

# Maryland Health Disparities Collaborative

## **Health and Health System Experience Workgroup**

A set of evidence-based options for communities, local health institutions, and health plans to consider in establishing effective community health proposals for Health Enterprise Zones and examples of successful models of care that address disparities.

## **Background**

In the U.S., more than 75% of health care spending is on chronic disease conditions. These conditions are the leading causes of death and disability and are major drivers of escalating health care costs throughout the life cycle of all population groups. In Maryland, the Health Disparities Workgroup of the Maryland Health Quality and Cost Council found that asthma, heart disease, and diabetes were conditions where disparities were large, and where ambulatory care could reduce disparities and reduce costs. Specifically, between 50% and 75% of Black hospital admissions in Maryland for these conditions could be avoided if Black hospital admission rates were equal to White rates.

To improve quality of life and contain the burgeoning cost of health care, communities must directly address the control of chronic disease. This can be achieved through a strategy that integrates disease management, health promotion and disease prevention to eliminate disparities and raises the health status of all population groups. In this new health care delivery system paradigm, prevention must be given the priority and payment systems aligned to incentivize providers and community stakeholders. To make this strategy work, communities must link the energies of the structural components that are present, to work in unison, forming a Health Promoting Community. The citizen (patient) is viewed as central, and interventions become patient-centered. See the attached Hub and Spoke model.

Prevention Works. There is mounting evidence for promising and best practices that use refreshed thinking and innovative efforts to implement community health improvement interventions (medical, dental, behavioral, social determinants, and others). This approach integrates the components of health (medical, behavioral, public health, and others) and requires them to communicate with community institutions whose mission and service impacts the health of the public (transportation, housing, schools, etc.). The attached Hub and Spoke model portrays dynamic relations and interaction among the structural components in a community.

A proposal to improve the health of population groups that reside in areas of poor health with unacceptably high, preventable mortality should select interventions from the following list and tailor them to fit the area's specific health needs. We have identified 10 evidence-based options (each with links to toolkits, sample materials, and contact information) for communities and local health institutions and health plans to consider for Health Enterprise Zones. We also recommend five innovative projects already underway in Maryland that use successful models of care to address disparities by improving population health, enhancing the patient experience or reducing costs.

## Recommendations for Evidence-Based Options

**An overall recommendation is to set up an interactive webpage of Chronic Disease evidence-based, promising and best practices that can provide communication and learning opportunities for Chronic Disease programs statewide.**

**Recommendation 1: Implement a *diabetes prevention* “Small Steps” campaign to create materials for people at risk for diabetes, using multipronged community outreach.**

National Diabetes Education Program (NDEP)’s Small Steps. Big Rewards. Prevent Type 2 Diabetes Campaign

<http://ndep.nih.gov/publications/PublicationDetail.aspx?PubId=118>

The NDEP’s Small Steps. Big Rewards. Prevent Type 2 Diabetes Campaign has created campaign messages and materials for people at risk for diabetes, including those at high risk. The program’s “18 Easy Ideas” include employers, utility companies, and hospitals using NDEP brochures as paycheck or bill stuffers; and minority organizations distributing NDEP posters to their member organizations and throughout communities.

**Recommendation 2: Launch a *tobacco cessation* campaign with advertising campaigns and historical, cultural, and socioeconomic influences targeted to specific groups.**

Pathways to Freedom: Winning the Fight Against Tobacco

[http://www.cdc.gov/tobacco/quit\\_smoking/how\\_to\\_quit/pathways/index.htm](http://www.cdc.gov/tobacco/quit_smoking/how_to_quit/pathways/index.htm)

Pathways to Freedom offers proven strategies for anyone who wants to quit, how friends and family can help, and how the community and its leaders can promote the value of gaining freedom from tobacco. The program was produced in partnership with key segments of the African-American community, including churches, service organizations, and educational institutions. Components include prevention materials, fact sheets, articles, and public service announcements.

**Recommendation 3: Promote *healthy eating* through church-based programs, pastor support, and peer counseling.**

American Cancer Society's Body & Soul Program

<http://www.cancer.org/MyACS/GreatLakes/ProgramsandServices/bodysoul>

The Body & Soul health program was developed by the American Cancer Society for African American churches. Body & Soul empowers church members to eat a healthy diet rich in fruits and vegetables every day for better health. Church members form a committee, then customize and run Body & Soul to fit the needs of their church. Key components of Body & Soul include pastor support and involvement, church activities

3

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that promote healthy eating, a church environment that promotes healthy eating, and peer counseling.

**Recommendation 4: Recruit barbershops to aid in *improving hypertension detection and control, helping black men beat high blood pressure, and controlling cardiovascular disease.***

Hypertension Detection in Barbershops: Barbershops as Hypertension Detection, Referral, and Follow-Up Centers for Black Men

<http://hyper.ahajournals.org/content/49/5/1040.full>

Data suggest that black-owned barbershops can be transformed into effective hypertension detection, referral, and follow-up centers.

Effectiveness of a Barber-Based Intervention for Improving Hypertension Control in Black Men: The BARBER-1 Study: A Cluster Randomized Trial

<http://archinte.jamanetwork.com/article.aspx?articleid=226700>

The effect of blood pressure screening on hypertension control among black male barbershop patrons was improved when barbers were enabled to become health educators, monitor blood pressure, and promote physician follow-up.

Cardiovascular Disease Control through Barbershops: Design of a Nationwide Outreach Program

<http://www.ncbi.nlm.nih.gov/pubmed/20437741>

The Black Barbershop Health Outreach Program (BBHOP) was established by clinicians to enhance community-level awareness of and empowerment for cardiometabolic disorders such as diabetes and cardiovascular disease. The program combines a grassroots organization approach and partner agencies with substantial marketing expertise and media literacy.

**Recommendation 5: Assist *people released from prison find primary care and navigate the health care system.***

Transitions Clinic Network: Linking High-risk Medicaid Patients from Prison to Community Primary Care

<http://innovations.cms.gov/initiatives/Innovation-Awards/california.html>

The San Francisco Community College District (City College of San Francisco) is working with the Department of Corrections to identify patients with chronic medical conditions prior to release and will use community health workers trained by City College of San Francisco to help these individuals navigate the care system, find primary care and other medical and social services, and coach them in chronic disease

4

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management. The outcomes will include reduced reliance on emergency room care, fewer hospital admissions, and lower cost, with improved patient health and better access to appropriate care.

**Recommendation 6: *Better use hospital emergency departments to test for HIV, HCV, and other infectious diseases and conditions, and then provide assistance and referrals.***

Payer Status, Race/Ethnicity, and Acceptance of Free Routine Opt-Out Rapid HIV Screening Among Emergency Department Patients

<http://www.ncbi.nlm.nih.gov/pubmed/22420816>

Researchers analyzed data from a prospective clinical trial between 2007 and 2009 at Denver Health. Patients in the ED were offered free HIV testing. Patient demographics and payer status were collected, and we used multivariable logistic regression to estimate associations with HIV testing acceptance. Many ED patients are uninsured or subsidized through government programs and are more likely to consent to free rapid HIV testing.

**Recommendation 7: *Promote the Community Health Worker (CHW) movement in Maryland***

CDC policy brief: “Addressing Chronic Disease through Community Health Workers”  
[http://www.cdc.gov/dhdsp/docs/chw\\_brief.pdf](http://www.cdc.gov/dhdsp/docs/chw_brief.pdf)

The CHW movement in the U.S. is modeled on the traditional role of lay health workers who have functioned as an integral part of health care delivery in regions such as Africa, Asia and Latin America. Massachusetts and Minnesota have established formal infrastructure to facilitate full integration of the CHW into their health delivery system. Sixteen other states have programs and networks in place to promote the use of community health workers.

Migrant Clinicians Network and Migrant Health Promotion have developed a new resource specifically tailored to the needs and objectives of teams participating in the Health Disparities Collaboratives. The document includes a grid that describes roles for CHWs in five of the six components of the Chronic Care Model.

[http://www.migrantclinician.org/files/resourcebox/Guide\\_For\\_Health\\_Disparities\\_Collaboratives-2007.pdf](http://www.migrantclinician.org/files/resourcebox/Guide_For_Health_Disparities_Collaboratives-2007.pdf)

**Recommendation 8: *Manage heart failure more effectively through the consistent use of medications, modification of diet, and an exercise and activity program.***

Two large multicenter trials evaluated the effects of telemedicine on mortality in patients with heart failure, and both found no change in mortality between the active and placebo

arms. Another study evaluated telemedicine plus the addition of nurse phone call follow-up and found a significant reduction in both mortality and heart failure readmissions.

Chaudhry SI, et al. Telemonitoring in patients with heart failure. *N Engl J Med*. 2010;363(24):2301-2309

<http://www.ncbi.nlm.nih.gov/pubmed/21080835>

Koehler F, et al. Telemedical Interventional Monitoring in Heart Failure Investigators. Impact of remote telemedical management on mortality and hospitalizations in ambulatory patients with chronic heart failure: the telemedical interventional monitoring in heart failure study. *Circulation*. 2011;123(17):1873-1880

<http://www.ncbi.nlm.nih.gov/pubmed/21444883>

Kasper EK, et al. A randomized trial of the efficacy of multidisciplinary care in heart failure outpatients at high risk of hospital readmission. *J Am Coll Cardiol*. 2002;39(3):471-480

<http://www.ncbi.nlm.nih.gov/pubmed?term=Kasper%20EK%20Gerst%20enblith%20G%20Hefer%20G%20Van%20Anden%20E%20Brinker%20JA%20Thiemann%20DR%20Terrin%20M%20Forman%20S%20Gottlieb%20SH.%20%20A%20randomized%20trial%20of%20the%20efficacy%20of%20multidisciplinary%20care%20in%20heart%20failure%20outpatients%20at%20high%20risk%20of%20hospital%20readmission>.

**Recommendation 9: *Employ proven effective drug treatment for addiction and combine with a broad community program in housing, medical care, social rehabilitation, job training, and social support.***

Pinto H, Maskrey V, Swift L, Rumball D, Wagle A, Holland R. The SUMMIT trial: a field comparison of buprenorphine versus methadone maintenance treatment. *J Subst Abuse Treat*. 2010;39(4):340-352

<http://www.ncbi.nlm.nih.gov/pubmed?term=Pinto%20H%20Maskrey%20V%20Swift%20L%20Rumball%20D%20Wagle%20A%20Holland%20R%20The%20SUMMIT%20trial%3A>

**Recommendation 10: *Tackle obesity by:***

**(a) Increasing the availability of safe places to play and exercise with improved street lighting, infrastructure to make street-crossing safer, use of traffic-calming approaches, and building playgrounds and walking trails; and**

**(b) Increasing access to healthy foods (eliminating “food deserts”) by developing and supporting farmer's markets and creating community gardens.**

Bryant Cameron Webb. Moving Upstream: Policy Strategies to Address Social, Economic, and Environmental Conditions that Shape Health Inequities. April 2012. Washington, DC: Joint Center for Political and Economic Studies  
<http://www.jointcenter.org/research/moving-upstream-policy-strategies-to-address-social-economic-and-environmental-conditions-t>

### **Other Tools for Intervention**

**Centers for Disease Control and Prevention’s listing of ALL risk-reduction interventions by characteristic:**

<http://www.cdc.gov/hiv/topics/research/prs/subset-best-evidence-interventions.htm>

#### **Intervention Level**

Individual-level interventions (ILI)  
Group-level interventions (GLI)  
Community-level interventions (CLI)

#### **Risk Category**

Drug users  
Heterosexual adults  
High-risk youth  
Men who have sex with men (MSM)  
People living with HCV (HCV+)  
People living with HIV/AIDS (HIV+)

#### **Race/Ethnicity of the Participants**

African Americans  
Asians & Pacific Islanders  
Hispanics  
Minorities  
Whites

#### **Sex of the Participants**

Females  
Males

## **CDC's Guide to Community Preventive Services**

<http://www.thecommunityguide.org/index.html>

The Community Guide is a resource for evidence-based Task Force recommendations and findings about what works to improve public health. The guide is based on a scientific systematic review process and answers questions critical to almost everyone interested in community health and well-being such as:

- What interventions have and have not worked?
- In which populations and settings has the intervention worked or not worked?
- What might the intervention cost? What should I expect for my investment?
- Does the intervention lead to any other benefits or harms?
- What interventions need more research before we know if they work or not?

### ***Success Stories:***

#### **Black Corals: A Gem of a Cancer Screening Program in South Carolina**

In rural South Carolina, where many African American women have limited access to lifesaving medical screenings, the risk of cancer-related death is a complex public health problem. The St. James-Santee Family Health Center launched Black Corals to increase cancer screening among women. The Community Guide served as a resource to help the Black Corals program dramatically increase breast and cervical cancer screenings in their community.

#### **Blueprint for Success in Reducing Tobacco Use**

The City of Lincoln and Lancaster County, Nebraska used Community Guide recommendations to build a plan to decrease tobacco use. Their step-by-step approach led to substantial reductions in tobacco use in their county, and led to the state's decision to model their smoking ban on the one developed by the City of Lincoln, and eventually, to monumental state-wide policy changes.

#### **Community-Wide Effort to Make Florida Tobacco Free**

Florida public health practitioners, community advocates, and residents joined forces to change state policy in order to stem the tide of death and disability caused by tobacco. Evidence-based interventions, like the ones found in the Community Guide, were implemented across the state and led to substantial reductions in tobacco use and personal health care expenditures.

#### **Creating Walkable Communities in Rural North Carolina**

Granville County, North Carolina wanted to reduce the health-related risks associated with obesity by increasing physical activity among residents. Using The Community Guide as a resource, the county created a plan—Granville Greenways Master Plan—to make physical activity more accessible by creating more walkable communities.

#### **Evidence-Based Recommendations Get Minnesotans in the Groove**

As chronic disease weighs on the nation's health, Blue Cross and Blue Shield of Minnesota has

8

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June 11, 2012

launched a long-term health initiative aimed at getting Minnesotans up, active, and embracing a healthier lifestyle through the use of evidence-based strategies found in The Community Guide.

### **A Good Shot: Reaching Immunization Targets in Duval County**

The Duval County Health Department in Jacksonville, Florida was challenged with low childhood immunization rates, particularly in its urban core. By implementing a quality improvement strategy that combined multiple Community Guide recommendations, they reached the national target within one year.

### **Investing in Worksite Wellness for Employees**

The Dow Chemical Company's health promotion program is part of an integrated health strategy to improve the health of its 52,000 employees around the world. Dow uses The Community Guide as a resource to shape these programs and address chronic disease risk factors such as obesity, physical activity, and tobacco use among its employees.

### **Lowering Legal Blood Alcohol Limits Saves Lives**

A team of experts used The Community Guide's systematic review process to examine the effectiveness of lowering the illegal blood alcohol concentration (BAC) limit for automobile drivers. The results of this assessment formed the basis for the independent Community Preventive Services Task Force (Task Force) recommendation that 0.08 percent BAC laws are effective in reducing alcohol-related motor vehicle fatalities. In October 2000, the President signed the transportation appropriations bill requiring states to pass the 0.08% BAC law by October 2003 or risk losing federal highway construction funds.

### **Maryland Businesses Support Worksite Wellness Effort to Combat Chronic Disease**

The Maryland Department of Health and Mental Hygiene launched an initiative to decrease obesity and diabetes by promoting wellness at worksites across the state. They used The Community Guide as a resource to assess and influence changes in employees' health. As a result, more than 150 businesses made a commitment to workplace wellness options for more than 180,000 employees.

### **Mobilizing Funding Support to Battle Overweight and Obesity**

The Western Maryland Health System used a health strategy that systematically leveraged funding and partnerships as a way to reduce obesity in their region. They used The Community Guide as a resource to develop an action strategy centered on behavioral, social, and environmental change, as well as an evidence-based approach to strengthen grant applications. This strategy helped Western Maryland Health System secure funding and multiply partnerships.

### **Planning a Strategy: Changing the Way a County Health Department Addresses Health Conditions**

Los Angeles County ranges from densely urban to sparsely rural, and includes extensive racial, cultural, linguistic, and socioeconomic diversity. LA County Department of Public Health addresses such diverse population health needs by including evidence-based approaches found in The Community Guide as a foundation for its strategic planning. Through using evidence, they have reduced rates of obesity, sexually transmitted infections (STIs), heart disease, tobacco use, and other preventable diseases.

### **Rural Community Works Together to Stay "Fun and Fit"**

The tribal communities in rural Hoonah, Alaska used The Community Guide as a resource to help counter the increasing rates of obesity. They partnered with the Alaska Department of Health and Social Services to expand access to places for physical activity and get the community moving.

## **Recommendations for Innovative Programs**

### **Recommendation 1: Bright Beginnings of Maryland**

<http://brightbeginningsmd.org/>

240-550-8607

[contact@brightbeginningsmd.org](mailto:contact@brightbeginningsmd.org)

Executive director: Bettye Muwwakkil, PhD: 240-264-0878

Program director: Deneen Long-White, MS, CHES

The Bright Beginnings Infant Mortality Reduction Program in Prince George's County is an extension of Access to Wholistic and Productive Living Institute Inc. and aims to reduce health disparities and improve the health status of populations that are disproportionately affected by health and social inequities. Bright Beginnings, which started in 2008, seeks to address adverse pregnancy outcomes including infant mortality, low birth weight, and other maternal pregnancy complications. The overall goal is to reduce poor pregnancy outcomes among low-income, underserved Prince George's women and their newborns.

The Bright Beginnings Community Advisory Team has worked to create a system of providers to prevent and remove barriers to access quality care for pregnant women and their newborns and ensure that the best policies and referral systems are in place to reduce infant mortality in Prince George's County; maintain a continuity of services with other community-based organizations; increase the number of pregnancy and

10

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June 11, 2012

preconception campaigns are held in multiple settings (hospitals, faith-based communities, Laundromats, homeless shelters, etc.); and build and sustain partnerships/collaborations.

Services include:

- Infant Mortality Reduction Toolkit
- Free Pregnancy Testing and prenatal screenings
- Access to Medical Care for Mother & Baby
- Transportation to Health Services
- Assistance in Obtaining Health Insurance Coverage
- Women's Health & Wellness Services
- Assistance in Obtaining Social Services
- Parenting Services
- Assistance in Obtaining Counseling
- Family Health Education
- Health & Social Skills Training

### **Recommendation 2: The REsidents Access to a Coalition of Health (REACH)**

[http://www.aahealth.org/physicianslink/access\\_reach\\_overview.asp](http://www.aahealth.org/physicianslink/access_reach_overview.asp)

The REsidents Access to a Coalition of Health program is a partnership of the Anne Arundel County Department of Health and the County Medical Society to increase the availability of primary and specialty health care services for the county's growing number of uninsured. Since its inception in 1999, more than 885 County physicians and health care providers have provided approximately \$44 million worth of charity care to eligible County residents.

Through a coordinated network of office and hospital based services, REACH facilitates the provision of affordable health care to uninsured working adults, using the services of a Department of Health administrator and six case managers.

Constructed as a fee-for-service program with discounted fees for physician, lab, X-ray, pharmacy care and ancillary services, the program serves as an alternative option to emergency room care for the uninsured. Both County hospitals, Calvert Memorial Hospital in Prince Frederick and Harbor Hospital in Baltimore City participate in the program. The program's design features limited paperwork from participating providers. Participating physicians can determine the number of REACH patients they are willing to see and they can refer uninsured patients in their practice for enrollment.

Patients are allowed to choose any participating primary care physician and are issued a REACH card that lists their discounted fees for office visits and procedures. Providers are asked to fax a one-page encounter form back to the Department of Health, where case managers are on hand to assist the patients with any referrals requested by their primary care physician.

Chosen as a "model practice" nationwide by the National Association of County and City Health Officials and an Innovations in Government awardee by the American Society of Public Administration - Maryland, REACH has provided care to more than 8,400 County residents.

Program manager: Kristina Dickinson, MPA  
410-222-4531, ext. 8

**Recommendation 3: S.M.I.L.E. Program (part of the African American Health Program in Montgomery County)**

<http://www.onehealthylife.org/our-programs/infant-mortality.html>  
[http://www.onehealthylife.org/sites/default/files/AAHP\\_SMILE\\_BROCHURE051710\\_F.pdf](http://www.onehealthylife.org/sites/default/files/AAHP_SMILE_BROCHURE051710_F.pdf)

The Start More Infants Living Equally-healthy (S.M.I.L.E.) Program was developed in 2003 to address the disparity of infant mortality in the African American population of Montgomery County. The program consists of nurse case managers with experience in maternity and newborn nursing who provide one-on-one home visitation services to fully support the needs of the pregnant/parenting mother.

The goal of the S.M.I.L.E. Program is to reduce the number of premature and low birth weight births among Black women in Montgomery County by addressing key factors such as stress, hypertension, diabetes, smoking, drug use, mental health, and social health.

Services include:

- Nurse Case Management for Prenatal Women and Newborns
- Monthly Home Visitation for Prenatal Women and Newborns
- Breast Pump Loan Program
- Free Childbirth Education Classes
- Free Breastfeeding Education Classes
- Health Education Presentations for Teens And Young Adults
- Caring Connection Infant Loss Program
- Referrals to Community Services

12

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June 11, 2012

## In-Home HIV Testing of Pregnant/Parenting Women

Nurse case manager: Nia Williams

301-421-5489

[Nia.williams@montgomerycountymd.gov](mailto:Nia.williams@montgomerycountymd.gov)

### **Recommendation 4: Diabetes Dining Club (part of the African American Health Program in Montgomery County)**

<http://www.onehealthylife.org/our-programs/diabetes.html>

The Diabetes Dining Club, started in 2004, now has three locations in Maryland where the club meets monthly for a healthy, catered meal as well as diabetes education and fun fitness activities.

Participants are weighed, and their blood pressure is monitored. The chef discusses the meal preparation. Cost to attend is \$5. Organizers track participants' weight and behaviors such as physical activity, and test their knowledge of diabetes and prevention.

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### **Recommendation 5: Community Health Partnership (CHP)'s Baltimore Community Health Action Team (B-CHAT)**

Study Results: <http://www.nmqf.org/presentations/10MullinsDJCP1.pdf>

Mullins CD, Shaya FT, Blatt L, Saunders E. A qualitative evaluation of a citywide Community Health Partnership program. J Natl Med Assoc. 2012;104(1-2):53-60.

<http://www.ncbi.nlm.nih.gov/pubmed/22708248>

Sanofi-aventis, along with key stakeholders in Baltimore, developed the Community Health Partnership (CHP) in 2008 to reduce health care disparities and connect patients to community health resources to enable patients to be more proactive about their health. The CHP uses a community health liaison (CHL) and a community health action team (CHAT) consisting of community health leaders who are hands-on activists and health care workers who coordinate activities and provide guidance for the CHP.

13

A qualitative evaluation of the Baltimore CHP was conducted through focus groups and key informant interviews with members of the CHAT and CHP. Results suggest that the CHP program has enhanced patient-provider relationships, brought together a wealth of resources, and made people more aware of health information. The CHP facilitated providers' ability to help patients find resources and empowered patients in the community to better manage their health conditions. In parallel, physicians requested additional culturally sensitive resources on medical conditions that addressed the health literacy of their diverse patients.

Some funding to keep CHP going is being provided by Baltimore Healthy Start; Baltimore Healthy Start Community Consortium/BCHAT meets monthly.

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[http://www.umm.edu/doctors/elijah\\_saunders.html](http://www.umm.edu/doctors/elijah_saunders.html)

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www.thecommunityguide.org/pa/environmental-policy/communitypolicies.html. Last updated: September 28, 2010.

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NCMHD's Center of Excellence at the University of Pittsburgh: Using Social Norms to Attack Prostate Cancer among African Americans. National Institute on Minority Health and Health Disparities. <http://www.nimhd.nih.gov/spotlight/prostate.asp>

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Releford BJ, Frencher SK Jr., Yancey AK, Norris K. Cardiovascular disease control through barbershops: design of a nationwide outreach program. *J Natl Med Assoc*. 2010;102(4):336-345

Sankoff J, Hopkins E, Sasson C, Al-Tayyib A, Bender B, Haukoos JS. Payer status, race/ethnicity, and acceptance of free routine opt-out rapid HIV screening among emergency department patients. *Am J Public Health*. 2012;102(5):877-883

Smedley, Brian D and Stith, Adrienne Y and Nelson, Alan R, eds. (2003) *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. National Academy Press, Washington, DC.