Northeastern North Carolina Partnership for Public Health
Heart Disease and Stroke Prevention
Strategic Planning

Results of Stakeholder Interviews and Surveys

April 2006

Participants:

Barbara Earley	Director Health Planning and Resource Development Hertford County Public Health Authority Director of Northeastern NC Partnership for Public Health *Formerly employed at Roanoke Chowan Hospital as chronic disease case manager, critical care nurse, emergency department nurse; helped to develop critical care paths*
Barbara Paul	Adult Health Nurse Beaufort County Health department *In charge of breast and Cervical Cancer Control Program; Volunteer Emergency Medical Technician (EMT) for town of Bath*
Crystal Dempsey	Health Promotion Supervisor Hertford County Public Health Authority *Oversees a cardiovascular disease prevention program in Hertford county churches which encourages people to reduce their risk of CVD, HTN, and Diabetes through increasing physical activity and healthy eating and participating in education classes;*
Debbie Klingler	Registered Dietician, Certified Diabetes Educator; Hertford County Public Health Authority *Works with ADA approved diabetes program; provides medical nutrition therapy; works with medical providers to provide nutrition education*
Diana Gardner	Touch No Tobacco Project Coordinator Northeastern North Carolina Partnership for Public Health *former director of marketing and Public Relations at Albemarle Hospital; helped to develop cardiac rehabilitation program at hospital*

Ellen Vaughan	Home Health Agency Director; Hertford-Gates Home Health Agency *provides skilled nursing, physical therapy, social work, nutrition counseling;*
Erin Riddle	Regional Health Disparities Coordinator Northeastern NC Partnership for Public Health
Janet Alexander	Regional Epidemiologist Northeastern NC Partnership for Public Health
Jill Jordan	Health Education Supervisor and Disparity Gap Coordinator Albemarle Regional Health Services
Kelli Strickland	Health Educator /Disparity Gap Coordinator Beaufort County Health Department
Leanne Fulcher	Emergency Department Nurse Manager Beaufort County Hospital *Advanced Care & Life Support Instructor (ACLS), oversees stroke registry at hospital*
Lisa Newsome	Director of Community Relations Roanoke-Chowan Hospital *Chairs the Hertford County Local Physical Activity and Nutrition Council*
Marry Marrow	Health Education Supervisor and Disparity Gap Coordinator Warren County Health Department
Schaum Woodard	Health Education Supervisor Beaufort County Health Department
Sharon Long	Health Education Supervisor Northampton County Health Department

Sue Liverman RN, certified Diabetes Educator
Hertford County Public Health Authority
NENC Diabetes Center

Tanya Miller Nurse Case Manager and Social Work Supervisor
Albemarle Hospital

Conducts discharge planning and utilization reviews; coordinates data collection for stroke registry at hospital

Yvonne Mullen Family and Consumer Sciences Agent
Pasquotank County Cooperative Extension Agency

Provides community education programs to the community on food, nutrition, health and wellness;

Tamara Jones Health Educator and Disparity Gap Coordinator
Pamlico County Health Department

Trish Blackmon Health Education Supervisor
Dare County Public Health Department

Interventions for Reducing the Burden of Heart Disease and Stroke in the Region

Strategic planning participants generated a list of 65 ideas for heart disease and stroke prevention activities for the region (appendix A). In general, five types of activities were described. These were (1) policy and environmental change activities, (2) access to care and screening activities, (3) social support and motivation activities, (4) information and education activities, and (5) exercise and nutrition programs.

Participants ranked these categories from 1 to 5, with 1 being the highest priority.

Median Ranking Score	
1	**Access to Care and Screening**—increasing access to preventive health care; secondary prevention resources; screening and referring people who have hypertension, high cholesterol, diabetes;
2	**Information and Education**—disseminating current information about: the importance of controlling blood pressure and cholesterol, healthy behaviors, signs and symptoms of heart attack and stroke, nutrition and healthy cooking, etc.
3	**Social Support and Motivation**—setting up social networks that help people to live healthfully
3	**Exercise and Nutrition Programs**—programs that provide access to fitness programs and healthy cooking programs
4	**Policy and Environmental Change**—working toward policy changes in government, insurance companies, worksites, churches and other organizations; changing communities to make them places that it is easier to live healthfully (increasing access to healthy foods and physical activity)

Within each category, the ideas that were selected most frequently as a "top ten choice" were the following:

Access to Care and Screening

- Increase workplace wellness programs
- Obtain funds to pay for programs like "Exerstyle" or Viquest ; programs provide a risk assessment for adults and also supervised exercise (risk assessment includes measurement of glucose, weight, blood pressure, cholesterol; offer scholarships for people who cannot afford membership costs)
- Work with hospitals to increase their secondary prevention activities
- Work more closely with doctors; linking all patients to medical model wellness programs that are free or affordable
- Blood pressure and cholesterol screenings in African American churches (through health departments). To include follow-ups, feedback on overall screenings and assessment of and education about policy and environmental factors that influence the health of church members
- Develop a medication program for the uninsured/underinsured
- Increase medication assistance program funding for people who cannot afford medications (make these programs provide service to more people and for greater variety of medications)
- Implement Wise woman program in the region ; this would include blood work to help monitor changes in cholesterol and diabetes or the potential for these;
- Do preventive health screening and education for all people waiting to get a drivers license at the DMV offices

Information and Education

- Create community wide campaign to increase awareness of high blood pressure and signs and symptoms of heart disease and stroke; use many types of media; o to health fairs
- Teach people how to fit exercise into their lives; teach them that exercise doesn't have to be something hard or something that is not enjoyable; and that this can be accomplished by exercising for 3 x 10 minute intervals
- Education program provided in community settings (churches, malls, walmart, doctors offices) teach them about lifestyle, exercise, diet and importance of HTN control; target 20 to 40 year olds
- Provide frequent messages in multiple media venues to educate about heart disease and stroke prevention
- Increase church programs; everyone can be touched by churches in community even if they are not technically a member; walking programs; have a mini-grant program for churches; to hold programs in their family life centers; focus on nutrition, involve multi-generation;
- Implement Wise woman program in the region ; this would include blood work to help monitor changes in cholesterol and diabetes or the potential for these;

Social Support and Motivation

- Have in-town walking trails and develop a walking program with group leaders leading walks at scheduled times
- Have a progressive healthy lifestyle education program with progressive incentives (goals and rewards);
- Implement case management for heart disease and stroke through the Community Care Plan (and fund this type of program for the working poor ; ie. those who do not qualify for Medicaid)
- Develop community garden programs through cooperative extension and the schools to teach about healthy eating, to provide free source of healthy fresh vegetables, and to increase physical activity through volunteer work in the garden; this might start out as a grant funded program , but it could eventually become a town or municipality project
- Increase church programs; everyone can be touched by churches in community even if they are not technically a member; walking programs; have a mini-grant program for churches; to hold programs in their family life centers; focus on nutrition, involve multi-generation;
- Implement prevention programs for children ages 5 to 11 and their parents; use the "Fun for Kids" program which is an 11 week program for seriously overweight children; have incentives for participation
- Implement a program for at-risk children and their families to teach them about lifestyle and nutrition; show them the "honey I'm killing the kids" program that was on TV
- Have a program that would connect older adults to work or a volunteer activity; get people to continue to be gainfully employed or volunteering; this would help older people feel connected to the community and provide social support.
- Fund community health advisors (peer educators) and have professionals to manage and oversee them

Physical Activity and Nutrition Programs

- Have in-town walking trails and develop a walking program with group leaders leading walks at scheduled times
- Implement the Take 10 program in a wider range of ages at the schools; this is a program that incorporates physical activity into the school curriculum (math, science, reading)
- Increase workplace wellness programs
- Develop community garden programs through cooperative extension and the schools to teach about healthy eating, to provide free source of healthy fresh vegetables, and to increase physical activity through volunteer work in the garden; this might start out as a grant funded program , but it could eventually become a town or municipality project
- Have an exercise education program; teach about different forms of exercise that are easy to accomplish (like parking car far away)
- Develop a dining with heart disease program modeled after dining with diabetes
- Increase church programs; everyone can be touched by churches in community even if they are not technically a member; walking programs; have a mini-grant program for churches; to hold programs in their family life centers; focus on nutrition, involve multi-generation;

(Physical Activity and Nutrition Programs continued)

- Have classes to help people to make lifestyle changes this would include diet, exercise, and also teach the things to look for that are warning signs for further heart and stroke problems;
- Have a progressive healthy lifestyle education program with progressive incentives (goals and rewards);
- Obtain funds to pay for programs like “Exerstyle” or Viquest; programs provides a risk assessment for adults and also supervised exercise (risk assessment includes measurement of glucose, weight, blood pressure, cholesterol) have scholarships to cover membership costs
- Provide cooking classes at churches to teach healthy cooking substitutions; teach them that they don’t have to attempt to totally change their diet, but that they can make small changes; would target women ages 20+

Policy and Environmental Change

- Increase workplace wellness programs
- Implement case management for heart disease and stroke through the Community Care Plan; have it available at their home (and eventually try to fund this type of program for the working poor ; ie. those who do not qualify for Medicaid) ;
- Work more closely with doctors; linking all patients to medical model wellness programs that are free or affordable
- Build community health centers in housing complexes; provide cardiovascular health screenings and preventive health visits and housing
- Implement CVH interventions to promote policy and environmental change to Help make African American churches more heart healthy ;(there is a Heart Check tool that has been used by New York to assess work sites)
- Increase medication assistance program funding for people who cannot afford medications (make these programs provide service to more people and for greater variety of medications)
- Fund diabetes self management for <u>all</u> with diabetes
- Increase funding for primary prevention
- Implement the Take 10 program in a wider range of ages at the schools; this is a program that incorporates physical activity into the school curriculum (math, science, reading)
- Blood pressure and cholesterol screenings in African American churches (through health departments). To include follow-ups, feedback on overall screenings and assessment of and education about policy and environmental factors that influence the health of church members

Primary and Secondary Prevention of Heart Disease and Stroke Challenges and Needs

Below are comments from participants when asked what the challenges are to working with people to reduce their risk of cardiovascular disease.

Changing the way we prepare and eat food

- The way they cook their food; there are a lot of cookouts at church events; events tend to be food centered with no healthy options; veggies are served but they are cooked in fat back;
- excessive eating out;
- the way we cook food in the south; people are starting to make changes in cooking, though;
- older population is set in their ways; they done want to change their diet because it is part of their tradition; when you tell them to cook with bullion instead of fat back they say that it doesn't taste right; cooking demos sometimes help to convince them that the food will be good;
- need to get people involved in better eating habits; dining with diabetes gets them actually cooking themselves; people attending classes should be doing the cooking themselves rather than a demo;
- education /community programs need to have professionals involved to assure quality and accuracy of info being disseminated;

Secondary Prevention

- People who have experienced a heart attack or stroke want to continue with normal activities; men don't think they need rehab; don't see benefit of strengthening; eating habits don't change after surgery; clean and new vessels; I replaced my pipes"
- for constant follow-up and education;
- community care plan should focus on CVD; they have success stories for the Medicaid population
- people who have had heart attack, stroke, bypass surgery are referred from the hospital to home health; we teach them about after surgery care, do rehab work with stroke survivors, provide education about medications and diet; challenge is medication non-compliance, like non-compliance for HTN medication; due to lack of understanding of importance/impact of lowering blood pressure and somewhat due to placing a higher priority on other expenses like cell phones, cable, etc. Some patients are on Medicaid and do not want to pay the 1 or 2$ co pay--other priorities;
- We need more follow-up case management and preventive education; we are doing better than we were 10 years ago, but we still need more; we have a cardiac wellness program (with dietician) program has grown over time; we are providing more services to more people;
- patients need education and support; they have no idea what they need to do; the think they know;
- Families need more education about medications for example;

- needs are ABCs of diabetes control; day to day self management;
- have seen homecare aides propping stroke survivors up in bed and making them eggs for breakfast; personal care service agencies need more education;
- need more guidelines for personal care service agencies; there is a misuse of Medicaid funds by personal care agencies that is taking away resources from heart attack and stroke patient follow-up care; may need to be some policy changes regarding the eligibility criteria of patients for these services ;
- education /community programs need to have professionals involved to assure quality and accuracy of info being disseminated;

Living in a Healthy Environment

- Barriers are environmental
- The way they cook their food; there are a lot of cookouts at church events; events tend to be food centered with no healthy options; veggies are served but they are cooked in fat back;
- people are scared to walk; even though there are trails marked out in downtown and in all the municipalities, they are afraid because people have gotten meaner;
- there is no YMCA in the county;
- no healthy choices when eating out
- overweight is acceptable in the culture; big is considered to be healthy and hearty; people with normal BMI they think that they are underweight and weak/sickly'; denser body build is considered desirable;
- I am seeing kids with borderline diabetes, and hypercholesterolemia, even as young as age 5 years;
- people in this county are not active; they don't want to got to the gym; need to give them different ideas about what they can do for exercise and that they can break it up into smaller increments; work in the garden park further away; they are used to doing things easy—getting the kids to mow the lawn; people used to work out in the fields, now there are machines that do their jobs;
- they give all sorts of excuses about why they cant exercise; they say they don't have time; some people work non-traditional hours which makes it hard for them to find a good time; this county has a lack of PA venues, especially for children; we don't have the skating rink anymore, and the parks are not up to par; municipalities are spread out

Community Education

- people don't understand the seriousness of HTN and cholesterol; once people on meds for HTN, for example, they do not consider themselves to be at risk; they will tell you that they do not have HTN; missing link is drug/medication education;
- there is need for education especially among lower SES to teach about lifestyle changes

- to convince people to make changes; we need to get them to believe that they can improve; it takes more than a visit to the doctor; doctors are too busy;
- see denial of heart attack or stroke; they think they are having indigestion and wait until they have shortness of breath before they call the ambulance;
- work in group settings and some of the participants are at risk of heart disease and stroke; people may be aware that lifestyle changes can make a difference but the perception is that drastic changes need to occur in order for a health benefit; not aware that even small changes can help reduce their risk;
- lack of knowledge understanding about tobacco and how to quit; people have no idea how to quit smoking or that after quitting their risk of disease will be reduced each year
- educating them about PA and lifestyle; one strategy that seems to work is to tell them that their health affects their family;
- older population is set in their ways; they done want to change their diet because it is part of their tradition; when you tell them to cook with bullion instead of fat back they say that it doesn't taste right; cooking demos sometimes help to convince them that the food will be good;
- patients need education and support; they have no idea what they need to do; the think they know;
- People are not sure of signs and symptoms of stroke;
- When talking to people who have had a stroke, it is frustrating …that they think they know what to do; they think they were having a headache and if they take a nap, they will get better;
- I want to raise awareness about stroke;
- people don't know what blood pressure value means they are at risk; patients cant answer the question, "what should your blood pressure be?" people need to know what their blood pressure, cholesterol, A1C numbers mean;
- education /community programs need to have professionals involved to assure quality and accuracy of info being disseminated;

Access to Care and Services

- cost of programs is a barrier, have had people drop out of Exerstyle because they could not pay the $20 risk assessment fee or the $20 yearly membership fee;
- major problem is affordability of medications;
- lack of funds to buy medicine;
- lack of transportation;
- through diabetes screening program at HD we see so many people who have never been to a doctor for their diabetes;
- people cant afford blood pressure and heart medications;

- see denial of heart attack or stroke; they think they are having indigestion and wait until they have shortness of breath before they call the ambulance;
- doctors are not treating high blood pressure;
- some people cant even afford Medicare part D; either you eat, or you take your meds; inability to buy medications
- we saw some highly motivated people; attendance in rehab classes was very good; when insurance no longer covered costs, attendance dropped; clients were angry when they had to start paying for Viquest membership; this has settled down now, though; Viquest membership has 30% on scholarships; membership seems to be representative of the county population;
- people who have had heart attack, stroke, bypass surgery are referred from the hospital to home health; we teach them about after surgery care, do rehab work with stroke survivors, provide education about medications and diet; challenge is medication non-compliance, like non-compliance for HTN medication; due to lack of understanding of importance/impact of lowering blood pressure and somewhat due to placing a higher priority on other expenses like cell phones, cable, etc. Some patients are on Medicaid and do not want to pay the 1 or 2$ co pay--other priorities;
- We need more follow-up case management and preventive education; we are doing better than we were 10 years ago, but we still need more; we have a cardiac wellness program (with dietician) program has grown over time; we are providing more services to more people;
- still a rural county; people don't have a family physician to start with; many patients don't access healthcare; affordability of healthcare is an issue; employment rates are low;
- access to transportation is an issue;
- we are seeing an increasing number of patients who don't have a regular doctor who can follow-up with them after a heart attack or stroke;
- patients need education and support; they have no idea what they need to do; the think they know;
- People are not sure of signs and symptoms of stroke;
- it is frustrating that they think they know what to do; they think they have a headache and if they take a nap, they will get better;
- have seen homecare aides propping stroke survivors up in bed and making them eggs for breakfast; homecare agencies need more education;
- need more guidelines for homecare ; there is fraud in home care that is taking away resources from heart attack and stroke patient follow-up care;
- people are having to decide which medications are a priority for them because they don't have financial resources;
- challenge of navigating the medical care system;
- barriers are the number of people who are uninsured or underinsured; insurance companies charging more for Lipitor;

- education /community programs need to have professionals involved to assure quality and accuracy of info being disseminated;

Social Support and Motivation

- work with high risk clients; challenge is trying to get them to make lifestyle changes; we believe that if there is a perceived need that this would be enough need
- to convince people to make changes; we need to get them to believe that they can improve; it takes more than a visit to the doctor; doctors are too busy;
- need support systems; support groups. education on prevention; families have changed so much--support is not there;
- work in group settings and some of the participants are at risk of heart disease and stroke; people may be aware that lifestyle changes can make a difference but the perception is that drastic changes need to occur in order for a health benefit; not aware that even small changes can help reduce their risk;
- we need one-on-one sense of caring to help people make changes to reduce their risk; show interest and caring and come up with a plan of action; case mgmt done right can go a long way;
- educating them about PA and lifestyle; one strategy that seems to work is to tell them that their health affects their family;
- need support financially,emotionally and educationally;
- people don't know how to change;

Other

- barriers are SES factors in the area; public health cant fix that but this is a variable that we need to keep in mind when developing programs;

Other Comments and Suggestions

NENCPPH should get suggestions from community members on which of these activities they would Most likely attend and benefit from

Appendix A.
Complete List Heart Disease and Stroke Prevention Ideas listed by Category

Policy and Environmental Change

4. Build community health centers in housing complexes; provide cvd health screenings and preventive health visits and housing

7. Subsidize restaurants to provide only healthy meals one day a week or for a whole week; provide this at sit-down restaurants; have it at an upscale restaurant and also at places like golden corral; offer free or half priced meals as an incentive for customers; to show them that healthy food can taste good too

13. Purchase low impact exercise equipment for communities (bicycles, treadmills, elliptical machines)

14. set up emergency care in communities where it is absent

17. Have in-town walking trails and develop a walking program with group leaders leading walks at scheduled times

18. Increase workplace wellness programs

23. Make free walking areas available to increase physical activity

26. Work more closely with doctors; linking all patients to medical model wellness programs that are free or affordable

29. Increase funding for primary prevention

33. Implement case management for heart disease and stroke through the Community Care Plan (and fund this type of program for the working poor ; ie. those who do not qualify for Medicaid)

38. Continue to work with schools to improve meals and reduce bad food sold through vending machines

39. Implement the Take 10 program in a wider range of ages at the schools; this is a program that incorporates physical activity into the school curriculum (math, science, reading)

40. Develop community garden programs through cooperative extension and the schools to teach about healthy eating, to provide free source of healthy fresh vegetables, and to increase physical activity through volunteer work in the garden; this might start out as a grant funded program , but it could eventually become a town or municipality project

41. Decrease fraud in home health care. Resources are being diverted from where it really needs to be (ie. money is being paid for people who may really not need services, while there is a real need to provide care for people who have had a heart attack or srtoke or for people who are at high risk of this)

42. Blood pressure and cholesterol screenings in African American churches (through health departments). To include follow-ups, feedback on overall screenings and assessment of and education about policy and environmental factors that influence the health of church members

44. Implement CVH interventions to promote policy and environmental change to help make African American churches more heart healthy ;(there is a Heart Check tool that has been used by New York to assess work sites)

48. Increase the number of family physicians in the region (to increase percent of population that has a primary medical provider)

52. Fund and increase case management for stroke survivors at their homes

53. Increase medication assistance program funding for people who cannot afford medications (make these programs provide service to more people and for greater variety of medications)

55. Have a "new southern" culinary institute at churches throughout the region. Hire professional chefs to teach the classes and offer certification to graduates; This could be a certification for church kitchens (that they are a "healthy kitchen" church.

60. Develop policies for new stores to place their parking lots further from the buildings

63. Fund diabetes self management for <u>all</u> with diabetes

64. Provide funding to clearly and permanently mark walking trails.

Screening and Access to Care

4. Build community health centers in housing complexes; provide cvd health screenings and preventive health visits and housing

14. set up emergency care in communities where it is absent

18. Increase workplace wellness programs

26. Work more closely with doctors; linking all patients to medical model wellness programs that are free or affordable

33. Implement case management for heart disease and stroke through the Community Care Plan (and fund this type of program for the working poor ; ie. those who do not qualify for Medicaid)

42. Blood pressure and cholesterol screenings in African American churches (through health departments). To include follow-ups, feedback on overall screenings and assessment of and education about policy and environmental factors that influence the health of church members

48. Increase the number of family physicians in the region (to increase percent of population that has a primary medical provider)

52. Fund and increase case management for stroke survivors at their homes

53. Increase medication assistance program funding for people who cannot afford medications (make these programs provide service to more people and for greater variety of medications)

63. Fund diabetes self management for all with diabetes

5. Implement a “drive though” screening program; give non monetary incentive;

8. market cardiac rehabilitation (info about the services and also the importance of it) at senior centers, malls

12. Obtain funds to pay for an “Exerstyle” program ; this program provides a risk assessment for adults and also supervised exercise (risk assessment includes measurement of glucose, weight, blood pressure, cholesterol)

16. Increase access to programs like Viquest (many people cannot afford to pay membership)

20. Develop a medication program for the uninsured/underinsured

21. Implement Wise woman program in the region ; this would include blood work to help monitor changes in cholesterol and diabetes or the potential for these;

25. Have programs in every African-American church; have $ incentives for participation; promote regular exercise, modifications in diet; track clinical outcomes; include parish nurses

30. Work with hospitals to increase their secondary prevention activities

31. Provide information to hospitals in region about resources that are available that will help to treat and prevention heart disease and stroke

32. Work closely with hospitals to ensure that secondary prevention efforts (case management) are reaching patients who have had a stroke or heart attack

46. Mass health screening for Hypertension, diabetes, cholesterol; target 20 to 40 year olds

54. Do blood pressure screen for all people waiting to get a drivers license at the DMV offices

58. Have a diabetes and heart disease case manager in every doctors office (remove financial barriers for people to participate in these programs)

59. Have a heart mobile that will come to the neighborhoods to provide education and screening

Social Support and Motivation

18. Increase workplace wellness programs

33. Implement case management for heart disease and stroke through the Community Care Plan (and fund this type of program for the working poor ; ie. those who do not qualify for Medicaid)

52. Fund and increase case management for stroke survivors at their homes

63. Fund diabetes self management for all with diabetes

58. Have a diabetes and heart disease case manager in every doctors office (remove financial barriers for people to participate in these programs)

59. Have a heart mobile that will come to the neighborhoods to provide education and screening

17. Have in-town walking trails and develop a walking program with group leaders leading walks at scheduled times

40. Develop community garden programs through cooperative extension and the schools to teach about healthy eating, to provide free source of healthy fresh vegetables, and to increase physical activity through volunteer work in the garden; this might start out as a grant funded program , but it could eventually become a town or municipality project

55. Have a “new southern” culinary institute at churches throughout the region. Hire professional chefs to teach the classes and offer certification to graduates; This could be a certification for church kitchens (that they are a “healthy kitchen” church.

3. Develop a couples/buddy system class called "I love you because your heart is healthy"; invite people to come with their friend or sister, spouses, significant other; teach cooking and exercise; share recipes; exercise together ; buddy support program;

6. Have a progressive healthy lifestyle education program with progressive incentives (goals and rewards);

9. “We wont replace the power of people”; assign person to be responsible for an area; to support a community; measure trails in neighborhood; teach how to shop and cook; this would in essence be a "coach" for every neighborhood; someone to motivate the community; someone to spend time in the homes; there is need for socialization and support;

10. Have a program that would connect older adults to work or a volunteer activity; get people to continue to be gainfully employed or volunteering; this would help older people feel connected to the community and provide social support.

11. Increase church programs; everyone can be touched by churches in community even if they are not technically a member; walking programs; have a mini-grant program for churches; to hold programs in their family life centers; focus on nutrition, involve multi-generation;

27. Implement prevention programs for children ages 5 to 11 and their parents; use the "Fun for Kids" program which is an 11 week program for seriously overweight children; have incentives for participation

37. Implement a program for at-risk children and their families to teach them about lifestyle and nutrition; show them the "honey I'm killing the kids" program that was on TV

56. Fund community health advisors (peer educators) and have professionals to manage and oversee them

57. Develop a community health advisory network; this means gathering local leaders who will form groups in their community; let these groups decide what types of programs are most needed in their community

62. Have free dance programs in the communities (they would offer dance lessons and sponsor dances

Information and Education

18. Increase workplace wellness programs

52. Fund and increase case management for stroke survivors at their homes

63. Fund diabetes self management for all with diabetes

58. Have a diabetes and heart disease case manager in every doctors office (remove financial barriers for people to participate in these programs)

59. Have a heart mobile that will come to the neighborhoods to provide education and screening

40. Develop community garden programs through cooperative extension and the schools to teach about healthy eating, to provide free source of healthy fresh vegetables, and to increase physical activity through volunteer work in the garden; this might start out as a grant funded program , but it could eventually become a town or municipality project

55. Have a “new southern” culinary institute at churches throughout the region. Hire professional chefs to teach the classes and offer certification to graduates; This could be a certification for church kitchens (that they are a “healthy kitchen” church.

9. “We wont replace the power of people”; assign person to be responsible for an area; to support a community; measure trails in neighborhood; teach how to shop and cook; this would in essence be a "coach" for every neighborhood; someone to motivate the community; someone to spend time in the homes; there is need for socialization and support;

11. Increase church programs; everyone can be touched by churches in community even if they are not technically a member; walking programs; have a mini-grant program for churches; to hold programs in their family life centers; focus on nutrition, involve multi-generation;

27. Implement prevention programs for children ages 5 to 11 and their parents; use the "Fun for Kids" program which is an 11 week program for seriously overweight children; have incentives for participation

37. Implement a program for at-risk children and their families to teach them about lifestyle and nutrition; show them the "honey I'm killing the kids" program that was on TV

56. Fund community health advisors (peer educators) and have professionals to manage and oversee them

8. market cardiac rehabilitation (info about the services and also the importance of it) at senior centers, malls

21. Implement Wise woman program in the region ; this would include blood work to help monitor changes in cholesterol and diabetes or the potential for these;

30. Work with hospitals to increase their secondary prevention activities

31. Provide information to hospitals in region about resources that are available that will help to treat and prevention heart disease and stroke

54. Do blood pressure screen for all people waiting to get a drivers license at the DMV offices

7. Subsidize restaurants to provide only healthy meals one day a week or for a whole week; provide this at sit-down restaurants; have it at an upscale restaurant and also at places like golden corral; offer free or half priced meals as an incentive for customers; to show them that healthy food can taste good too

38. Continue to work with schools to improve meals and reduce bad food sold through vending machines

39. Implement the Take 10 program in a wider range of ages at the schools; this is a program that incorporates physical activity into the school curriculum (math, science, reading)

44. Implement CVH interventions to promote policy and environmental change to help make African American churches more heart healthy ;(there is a Heart Check tool that has been used by New York to assess work sites)

15. Have a "Healthy Eating and Exercise through the Life Cycle" education program; there could be a series of classes tailored to specific age groups (ages 0-5, elementary, junior high, high school age, middle age, and seniors)

19. Have classes to help people to make lifestyle changes this would include diet, exercise, and also teach the things to look for that are warning signs for further heart and stroke problems;

22. Increase knowledge about nutrition; target employees at restaurants, service industry workers (not just government employees) and other worksites

28. Provide frequent messages in multiple media venues to educate about heart disease and stroke prevention

35. Teach people how to fit exercise into their lives; teach them that exercise doesn't have to be something hard or something that is not enjoyable; and that this can be accomplished by exercising for 3 x 10 minute intervals

36. Implement color me healthy programs in the child care facilities in NENC; this is a lifestyle, health and nutrition education program for children ages 2-5

43. Create community wide campaign to increase awareness of high blood pressure and signs and symptoms of heart disease and stroke

45. Education program provided in community settings (churches, malls, walmart, doctors offices) teach them about lifestyle, exercise, diet and importance of HTN control; target 20 to 40 year olds

47. Go to elder fairs and use media to teach the signs and symptoms of heart attack and stroke

49. Educate the elderly and middle aged population about heart disease and stroke and prevention

50. Conduct more education programs at places like health fairs

51. Have school based education program about lifestyle and prevention of HD and Stroke;

Exercise and Nutrition Programs

18. Increase workplace wellness programs

40. Develop community garden programs through cooperative extension and the schools to teach about healthy eating, to provide free source of healthy fresh vegetables, and to increase physical activity through volunteer work in the garden; this might start out as a grant funded program , but it could eventually become a town or municipality project

55. Have a “new southern” culinary institute at churches throughout the region. Hire professional chefs to teach the classes and offer certification to graduates; This could be a certification for church kitchens (that they are a “healthy kitchen” church.

11. Increase church programs; everyone can be touched by churches in community even if they are not technically a member; walking programs; have a mini-grant program for churches; to hold programs in their family life centers; focus on nutrition, involve multi-generation;

39. Implement the Take 10 program in a wider range of ages at the schools; this is a program that incorporates physical activity into the school curriculum (math, science, reading)

19. Have classes to help people to make lifestyle changes this would include diet, exercise, and also teach the things to look for that are warning signs for further heart and stroke problems;

17. Have in-town walking trails and develop a walking program with group leaders leading walks at scheduled times

3. Develop a couples/buddy system class called "I love you because your heart is healthy"; invite people to come with their friend or sister, spouses, significant other; teach cooking and exercise; share recipes; exercise together ; buddy support program;

6. Have a progressive healthy lifestyle education program with progressive incentives (goals and rewards);

62. Have free dance programs in the communities (they would offer dance lessons and sponsor dances

12. Obtain funds to pay for an “Exerstyle” program ; this program provides a risk assessment for adults and also supervised exercise (risk assessment includes measurement of glucose, weight, blood pressure, cholesterol)

16. Increase access to programs like Viquest (many people cannot afford to pay membership)

25. Have programs in every African-American church; have $ incentives for participation; promote regular exercise, modifications in diet; track clinical outcomes; include parish nurses

13. Purchase low impact exercise equipment for communities (bicycles, treadmills, elliptical machines)

23. Make free walking areas available to increase physical activity

1. Provide cooking classes at churches to teach healthy cooking substitutions; teach them that they don't have to attempt to totally change their diet, but that they can make small changes; would target women ages 20+

2. Have an exercise education program; teach about different forms of exercise that are easy to accomplish (like parking car far away)

24. Provide scholarships for gyms, parks and recreation programs

34. Educate population about eating healthy; and that it does not have to be expensive eat healthy

61. Develop a dining with heart disease program modeled after dining with diabetes