activities developed specifically for members, and similar incentives. Participants suggested displaying a “healthy soul food” pyramid on the card. Membership clubs of this type would also serve as a partnership database, and could be used for marketing with the public and with partners, such as a source of customer information for retailers of heart healthy products.

Another participant suggested that partners could also participate in tracking project activities and success. One participant suggested tracking behavior changes, such as the purchase of heart healthy foods by means of public assistance programs, such as food stamps (Food assistance programs now use ATM-type cards, such as Baltimore’s “Independence Card,” and could help track changes in food purchases).

## **Policy**

Partnerships with policy and decisionmakers at the state and local levels were discussed as ways to impact the initiative’s efforts. One participant suggested that the recipients of state and city food assistance dollars receive bonuses or discounts to encourage the purchase of heart healthy foods (e.g., fruits and vegetables). Another suggestion was to create an alliance with African American farmers in Maryland to promote the consumption of their farm products creating a synergy between rural farmers and urban city dwellers. A possible Federal partner to facilitate this initiative would be the U.S. Department of Agriculture. Another policy advocacy tool identified by a participant was nontraditional community assessments to identify, CVD “hotspots.” This would be modeled after crime prevention activities that identify areas with high crime rates. CVD community “hotspots” would identify neighborhoods with high rates of CVD morbidity or mortality, as well as environmental factors that contribute to CVD, such as fast food restaurants and liquor stores. Community hospitals would be appropriate partners to participate in this sort of policy advocacy approach. A map showing Baltimore City CVD hotspots at the neighborhood level would be shared with Baltimore City policy and decisionmakers responsible for these jurisdictions.

## NEXT STEPS

**T**his workshop summary captures the recommendations participants made regarding CVH education and outreach programming strategies. CVH education and training tools are needed, to operationalize and support the programming recommendations made during the workshop. This next step requires further exploration with the public housing community to develop contextually appropriate and user-oriented tools and materials that will address this audience's CVH knowledge, perceptions, and behaviors. Women, young people, tenant council lead-

ers, seniors, and HABC staff are the primary target audiences. The acquisition of information through informal meetings with members of these audiences will support the development of tools and materials specific and appropriate for use by these groups in public housing settings. This public health based approach has been used in other programs targeting public housing residents. The NHLBI will work with core partners of the BCCHP to conduct these assessments and develop targeted CVH materials for use in public housing and other settings.



Archie Veale, 1998, Church Square Shopping Center, 900 N. Bond St. Photo courtesy of Baltimore Office of Promotion and the Arts.

## APPENDIX: BREAKOUT GROUP DISCUSSION QUESTIONS

### Public Education and Media

**Goal:** To stimulate members to actively participate in a discussion of the public education and media needs for Baltimore City residents and to identify public education and media strategies to raise awareness about CVH.

**Charge:**

1. Identify the target audiences, including public housing residents and youth, for a CVH public education/mass media campaign in Baltimore.
2. Identify local media channels and partners who should be involved to reach the target audience(s).
3. Identify the types of possible themes, messages, and materials that might appeal to the target audiences.
4. Identify incentives and motivators that can influence the target audience(s) participation in public education activities.
5. Discuss how the campaign may be used to influence policy and decisionmakers in the local community.
6. What assets and resources do media bring to the partnership?
7. Identify the barriers to a community-wide public education campaign for the identified audience(s).
8. Discuss ways to track the success of the public education and media activities.

### Public Housing Community

**Goal:** To stimulate members to participate actively in a discussion of the needs and opportunities to conduct CVH education activities within public housing developments in Baltimore City, and to identify existing programs and activities to which CVH education activities can be added.

**Charge:**

1. Identify the target audience(s) within public housing developments, including youth, which could receive CVH education.
2. What is the reason for selecting these groups?
3. Prioritize these audiences (which should be first, second, third, etc.).
4. What groups within housing developments should be asked to participate in health education activities? What are they doing already?
5. Who are already very active in social programs within the development?
6. Identify all the possible housing development communities that could participate.
7. Prioritize the list as to where to start first with educational activities.
8. Identify the barriers to starting a public housing CVH education effort for the identified target audience(s).
9. Identify all partners who should be involved to reach the target audience(s).
10. Identify the types of possible themes, messages, and materials that might appeal to the target audience.
11. Identify incentives and motivators that can influence the target audience(s) participation in public education activities.
12. Discuss ways to track the success of the housing developments outreach and education efforts (data and evaluation).
13. How can members of housing developments who are involved in churches, the BCDRP, CBOs, and civic and social activities become more involved in educating housing residents?
14. Discuss how the educational efforts may be used to influence policy and decisionmakers in the local community.
15. What assets and resources do housing developments and residents bring to the partnership?

### Training CHWs to Promote CVH

**Goal:** To stimulate members to actively participate in a discussion of the training needs of CHWs related to improving CVH and identify elements that will be needed to

sustain these workers over time as resident “deliverers” of heart health information in housing developments and other sites (schools, parks and recreation centers, churches, etc.) identified by the BCCHP.

**Charge:**

1. Discuss and list the criteria for becoming a CHW.
2. Identify and list the content areas for training.
3. Identify how the CHWs would be recruited.
4. What are the barriers/motivators to someone becoming a CHW?
5. Who would be responsible for conducting the training? How long would the training take and how often?
6. What topics in CVH may be of most interest to members of housing developments? To the community in general?
7. How should a program session be organized? Are there some appealing ways to capture the attention of the target group before getting into the training’s detail?
8. What incentives would encourage participation in training those who are trained to train others (Train-the-Trainer Program)?
9. Who are possible partners to help with the training?
10. Discuss ways to track the success of the training efforts (data and evaluation).
11. How could the educational efforts be used to influence policy or decisionmakers in the local community?
12. What is the role of youth as CHWs?
13. What assets and resources do CHWs bring to the partnership?

**Integrating Public Health Students in Communitywide CVH Promotion Activities**

**Goal:** To stimulate members to participate actively in a discussion of the need to integrate public health students from Morgan State University into the CVH community education activities by identifying specific roles and responsibilities that they could play throughout the project implementation.

**Charge:**

1. What types of activities can students be involved in?
2. What strategies that the NHLBI might be able to foster would implement enhanced student training?
3. What barriers/motivators impact students’ involvement?
4. How could funds be secured to support students’ involvement in community activities?
5. What partners could support this?
6. How should this program be organized? Who should take a leadership role?
7. What incentives would encourage participation?
8. How best to track the success of the student activities (data and evaluation)?
9. How can the educational efforts be used to influence the local community policy and decisionmakers?
10. What other student populations should be addressed? What assets and resources would they bring to the partnership?

**Building and Sustaining Collaborative Partnerships for CVH Education and Outreach.**

**Goal:** To stimulate members to participate actively in a discussion on ways to increase partners’ interest in the project and promote efforts’ sustainability.

**Charge:**

1. Discuss and list the criteria for becoming a partner—member of the BCCHP.
2. Identify and list the additional CBOs, including youth organizations, who would add value to the partnership.
3. What organizations, foundations, and nonprofits might want to hear about this effort and could be a source of future or ongoing support? What assets and resources would they bring to the partnership?
4. How best to communicate with these groups?
5. How best to track the success of the overall partnership activities (an overall evaluation plan)?
6. How could the educational efforts be used to influence policy and decisionmakers at the local and state levels?



