CHANGE

**CAROLINA
HEART
ALLIANCE
NETWORKING FOR
GREATER
EQUITY**

A PROGRAM TO IMPROVE HEART HEALTH

Dissemination Toolkit

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Dissemination Toolkit

Center for Health Promotion and Disease Prevention

a CDC Prevention Research Center

at The University of North Carolina at Chapel Hill

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Overview

CHANGE Dissemination Toolkit

UNC Center for Health Promotion and Disease Prevention

Overview

This dissemination toolkit provides the information organizations need to implement and deliver the CHANGE Lifestyle Program in rural communities. The information included in this toolkit explains how and why the program works, what we learned from our implementation in two N.C. counties, and what's needed to adapt and implement it to fit a community's distinct needs and resources. Since this is not a complete 'how to" guide for implementing the CHANGE Lifestyle Program, we are planning to provide additional training on how to implement the program.

Who should use this toolkit?

This toolkit is for decision makers in community-based organizations, health care delivery agencies, and local health departments seeking information about feasible and evidence-based programs to reduce cardiovascular disease risk factors among rural, medically underserved populations. Toolkit information will help agencies plan for possible adoption by identifying what's needed for program delivery, key considerations for successful implementation, and potential program effects.

What's in the toolkit?

There are two main parts of this toolkit. The first part provides an overview of the CHANGE Lifestyle Program and includes information about what the program does, how it was designed and how it works, what resources are needed for implementation, what program outcomes were observed, and what we learned from our implementation of the CHANGE Program. The second part consists of **10 appendices** that include the participant manual, delivery protocols, other program materials, and details on the measures used to evaluate program outcomes. Additionally, several "Success Stories" are included to provide a more personal account of what it meant to be a participant in the CHANGE program.

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The CHANGE Program — An Overview

OVERVIEW PART 1:

Intent of the Program

CHANGE Lifestyle Program

UNC Center for Health Promotion and Disease Prevention

Intent of the Program

The CHANGE Lifestyle Program is a research-tested program delivered by Community Health Workers (CHWs) and designed to help reduce the risk of cardiovascular (heart and blood vessel) disease among adults in rural and medically underserved communities. CHANGE reduces heart disease risk by:

- Improving healthy eating habits
- Improving physical activity behaviors
- Reducing tobacco use
- Improving medication-taking behaviors
- Linking participants to community support resources

CHANGE addresses multiple levels of factors that influence health behaviors. When programs address factors on many levels, they tend to be more effective. The CHANGE program addresses factors at the following levels of the Socio-Ecological Model:

❶ **Individual** level – The CHANGE Program's counseling sessions and educational materials are designed to change individuals' knowledge, attitudes, beliefs, values, habits, and confidence related to changing their health behaviors.

❷ **Interpersonal** level –In CHANGE, the CHW develops a supportive relationship with the participant. Because the CHW is from the community and understands the local challenges to making behavior changes, she or he can more readily build rapport and trust with participants.

❸ **Community** level – The CHANGE Program involves engaging with community stakeholders to identify local resources that are supportive of healthy behavior changes, and then creating a Resource Manual that CHWs can use for participant referrals. [See the *PROGRAM MATERIALS* section for more information about the Resource Manual.]

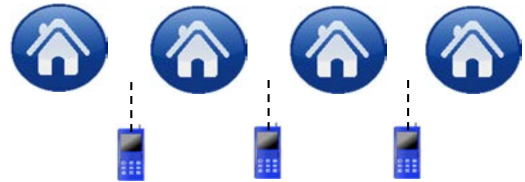
OVERVIEW PART 2:

CHANGE Program Overview

CHANGE Program Overview

CHANGE is a short, CHW-delivered program with 4 monthly visits (in the home or at a community location) plus 3 interim brief phone contacts, with the goal of promoting:

- Healthy Eating
- Physical Activity
- Smoking Cessation
- Medication Adherence



CHW visits and phone calls are designed to:

- Meet participants where they are and have conversations about making behavior changes that are important for them to make to improve health.
- Provide information in an easy to understand way that helps to increase the confidence participants have in changing their behaviors.
- Work with participants to set achievable goals and make plans to increase the chances of successful behavior changes.
- Encourage and support participants in their efforts to make changes by celebrating successes and problem solving when barriers get in the way.
- Refer participants to community resources that are supportive of healthy behaviors.

Intended Population

The CHANGE Program is designed for:

- Low-income adults and minority populations;
- Residents in rural and medically underserved communities;
- Adults with limited literacy skills. (Participant materials are written at a 5th to 6th grade reading level, in a user-friendly format that includes many pictures and other graphics.)

Settings

CHANGE is designed to be used in community health centers, public health departments, and other community-based organizations such as churches.

Length of time in the field

The CHANGE program was first tested in 2016-2017 as an adaptation of the Heart to Health evidence-based program. [See *ADDITIONAL INFORMATION* for a link to this reference.] A refined version of CHANGE was then tested from 2017-2019 in two health care sites – a community health center and a local health department.

OVERVIEW PART 3:

Health Equity Considerations & Core Elements

Health Equity Considerations

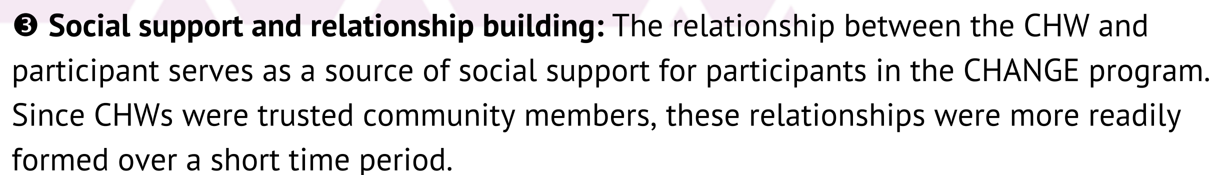
The CHANGE Program is designed for a rural, low-income, health-underserved population. In both communities where CHANGE was tested, the population was predominantly African Americans. The program format and materials are suited for participants with low or limited literacy, and appropriate for a southern U.S. culture. Program delivery by Community Health Workers adds another important level of cultural fit.

Core Elements

Core elements are aspects of the program that are believed to be responsible for its effectiveness (why it works to improve health). Core elements are *key features* of the program and should be *kept intact* when the program is implemented or adapted to fit other groups or settings.

❶ **Brief assessments of lifestyle behaviors and heart disease risk**: In the CHANGE Program, lifestyle and cardiovascular risk factors (such as smoking, taking medications, dietary and physical activity behaviors) are assessed at the first counseling visit with short versions of lifestyle risk assessment surveys. The CHW uses the findings from these risk assessment findings to guide conversations about problem areas, barriers to change, priority concerns, and areas where participants already have healthy habits. When CHANGE is delivered in a health care setting, it also includes a cardiovascular disease risk calculator. [Use of the risk calculator is only possible in settings where the CHW has access to the electronic medical record, because blood cholesterol values are needed to calculate risk.] The CHW uses the risk calculator to show participants their risk of having a cardiovascular event in the next 10 years and how changes in behaviors like smoking, taking medications, and diet and physical activity, could reduce their risk. Throughout the program, assessment results are also used to help participants set their goals, keep track of progress made, troubleshoot problem areas, and celebrate successes.

❷ **Building participants' confidence (self-efficacy) in making behavior changes**: An essential part of being motivated to make a behavior change is feeling like you have what it takes to make that change. With each program visit or call, the CHW built participants' confidence by using positive reinforcements and encouraging participants to take small, achievable steps to make big lifestyle behavior changes.



❸ **Social support and relationship building:** The relationship between the CHW and participant serves as a source of social support for participants in the CHANGE program. Since CHWs were trusted community members, these relationships were more readily formed over a short time period.

❹ **Goal setting with follow-up on progress:** Collaborative goal setting is a behavior strategy proven to enhance behavior change outcomes. Goal setting with action planning happens at each counseling visit, where participants set goals that are specific, measurable, achievable, realistic, and time-bound. After setting each goal, participants discuss with the CHW the action steps they intend to take to reach their goal. During booster calls and the next in-person visits, participants discuss progress made towards reaching their goals and work with the CHW to solve problems and address any challenges they encounter.

❺ **Resource referrals and follow-up:** A key component of the CHANGE program is linking participants to community resources that address health-related needs. At each counseling visit, the CHWs work with participants to identify local resources that could assist the participant in making the desired behavior changes. [See local resource manual information in *PROGRAM MATERIALS* below.] Referrals made at counseling visits are discussed at follow-up booster calls to determine if participants are getting the help needed and problem-solve if there are barriers to acting on these referrals.

OVERVIEW PART 4:

Resources Required

Resources Required

Staff

Two types of personnel are required for successful program implementation. The time requirement (e.g. full-time, part-time, etc.) depends on the scope of the project.

❶ **Program Manager/Supervisor:** This staff should be an experienced health professional (e.g., nurse, dietitian, or health educator) who will direct the program and supervise the CHWs. Other key roles of the supervisor include: 1) training the CHW in the organization's procedures for documentation of contacts with patients or program participants; 2) identifying sources of health information or training for the CHW; and 3) monitoring program progress (e.g., enrollment, completion, and outcomes).

❷ **Community Health Worker (CHW):** The primary purpose of this position is to reach underserved populations by engaging existing social networks, linking community members to clinical health care and public health community-based services that promote cardiovascular health. The CHW delivers the CHANGE program to participants at high risk for cardiovascular disease and should be carefully selected. To be successful in this role, the CHW should be a community member who has completed some training in peer counseling, community health coaching, or other accepted CHW training. (S)he should be a trusted community member, have good interpersonal skills, and be knowledgeable about community resources that could promote the health of participants.

Training

To deliver the CHANGE program some basic training will be required for the Supervisor and CHW roles. Staff will require training in CHANGE program content, participant data collection, and general program implementation strategies. [For more information see the TRAINING AND TECHNICAL ASSISTANCE section below.]

Materials

See the “PROGRAM MATERIALS” section below for a list of the materials needed to deliver the CHANGE program. Staff trainings are outlined in the appendix of this toolkit. Training materials may be made available upon request.

Program Delivery Costs

The estimated cost of delivering the CHANGE program to 100* participants in one year includes:

	Cost
CHW salary, annual	$22,830
Travel, in-state mileage	$3,450
Training	$1,250
Ipad + case	$630
High-quality portable scale	$310
Portable blood pressure machine + accessories	$639 $73
Participants manuals (50)	$1,000
TOTAL Costs	**$30,182**
Cost per participant	**$302**

* During implementation of the CHANGE program at the health department in Edgecombe, we found that it was feasible for 2 half-time CHWs to recruit, enroll, and deliver the program to over 100 participants in a 1-year period.

OVERVIEW PART 5:

Implementation

Implementation

How it Works

➊ **Program Strategies:** CHANGE integrates theory-derived behavior-change strategies with up-to-date scientific evidence on heart healthy recommendations for healthy eating, physical activity, medication adherence, and smoking cessation to create a heart disease prevention program. There are 5 basic strategies used in this program:

- **Health behavior education** strategies are designed to give participants evidence-based recommendations for improving healthy eating, physical activity, medication adherence, and smoking cessation. The participant manual provides specific recommendations for how health behaviors can be changed to reduce heart disease risk.

- **Goal-setting** strategies are designed to teach participants how to set goals to improve health behaviors. Sample goals are provided in the participant manual and are related to the educational materials covered**.**

- **Linkage to community and clinical services** provides participants with additional supports to help them meet the goals they set to improve their health behaviors. Community and clinical services should be readily accessible in the community and provide participants with additional support to reach their goals. Referral services can provide a specific resource (e.g., where to get healthy foods, where to walk in the community), provide additional social support, or help participants overcome barriers to reaching health behavior goals they've identified (e.g., lack of transportation, employment resources).

- **Follow-up on goals and referrals** provides participants with ongoing support, encouragement, and accountability toward meeting goals set and referrals received.

- **Social support** provides participants with support and encouragement related to their health behavior improvements. Support is given by helping participants identify and focus on success and celebrating small improvements in health behaviors. Additionally, community health workers were selected to deliver this program because of their knowledge of the community and cultural congruence

with participants. These factors facilitate providing social support as a program strategy.

❷ **Program Delivery:** CHANGE is a community health worker-delivered program, designed to be delivered one-on-one with 4 in-person sessions (in the participant's home or at an alternative location of the participant's choice) and 3 phone calls over a period of 3-5 months. Depending on the participant's health behavior change goals, different educational topics may be covered at each in-person session, with a goal to cover at least one session of each applicable health behavior over the course of the program (i.e., healthy eating, physical activity, smoking cessation, medication adherence). An overview of the 4 in-person sessions, 3 phone calls, and program strategies are provided below.

Although CHANGE is designed to be delivered in one-on-one sessions, we also had success with participants who wanted to participate in the program with a friend or family member. In these cases, participants covered the same educational material, but set their own goals and received referrals tailored to their specific needs. Phone calls should, however, always be conducted individually.

- Advantages of friends and family participating in CHANGE together is that they may experience additional social support, a strategy shown to encourage improved health behaviors and reduced heart disease risks.

- Disadvantages of friends and family participating together are that one person may dominate the conversation. Strategies to overcome this dynamic include setting individualized goals and providing individualized referrals.

❸ **Program Procedures:** At the first counseling visit, the CHW collects from each participant basic demographic and health status information and completes brief assessments of lifestyle behaviors. [These data collection and assessment tools are included in this toolkit.] Details on delivery of program strategies are below:

- **Health behavior education:** CHWs cover one to two health education sessions from the participant manual (from different topics). The first topic covered is the health behavior the participant is most interested in improving. Subsequent topics should be based on the (applicable) health behaviors that provide the largest reduction in heart disease risks: (1) medication adherence, (2) smoking cessation, (3) healthy

eating, (4) physical activity. It is essential to encourage participants to cover a variety of topics during the course of the program.

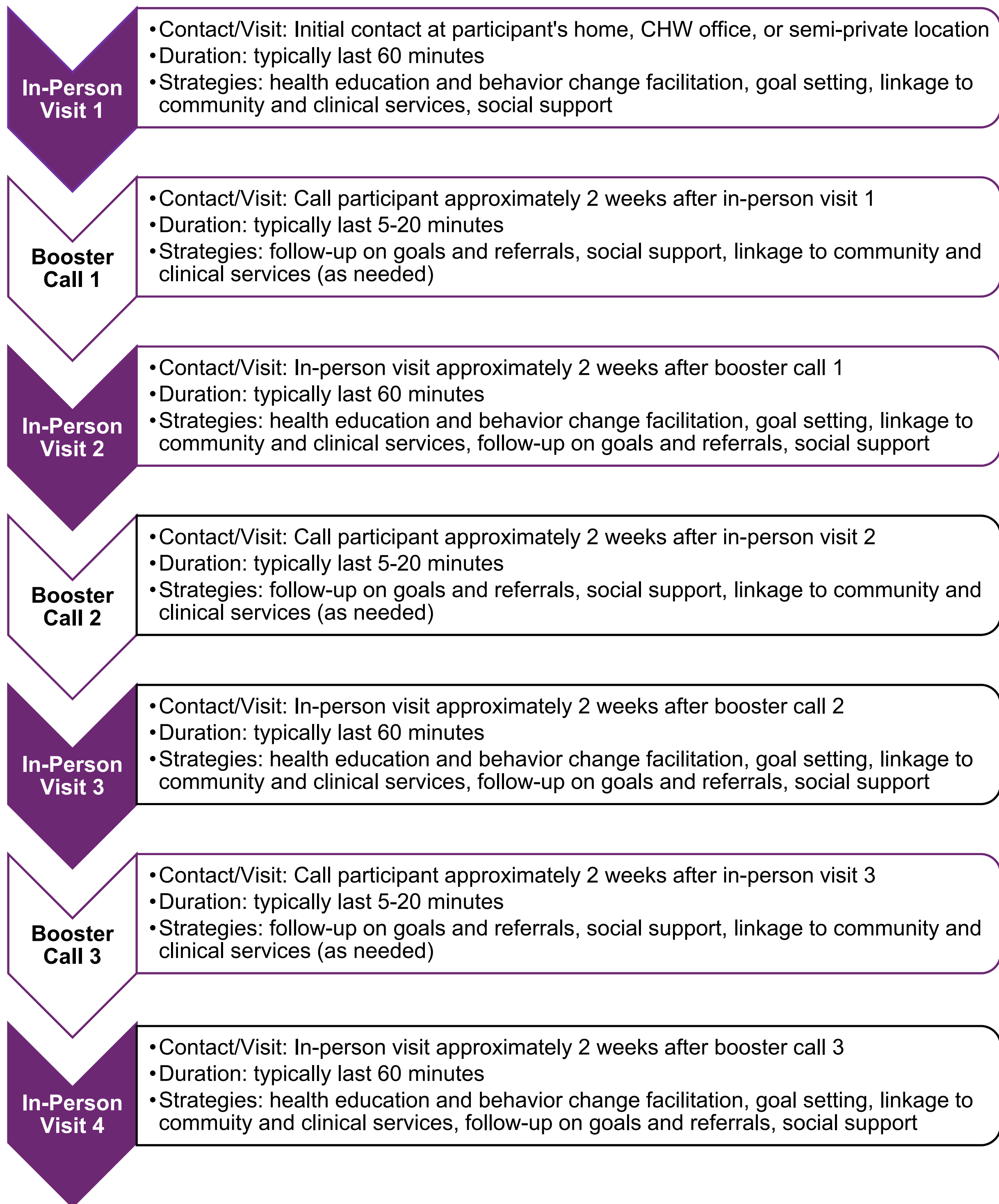
- **Goal setting:** Based on the health behavior education covered, participants are encouraged to set 1-2 specific, measurable goals that can be reached within 2-4 weeks. Once participants set goals, CHWs should encourage participants to talk about specific steps they can take to reach these goals and overcome barriers (action planning).

- **Linkage to community and clinical services:** CHWs provide participants with information about community and/or clinical services to support their health behavior goals. CHWs should provide the participants with contact information or referrals (if applicable) to these services.

- **Follow-up on goals and referrals:** CHWs should check in with participants about the progress made in meeting goals and/or taking action on referrals. This follow-up includes: 1) asking participants about goals and referrals set at prior sessions; 2) identifying any barriers or challenges to reaching goals or acting on referrals; 3) celebrating successes; and 4) providing additional support as needed.

- **Social support:** CHWs should help participants identify and focus on success and celebrating any improvements in health behaviors (no matter how small). CHWs can also encourage participants to reach out to friends and family for additional support.

❹ **Program flow (contact/visit, duration, strategies delivered):** (NOTE: *To track changes in participants' health behaviors during the program, health behavior and heart disease risk questionnaires can be administered at in-person visits 1 and 4. Blood pressure and weight were measured at each in-person visit*).



Keys to Success

- To be successful, Community Health Workers need training on delivering the program and the program content.
- Community Health Workers can serve a community or clinic population better when they are integrated into an existing system of care as a valued member of the team, and receive referrals from the existing setting (e.g., primary care clinic, health department, etc.)
- Collaboration with key agency personnel and ongoing support of the CHW are essential to effective program delivery.
- It is important for the CHW Supervisor to establish regular meeting times to follow up with CHWs on program recruitment, enrollment and implementation goals. This is also the time to identify additional training needs and discuss any challenges to program delivery and effectiveness.
- CHWs hired by local health departments should be well connected to the community if they are to be effective in recruiting community members to the program and referring participants to community resources.
- Share success stories along with interim reports of program outcomes with agency decision makers and community stakeholders as a way of generating interest in the program and supporting long-term sustainability.

Barriers to Implementation

- Staff turnover can cause disruption to program delivery for participants. Make plans during the training phase to address who will cover the duties of the supervisor or CHW when they are not available.
- Without buy-in from clinical providers, you can expect patient referrals to be limited. To overcome this barrier, it is important to start the process of engaging with providers and other health care staff very early in the pre-implementation phase.

- Local health departments interested in sustaining the CHW position should identify early in the process what documents or information would be needed by decision makers.

- Expect changes in the availability of community resources identified in your Resource Manual and make plans for how the CHWs and clinic staff will keep track of changes in listed resources, and identify new community resources.

Implementation Tool

Planning for implementation is important to delivering a successful CHANGE program. The “*CHANGE Implementation Checklist*” on the following page can help you plan for success.

CHANGE Implementation Checklist	✓
Step 1: Create an implementation team	
a. Does the team include the person who will supervise the CHWs?	
b. Is there someone on the team with experience implementing improvements to practice (e.g., a Quality Improvement specialist)?	
c. Does the team include others with the knowledge needed to implement a CHW-led lifestyle change program?	
d. Do you know when and how often the team will meet?	
e. Has someone been designated to lead the team?	
Step 2: Hire and train the CHWs	
a. Have you created the CHW position description?	
b. Have you worked with Human Resources to recruit, interview, and hire a CHW?	
c. Have you created a plan for training the CHWs?	
d. Have you created a plan for providing ongoing supervision for the CHWs?	
e. Have you developed a plan for how a CHW's workload will be covered when they are on leave?	

Step 3: Develop a system for referring eligible patients/clients to the CHWs	
a. Have you established criteria for which patients/clients will be referred to the CHW?	
b. Have you mapped the process that will be used to refer patients to the CHWs?	
Step 4: Create a communication plan to promote the program and recruit participants	
a. Have you identified the audiences you need to communicate with about the program (patients/clients, providers, wider community, etc.)?	
b. Have you developed a plan for the messages and communication channels that will be used to communicate to each audience and who will be responsible for doing what, when?	
Step 5: Develop a system for keeping track of CHWs' completion of program contacts	
a. Have you developed a system to keep track of how many visits and phone calls the CHW has completed with each patient/client?	
b. Have you developed a system to keep track of the sessions completed, goals set, and referrals made so that CHWs can follow-up at the next contact?	

Step 6: Create an inventory of community resources that CHWs can refer patients/clients to for additional support of behavior changes	
a. Have you identified resources in your community where patients/clients can get healthy food, be physically active, get assistance paying for medications, get support for smoking cessation, etc.?	
b. Have you created an inventory of available resources with times open, address, cost, and contact information?	
Step 7: Develop a plan for monitoring and continuously improving program processes and outcomes	
a. Have you identified the methods and tools for measuring successful implementation of your program?	
b. Have you created a monitoring plan to identify who will collect data on those measurements and when?	

OVERVIEW PART 6:

Evidence Review Summary

Evidence Review Summary

Underlying Theory

Like the Heart to Health Program from which it was adapted, the CHANGE program is based on several theories and models of how to facilitate behavior change. These include:

- *Social Cognitive Theory*: This theory stresses that our behaviors are influenced by observing others around us and the interactions we have with our environment.

- *Social Ecological Theory*: The basis for linking clinic patients to community resources lies in this theory. Creating linkages between the participant and agencies or resources in the community is important to promoting health.

- *Stages of Change*: To be effective in promoting healthy behaviors, it's important to know how 'ready' the person is to make changes. This theory guides how the counselor engages with participants about making behavior changes.

- *Health Behavior Model*: According to this model, a person will take a health-related action if (s)he believes: 1) a negative outcome (e.g., heart attack) can be avoided; 2) by doing what's recommended it will lead to a positive health outcome (a benefit); and 3) the health action required is one that's possible, and perceived barriers could be overcome.

Strategies Used

The evidence-based strategies used in the CHANGE program include:

- During home visits, CHWs **individually counsel** participants about healthy eating and physical activity behaviors. Counseling centers around participants' priority areas for behavior changes and helping participants find the resources needed to reach their behavioral goals.

- Reinforcement and follow-up to goals set at counseling visits happens at **brief phone contacts** between counseling visits. These contacts are important to keeping participants on track with achieving their goals because of the length of time between counseling visits.

Research Findings

The CHANGE program was first tested in Hertford County, N.C. and was later tested in Edgecombe/Nash Counties. The preliminary research findings below are based on a sample of 244 participants from both Hertford and Edgecombe/Nash counties. Participants included mostly women (77%) and African Americans (90%), with an average age of 60 years. At baseline, 63% of participants reported being diagnosed with hypercholesterolemia, 85% with hypertension, and 47% with diabetes. Twenty-seven percent (27%) reported being current smokers.

Dietary Results: Participants self-reported their dietary intake for nuts, fruits, vegetables, and sugar-sweetened beverages at visit 1 and at the end of the program (visit 4). We observed significant ($p<.0001$) or meaningful improvements in all dietary behaviors!

- Daily fruits and vegetables intake increased by 0.88 servings.
- Daily intake of sugar-sweetened beverages was lower by 0.27 servings.
- Weekly intake of nuts increased by 0.4 units.

Physical Activity Results:

- Moderate level physical activity increased by an average of 43 minutes per week ($p<.0001$)

Blood Pressure Results:

- The average decrease in systolic blood pressure was 5 mm Hg ($p<.0001$), and 2.3 mm Hg in diastolic blood pressure ($p<.01$).
- The proportion of participants who had uncontrolled blood pressure at baseline was greatly reduced (from 36% to 18%) by the end of the program!

Other results:

- Sixty percent (60%) of participants lost weight. On average, participants lost 2.0 lbs. by the end of the program ($p<.01$).

OVERVIEW PART 7:

Program Materials

Program Materials

Participant Manual

A copy of the CHANGE participant manual is available online at the CHANGE website: https://change.web.unc.edu/. The appendix of this toolkit includes only a content guide for the participant manual.

The CHANGE Participant Manual was designed to be the main resource for participants while completing the CHANGE Program. It provides participants with helpful, easy-to-read information on:

1. Medication Adherence
2. Smoking Cessation
3. Healthy Eating
4. Physical Activity

The Participant Manual was adapted from the Heart to Health study materials and refined over two waves of the CHANGE study with the help of participants, staff, and CHW feedback.

There were two different Participant Manuals for each Program Site of the CHANGE Study. For Site 1, Hertford County, the CHANGE manual contained site-specific wording and people, while with the review for Site 2, Edgecombe/Nash Counties, site-specific wording was removed except for a few instances where examples of resources were necessary during visits.

The participant manual includes a community resource manual that focuses on resources such as parks, places to get fresh produce, smoking cessation resources, and drug discount programs that could assist participants in changing health behaviors. Because the CHANGE Program is only a 4-month program, it was important that Community Health Workers had knowledge of available resources to make referrals that would help or support participants. Creating these community linkages was essential for participants to continue with their lifestyle changes even after the CHANGE program ended.

Community Resource Manual

To create a Resource Manual for each site, project staff were tasked with researching and exploring Hertford and Edgecombe/Nash communities for places and services that could support changes to the major health behaviors targeted by CHANGE. The user-friendly resource manual was organized to accompany the modules in the participant manual and includes website links for online users.

➊ **Medication Adherence and Smoking Cessation** resources were compiled by contacting local Health Departments, Community Centers, and pharmacies to help identify available educational and discount programs.

➋ **Physical Activity** resources included primarily local parks, gyms, and sports complexes that had classes or groups available at no or low cost to the community.

➌ **Healthy Eating** resources included food pantries, food banks, and farmers markets, often run by local churches.

➍ **Transportation** resources were added to address the possibility of transportation being a barrier to utilizing resources. This section focused on free and low-cost transportation that was identified by contacting the local health department for services to which they referred patients.

OVERVIEW PART 8:

Training and Technical Assistance & Additional Information

Training and Technical Assistance

Training opportunities and technical assistance may be available to community organizations interested in adopting the CHANGE program. Please contact cdsamuel@email.unc.edu for additional information.

Additional Information

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Related Resources

CHANGE Website: https://change.web.unc.edu/

At the CHANGE website, you can find a description of the CHANGE Program, see profiles of the program staff, read participant success stories, and find links to tools and program materials (e.g., local resource guides).

The Association of American Medical Colleges (AAMC) 2018 Health Equity Research Snapshot: https://www.aamc.org/initiatives/research/healthequity/488340/2018-snapshot.html#

The CHANGE Project is featured in this health equity research snapshot (see the Chapel Hill, N.C. highlight video). CHANGE is featured as an 'innovative community-partnered research project' at one of the nation's 26 CDC Prevention Research Centers – University of North Carolina at Chapel Hill.

Oral and Poster Presentation Abstracts

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3. Cykert S, Samuel-Hodge C, Ammerman A, Schwartz K. A community health worker program to reduce cardiovascular risk in rural communities. American Public Health Association 146th Annual Meeting, San Diego, CA, November 10, 2018.

4. Cykert S, Samuel-Hodge C, Bunton A, Allgood S. A Community Health Worker Program to reduce cardiovascular risk in underserved rural communities. Society of General Internal Medicine Annual Meeting, Washington, DC, May 2019

5. Cykert S, Samuel-Hodge C, Bunton A, Allgood S. A Community Health Worker program to reduce cardiovascular risk in rural communities of color. American Public Health Association 147th Annual Meeting, Philadelphia, PA, November 5, 2019

Publications

We are currently working on journal manuscripts that will result in publications describing how we engaged community stakeholders to develop the CHANGE Program from a previously tested cardiovascular disease risk reduction program, and our outcomes from the CHANGE feasibility study in Hertford County, N.C. Once we've completed implementing the CHANGE Program in Edgecombe/Nash County, we will report on our overall study findings.

1. Thomas C. Keyserling TC, Sheridan SL, Draeger LB, Finkelstein EA, Gizlice Z, Kruger E, Johnston LF, Sloane PD, Samuel-Hodge C, Evenson KR, Gross MD, Donahue KE, Pignone MP, Vu MB, Steinbacher EA, Weiner BJ, Bangdiwala SI, Ammerman AS. A comparative effectiveness trial comparing a counselor vs. web delivered lifestyle and medication intervention to reduce coronary heart disease risk: the Heart to Health Study. JAMA Internal Med 2014;174(7):1144-57.

2. Allgood S, Leeman J, Rosemond C, Ammerman A, Samuel-Hodge C, Cykert S. Strengthening community-clinical linkages through the design of a community health worker-led intervention to reduce cardiovascular disease risk: A case study. Public Health Nurs, 2019;00:1-7.

3. Samuel-Hodge C, Gizlice Z, Allgood S, Bunton A, Erskine A, Leeman J, Cykert S. Strengthening community-clinical linkages to reduce cardiovascular disease risk in rural NC: Feasibility phase of the CHANGE study. [*Under Review 2019*]

Appendices

Appendices

1. Pre-Implementation Timeline
2. Community Health Worker Job Description
3. Study Roles and Expectations
4. Recruitment Materials
5. Training Materials (CHW and Site Staff)
6. Protocols — Delivering CHANGE Program Contacts
7. Program Enrollment and Evaluation Forms
8. Participant Manual
9. Resource Manual
10. Success Stories

APPENDIX 1:

Pre-Implementation Timeline

Pre-Implementation TIMELINE
Month
-6
-5
-4
-3
-2
-1
Engage community stakeholders
Create CHW job description (Approve and post)
CHW interviews & selection
CHW start
CHW & Supervisor training
Create Community Resource Guide
Participant recruitment & enrollment
Intervention START

APPENDIX 2:

Community Health Worker Job Description

CHANGE Lifestyle Program

UNC Center for Health Promotion and Disease Prevention

Community Health Worker – Health Department

CHW Role

The CHW will work directly with patients and their families to facilitate lifestyle behavior changes that improve their cardiovascular health and to assist them in accessing clinical and community resources to support their efforts to improve overall health. The CHW will work closely with the health department staff, and with professionals in local health agencies, community-based organizations and UNC-Chapel Hill researchers to promote lifestyle and medication adherence behaviors for cardiovascular health.

The Population Served

The primary purpose of the CHW is to reach underserved populations by engaging existing social networks, linking community members to clinical health care, public health and community-based services that promote heart health. The CHW will also work with patients' family and friends. In addition, CHWs will work to deliver an evidence-based program, Heart to Health, share other resources with community members, and support culturally relevant and heart healthy changes in community environments where people live and work.

Essential Functions: Program Recruitment and Referral

- Contact patients referred by the primary care provider and (a) enroll them in the CHANGE project, (b) gain informed consent, and (c) schedule visits.
- Deliver CHANGE Program to participants in their homes or other agreed upon locations. CHANGE includes 4 monthly in-person visits delivered by the CHW. CHWs also will make phone calls between visits to check in with patients about their progress reaching goals set at the in-person visit.

- Assist patients with accessing clinical and community services to support their efforts to improve their cardiovascular health (e.g., smoking cessation programs, exercise classes, medication assistance programs).
- Measure blood pressure and weight, and collect baseline and follow-up survey data on CHANGE participants' dietary behaviors, physical activity, smoking status, and medications.
- Assist participants with getting immediate treatment or timely follow-up for high blood pressure according to established protocols and refer to primary care providers or the partnering community health center to enroll into care.
- Collect and enter confidential data for clinical and research purposes using a portable tablet computer and/or desktop computer.
- Collect and enter confidential client information for public health and research purposes.
- Reach out to patients' family members and acquaintances (suggested by the patient). Invite them to participate in the CHANGE project, screen for cardiovascular disease risk, and refer to clinic as indicated.
- Make follow-up phone call to clients per practice and research protocols.
- Deliver presentations and introduce CHANGE resources to community groups.
- Provide community educational session to individuals and groups regarding healthy eating, weight management, physical activity, and tobacco prevention.
- Work as part of the health department / center health care team and the CHANGE project research team.

Community Outreach and Education

- Identify/Recruit individuals to participate in the CHANGE program.
- Establish relationships with local agencies, doctor's offices, etc. so they can be a referral source to the CHANGE program.
- Establish relationships with local faith-based organizations and other community-based organizations to provide the CHANGE program.
- Attend church/community-based organization meetings to promote and gain interest in the CHANGE program for implementation.
- Pre-screen clients to know if they are eligible to participate in the CHANGE program, obtain consent and enroll eligible clients.

- Provide referrals to individuals in the CHANGE program to other resources as needed including assisting participants with getting immediate treatment or timely follow-up for high blood pressure.
- Identify resources in the community to support program participants' needs.

Administrative/Other Duties

- Attend scheduled CHANGE meetings.
- Provide reports to CHANGE Project Manager as required.
- Participate in continuing education classes/training as needed.
- Cross train with clinical CHW located at the Community Health Center site.

APPENDIX 3:

Study Roles and Expectations

Study Roles and Expectations

UNC Center for Health Promotion and Disease Prevention

Site Director

The ***Site Director*** will:

- Fully participate in the monthly Community CHANGE Planning Team meetings
- Act as a primary liaison to community collaborators
- Ensure development and maintenance of trusting relationships with community collaborators

Community Health Worker Supervisor

The Health Educator (***Community Health Worker Supervisor***) will:

- In collaboration with others on the UNC and Community CHANGE Planning Team, oversee supervision and training of the CHW and ensure the CHW has access to and properly uses informatics, reporting, and communication supports
- Fully participate in the monthly Community CHANGE Planning Team meetings
- Serve as a direct point of contact for the CHW
- Ensure the CHW is fully integrated into the site-agency workflow
- Ensure the CHW links with the partnering CHW and site
- Be involved with planning CHW activities, identifying CVD-related activities, and developing referral systems to community risk reduction programs
- Meet at least monthly with members of the partnering site to ensure that the public health and clinical care efforts remain closely connected, resource lists are updated, and that the participating patients and community connections are progressing
- Be part of a team that maintains a resource and referral directory of community services that can potentially contribute to evidence-based CVD interventions and contribute insight into the process of successfully implemented community programs
- Continue to connect the CHANGE Planning Team with potential community champions and help us build trusting relationships with these individuals and groups

Community Health Worker

The ***Community Health Worker*** (***CHW***) will:

- Be responsible for conducting a series of planned contacts (4 in person and 3 by phone) with study participants.
- Conduct up to 4 contacts in participants' homes or community locations
- Spend time planning for these visits and making follow up phone calls
- During participant contacts, administer the Heart-to-Health decision aid and offer guided coaching and referral support to address lifestyle behaviors, such as increasing physical activity, improving nutrition, and quitting smoking
- Work with participants to identify family members, neighbors, and others who would be interested in enrolling in the CHANGE study
- Enabled by technology, provide lifestyle behavior change support and referral to community learning opportunities
- Meet at least monthly with members of the partnering site, to ensure that the public health and clinical care efforts remain closely connected
- Identify resources in the community to assist with program participants' needs

The table below includes the current meeting schedule for the CHANGE study.

Event Type	Day	Time	Place	Team Members
Supervisors Meeting	1st Monday	10:00-10:30am	Conference Call	→ UNC Project Manager → Site Supervisors
CHW Conference Call	1st Monday	11:00am-12:00pm	Conference Call	→ Project Manager → Research Assistants → CHWs → Site CHW Supervisors (***if available***)
Study Team Meeting/Site Visit	2nd Tuesday	11:00am-1:00pm	Edgecombe-Nash (In-Person)	→ UNC PI(s) → Project Manager → Research Assistant(s) → CHWs → Site CHW Supervisors → Site Director(s) → Site study staff
Site Visit	4th Monday	11:00am (end time will vary)	Edgecombe-Nash (In-Person)	→ UNC Staff [Project Manager and/or RA(s)] → CHWs
CORE Team Meeting	4th Tuesday	10:30-11:30am	Conference Call (with sites) & In-Person (with UNC team)	→ UNC PIs → Project Manager → IT Team → Research Assistants → CHWs → Site CHW Supervisors

NOTE: Study staff are expected to attend the study meetings. If unable to attend a meeting, CHWs should communicate with <u>both</u> the site supervisors and the UNC Project Manager.

APPENDIX 4:

Recruitment Materials

Interested in a no-cost program to improve heart health? Work with a Community Health Worker to reduce your cardiovascular disease risk factors as part of the CHANGE study.

CHANGE (Carolina Heart Alliance Networking for Greater Equity) study focuses on helping people to:

- Make healthier food choices
- Become more physically active
- Stop smoking
- Work closely with a doctor for medication needs
- Connect with Others

Time Commitment (~4-5 months):

- Four (~60 minute) face-to-face meetings
- Three (~10 minute) monthly phone meetings

Eligible Participants are:

- Ages 18-80 years old
- Residents of Edgecombe-Nash Counties, NC or receive public health or healthcare services in Edgecombe-Nash Counties, NC
- Speaks English
- Not currently pregnant
- At elevated risk of cardiovascular disease

Incentive Information:

- No Cost to Participate
- Receive a participant manual at the start of the interview
- Receive a $10 incentive after completing a survey following the final visit

For more information and to enroll in the study, call:

- Angela Heath at 252-641-0945 or
- Donia Simmons at 252-641-6452.

For additional study information, contact Audrina J. Bunton (Project Manager) at 919-843-3084 or email at: audrina_bunton@unc.edu.

CHANGE

(Carolina Heart Alliance Networking for Greater Equity)

The **CHANGE** study

focuses on helping people to:

- ⇒ Make healthier food choices
- ⇒ Become more physically active
- ⇒ Stop smoking
- ⇒ Work closely with a doctor for medication needs
- ⇒ Connect with Others

Time Commitment (~ 4-5 months), to include:

Four (~60 minute) face-to-face meetings at an agreed upon location

Three monthly phone meetings

Eligible Participants are:

- ⇒ Ages 18-80 years old
- ⇒ Resident of Edgecombe-Nash Counties, NC or receive public health or healthcare services in Edgecombe-Nash Counties, NC
- ⇒ Speaks English
- ⇒ Not currently pregnant
- ⇒ At elevated risk of cardiovascular disease

Incentive Information:

No Cost to Participate

Receive a participant manual at the start of the interview

Receive a $10 incentive after completing a survey following the final visit

If you have eligible patients, please contact one of the *Community Health Workers*:
Angela Heath** at **252.641.0945 (email: *angelaheath@edgecombeco.com) or*
Donia Simmons at **252.641.6452** (email: doniasimmons@edgecombeco.com)
For additional study information, contact
Audrina J. Bunton (Project Manager) at ***919-843-3084*** or email at: **audrina_bunton@unc.edu**

CHANGE is a research study funded through a grant from the Centers for Disease Control and Prevention (Cooperative Agreement Number U48-DP005017) to the University of North Carolina at Chapel Hill. This study has been reviewed and approved by the University of North Carolina at Chapel Hill Institutional Review Board for the Protection of Human Subjects (IRB# 15-2822).

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- ⇒ Speaks English
- ⇒ Not currently pregnant
- ⇒ At elevated risk of cardiovascular disease

Incentive Information:

No Cost to Participate

Receive a participant manual at the start of the interview

Receive a $10 incentive after final survey completed

If you have eligible patients, please contact ***Tanja Murray*** (*Community Health Worker*)
at **252.210.9856 (Ext. 9881)** or via email at **tmurray@oicone.org**

For additional study information, contact
Audrina J. Bunton (Project Manager) at ***919-843-3084*** or email at: **audrina_bunton@unc.edu**

CHANGE is a research study funded through a grant from the Centers for Disease Control and Prevention (Cooperative Agreement Number U48-DP005017) to the University of North Carolina at Chapel Hill. This study has been reviewed and approved by the University of North Carolina at Chapel Hill Institutional Review Board for the Protection of Human Subjects (IRB# 15-2822).

APPENDIX 5:

Training Materials (CHW and Site Staff)

Training materials (CHW and Site Staff)

UNC Center for Health Promotion and Disease Prevention

CHW Supervision Protocol

The CHWs assume the most important role in this community-based translation of an evidence-based intervention. As such, the supervision of the CHWs by site supervisors and UNC project managers becomes equally important. With the right supervision, the entire research team can be confident that all aspects of conducting a successful study are in place. This protocol includes guidance on essential components of CHW supervision and outlines the roles and expectations of both supervisors and CHWs in this research project.

UNC and Site Supervision

UNC

The UNC Project Manager and staff will lead the supervision of CHWs in conducting the CHANGE study. The UNC Project Manager will work closely with the study Principal Investigators to coordinate research team activities, including research team and community meetings, CHW training, and data collection and work plan progress.

The UNC Research Assistant(s) under the direction of the Project Manager will make monthly visits to the study sites to provide support to the sites and to ensure compliance with research and clinical workflows, study protocols, and other activities to support study efficiency and integrity. Supervision will happen via regularly scheduled contacts (phone conferences and site visits) with site supervisors and CHWs (see table below).

Site

At each site, the Site Director and Site Supervisor are responsible for directing study activities. Together they coordinate the research activities of the CHWs and communicate regularly with the UNC staff about research progress. Key components of CHW supervision include:

- Regular on-site meetings with Site Directors and Site CHW Supervisors, and between CHW Supervisors and CHWs.
- Participation in scheduled meetings with UNC research staff
- Knowledge of study protocols, and planning of study-related tasks and timelines
- Ongoing assessment of progress toward reaching study goals for participant enrollment and retention
- Caseload management
- Problem solving to address challenges to reaching study goals

[NOTE: Refer to the 'Study Roles and Expectations' of the Site Director and CHW Supervisor for additional details. See also, the 'CHW Roles and Responsibilities' in **Appendix 3**.]

CHW Supervisor Training | Outline

Training time: **~ 2 hours** using a discussion (interactive) format. For example, we drafted the supervision protocol and gave the group the opportunity to review and edit.

Lessons Learned from Site 1

- We are **partners** in RESEARCH
    - It will take BOTH partners to reach goal
        - Enrollment
        - Outcome (Participants)
    - Focus on the 'Research' is important to good **process** and **outcomes**
    - CHWs are the KEY!
    - Good RESEARCH = Good DATA (complete & from ~ALL who enroll)
- This research is important

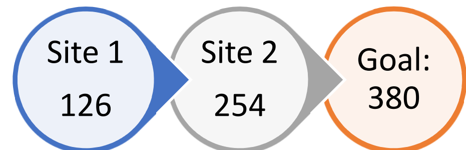
Site Supervision of CHW

- What is the **goal**?
- How do we reach this goal?
    - What do you think is important to good supervision of CHWs as research staff?
    - How can CHWs be engaged with clinic/site staff and activities while remaining focused on the research activities?
    - What should engagement and communication with UNC look like?
- **Draft Protocol** – Review & Edit (See below)

UNC Research Supervision of CHWs

- What is the **goal**?
- How do we reach this goal?
  - What will make the Site-UNC research partnership work best?
  - How should UNC engage with sites (supervisors and CHWs) to ensure that the research is conducted as intended and our data is complete?
  - What should engagement and communication with UNC look like?
- **Draft Protocol** – Review & Edit

CHW & Caseload Management – Enrolling and Retaining CHANGE Participants



- Each site has 1-2 CHWs working **40 hours/week** (total) on:
  - Recruitment
  - Participant enrollment, contacts, and follow-up
  - Data collection
  - Meetings and reporting to UNC
  - Planning
- Enrollment period = **December 2017** to **May 2019**
  - **~17 Total months** for enrollment (including only ½ month for December)
  - **254 participants** enrolled in 17 months **= 15 participants/month (both sites)** or about **4 participants/week**

15

CHW Training | Day 1 Outline

Training time for this segment: **~ 8 hours** including time for practice of appropriate skills.

Heart Disease Background

- Heart disease is the #1 cause of death.
- More than 1/3 of all deaths are due to heart disease.
- 1 of every 3 adults has 1 or more cardiovascular disease(s)
- 80 million American adults have hypertension
  - Almost half of these are under 60 years of age
- More heart disease deaths in African-American men and women
- African-American women are less aware of heart disease

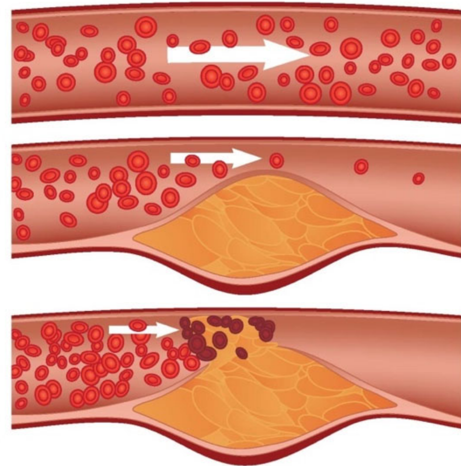
How the Cardiovascular System Works

- **Arteries** carry oxygen-rich blood **A**way from the heart to the rest of the body.
- **Coronary arteries** are the arteries that supply blood to the heart muscle.
- **Capillaries** are smallest types of blood vessels and are where oxygen and nutrients are delivered to cells.
- **Veins** return the oxygen-poor blood to the heart.

What is cardiovascular disease?

Cardiovascular disease refers to several problems with the heart and/or blood vessels. Blood vessels are responsible for taking blood and oxygen to all parts of your body, including your heart muscle. Cardiovascular disease is also is called CVD or heart disease.

Atherosclerosis is the most common cause of cardiovascular disease. Atherosclerosis is a condition where plaque, a hard substance, attaches to the blood vessel wall and causes the blood vessel to harden and narrow. This makes it harder for blood to flow through the vessel and makes it easier for a clot to form. Clots can block the flow of blood to different parts of your body. When the blood flow to your heart muscle is blocked, a heart attack can occur. When blood flow to the brain is blocked, an ischemic stroke (one kind of stroke) can occur.



© http://www.secondscount.org/heart-condition-centers/info-detail-2/angina-causes-risk-factors-2

Heart Attack

- **Heart attack** is when a coronary artery gets blocked by a plaque or blood clots
- Consequences of a heart attack
  - Heart muscle can be permanently damaged, heart failure, electrical signaling problems, disability, risk of future heart attacks, death
- Classic symptoms of heart attack
  - Chest pain or discomfort
  - Shortness of breath
  - Pain in the neck, jaw, throat, upper abdomen, or back
  - Cold sweat, nausea, or lightheadedness
- Women may have different symptoms
  - Chest pain for more than 1 minute
  - Shortness of breath without chest pain
  - Pain or discomfort in one or both arms, back, neck, jaw, or stomach
  - Nausea/vomiting
  - Indigestion
  - Anxiety or sleep disturbance
  - "I thought I had the flu"

Immediate medical care can prevent damage!

< 1 hour

Angina

Angina is a warning sign that a **heart attack may be getting ready to happen**. Angina happens because a coronary artery is narrowed or partially blocked, and not enough blood can get through to the heart muscle. This causes a person to feel pain after they've increased their physical activity, because during activity the demand for oxygen by the muscles goes up. The heart can't keep up, causing pain.

Stroke

Face Drooping – Does one side of the face droop or is it numb? Ask the person to smile. Is the person's smile uneven?

Arm Weakness – Is one arm weak or numb? Ask the person to raise both arms. Does one arm drift downward?

Speech Difficulty – Is speech slurred? Is the person unable to speak or hard to understand? Ask the person to repeat a simple sentence, like "The sky is blue." Is the sentence repeated correctly?

Time to call 9-1-1 – If someone shows any of these symptoms, even if the symptoms go away, call 9-1-1 and get the person to the hospital immediately. Check the time so you'll know when the first symptoms appeared.

Blood Pressure and Hypertension

Blood pressure is a measurement of how hard the blood inside the arteries is pushing against the artery walls. Blood pressure is a measure of how hard the heart is working to pump blood.

There are **3 main factors** that cause the blood pressure to go up or down.

1. The **diameter of the artery**, which refers to how big around the inside of the artery is, where blood passes through. If the tube is wide, blood passes through easily, and the pressure is low. If the tube is narrow, the heart has to pump harder to make the blood flow through, and the pressure is high. The diameter can be narrowed because of plaques inside the artery, or from hormones in the body that signal the arteries to squeeze tighter.
2. **Blood volume** is the amount of blood moving around the whole body. Adding fluid to the blood increases the volume. This is the main reason why salt is a problem for blood pressure. It causes the body to retain water, to try to balance out the sodium in the salt.
3. **Blood that's thicker** than usual can also increase blood pressure. Blood gets thick when the cells in it, such as red blood cells and plasma cells are highly concentrated in the serum. This can happen from certain blood diseases and even in hypothermia.

Blood Pressure Category	Systolic mm Hg (upper #)		Diastolic mm Hg (lower #)
Normal	< 120	and	< 80
Prehypertension	120 – 139	or	80 – 89
High Blood Pressure, Stage 1	140 – 159	or	90 – 99
High Blood Pressure, Stage 2	> 160	or	> 100
Hypertensive Crisis (Emergency care needed)	> 180	or	> 110

Heart Disease Prevention and Management

Talk to your doctor to find out if you have high blood pressure, high cholesterol, or diabetes, and follow your doctor's recommendations to manage these conditions, including taking medications as prescribed. Heart disease risk can be reduced by:

- Not smoking
- Eating a healthy diet including fruits and vegetables
- Exercising regularly
- Maintaining a healthy weight
- No excess alcohol intake
- Reducing stress

Heart Disease is the #1 killer in the U.S.

But 80% of heart disease is preventable.

CHANGE Program Overview

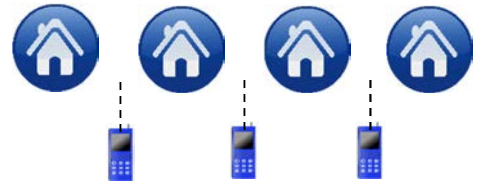
CHANGE program is delivered by Community Health Workers

- o Seven Core Functions of community health workers:
    1. Bridge between communities and health systems
    2. Provide culturally appropriate health education
    3. Link people to needed services
    4. Provide informal counseling and social support
    5. Advocate for individual and community needs
    6. Provide direct service (e.g., health screening)
    7. Build individual and community capacity

- The CHANGE program is delivered over 3-4 months

  4 face-to-face visits

  3 phone calls (2-weeks after each face-to-face visit)



- CHANGE program curriculum:
    - o Med South Diet
    - o Gradually increasing physical activity

- Medication adherence
- Smoking cessation (when relevant)

- Why this is important:
  - Controlling high blood pressure decreases cardiovascular disease risk by 25%
  - Smoking cessation decreased cardiovascular disease risk by 50% (over 4 years)
  - A Mediterranean style diet decreases cardiovascular disease risk by 30%
- *[CHANGE program results can be shared here as well.]*

Participant Recruitment and Enrollment

- Your agency guidelines for seeing a new patient/client should go here
- Overview of CHANGE recruitment (see protocol)
  - Protocol includes scripts and communication logs
- Assessing Motivation:
  - This is to aid in retention of participants in the CHANGE program

The Participant Flow Diagram can be shared with patients (this can be found in **Appendix 7**)

Assessing Motivation

Ready, Willing, and Able to Change

When do people change their behaviors? When they are motivated.

Motivated means…

Willing – when you **want** to change and making the change is **important**. Sometimes this importance is realized when where you see yourself is not where you want to be.

Able – when you believe you have what it takes to change (you are confident that you can). If you believe you can, then you are more likely to try harder and stick with making changes for a longer time

Ready – when the change in behavior is high on your list of priorities. You can be willing and able, but if you are not ready to make a change, you will not.

Overview of the Community

- Provide information about the population and demographics of the community served
- Information about health behaviors and heart disease risk can be found at:
  - http://www.countyhealthrankings.org/
  - Your local community health assessment
  - Your agency's records

Overview of the Community Resource Guide | Community Resources | Resource Referrals Process

Provide a copy of the community resource guide and introduce the community health worker to community stakeholders and contacts for resources.

Give the community health worker time to get familiar with these resources following training, but prior to recruiting the first participants.

Provide information to the community health worker about your agency's specific referral process for referrals to outside resources and the process for following-up with these referrals (i.e., your agency's policy for closed-loop referrals).

Home Visiting Basics

Provide an overview of home visiting safety.

- Review agency policy (if your agency does not have a policy, consider creating one)
- Review basic safety tips

Resources available at
https://vkc.mc.vanderbilt.edu/assets/files/tipsheets/homevisittips.pdf

Cultural Competency

Four elements of Empathy:

1. **See their World** – seeing the world from others' point of view.
2. **Appreciate them as Human Beings / No-Judgement** – avoid judging and discounting another persons' situation so that we can avoid experiencing their pain. For us to express empathy, we need to see the person as a human being – someone who is valuable in their own right.
3. **Understand Feelings** – to truly understand and connect with another person's feelings, we need to get in touch with our own emotions.
4. **Communicate Understanding** –communicate your understanding of another person's feelings so they feel like they are understood, seen, and heard. If you are stuck try "It sounds like you are in a hard place now. Tell me more about it."

Resources are available at:

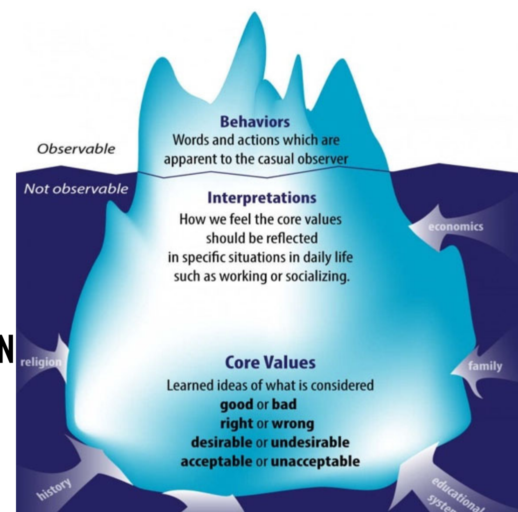
https://www.hhs.gov/ash/oah/resources-and-training/tpp-and-paf-resources/cultural-competence/index.html

https://hpi.georgetown.edu/cultural/

Activities:

1. Circles of My Multicultural Self

http://www.edchange.org/multicultural/activities/circlesofself.html



2. Cultural Iceberg

https://www.spps.org/cms/lib/MN01910242/Centricity/Domain/125/iceberg_model_3.pdf

https://www.languageandculture.com/cultural-iceberg

CHW Training | Day 2 Outline

Training time for this segment: **~ 8 hours** including time for practice of appropriate skills.

CHANGE Program Sessions

Review the material in the CHANGE program handbook.

- Taking Medication
- Stopping Smoking
- Healthy Eating
- Physical Activity

Data Collection, Entry, and Management

Teach CHW how to measure weight and blood pressure correctly

- Provide guided practice for measuring weight and blood pressure
- Provide information about where to record data

How to collect information about health behaviors

- Overview of different interviewing techniques for health behavior questionnaires and therapeutic counseling skills (see **Appendix 6**)
- Provide guided practice for administering the health behavior questionnaires

CHANGE Program Monitoring, Supervision, Data Collection, Evaluation

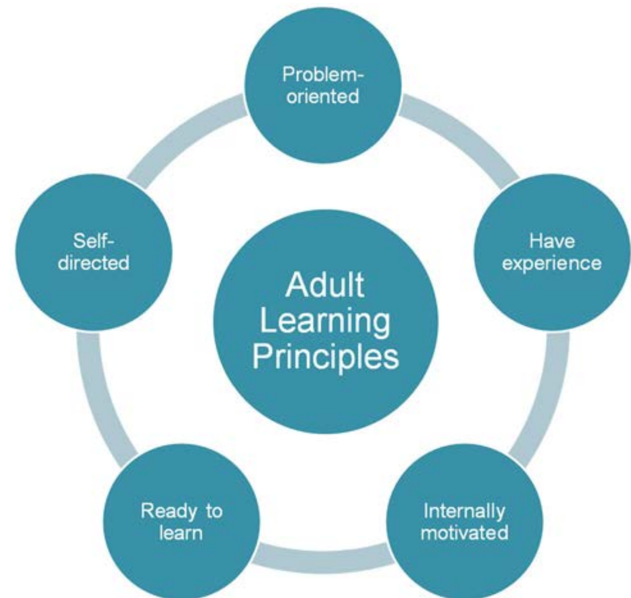
- Discuss with the CHW what program monitoring and supervision will look like
- CHWs roles are typically different from other employees, as they spend more time in the community. Make sure to have an open discussion with them about this difference and what their expectations should be.

CHW Training | Day 3 Outline

Training time for this segment: **~ 4 hours** including time for practice of counseling skills.

Behavior Change in Adults | How Adults Learn and How Change Happens

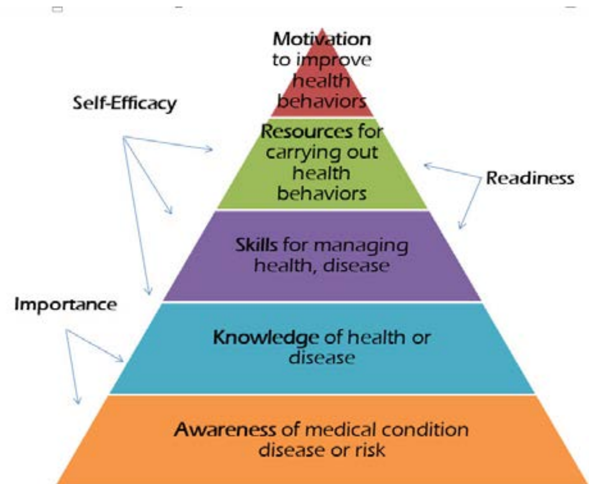
Adult Learning Principles:



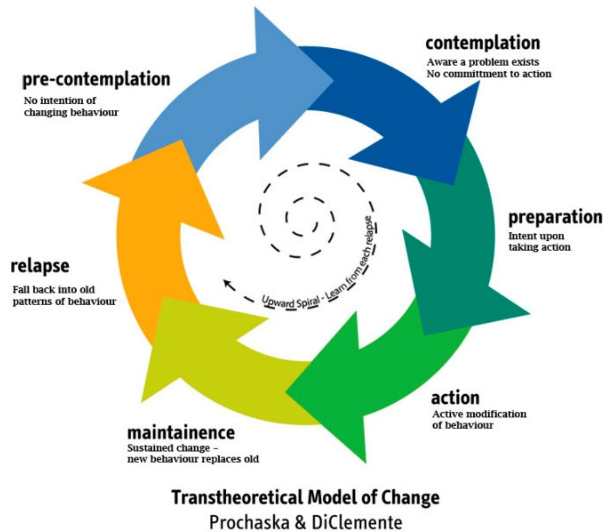
1. **Look at the ways adults prefer to learn.**
    - What stands out for you?
    - What makes a learning experience meaningful to you?
    - How could you use in CHANGE?

Motivation:

1. **Think back to a change you made...**
    - What motivated you to change?
    - How could you use this information in CHANGE?



Stages of Change:



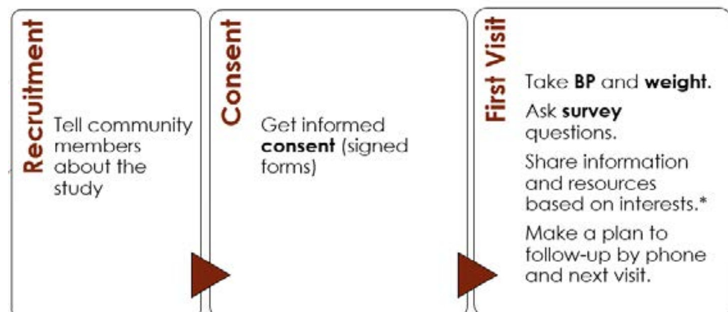
1. Think of a change **you want to make…**
   - What is your stage of change?
   - How could you use this information in CHANGE?

Counseling Skills – Part 1 | Introduction to Motivational Interviewing (MI) Skills and Practice

First Visit

Priority order of Topics:

- Medication Taking
- Smoking Cessation
- Healthy Eating
- Physical Activity



- Counseling Skills
- Ways to Listen (Are you a good Listener?) HANDOUT provided.
    - ZINGERS – How would you listen with a **Reflection**?
        1. I can never seem to stick to anything for long.
        2. My blood pressure is never under control.
        3. People in my family have heart problems.
        4. My family loves to cook. I'm not sure I can give up all my favorite foods.
        5. Physical activity (especially walking) can be so boring.
        6. I don't have a lot of will power.

Motivational Interviewing Principles

- A **communication style** that helps a person look into and deal with the uncertainty of changing lifestyle habits
- See 14 principles HANDOUT provided

Sharing Information, Problem Solving and Goal Setting

- In-Person and Phone Contacts
    - Checking-In and Starting the Conversation
    - Sharing information
    - Problem-solving, Goal-Setting, and Action Planning

Elicit-Provide-Elicit

A Simple Strategy for Sharing Information

	Tasks	In Practice…
Elicit	• Ask **permission** • Clarify Information, needs, and gaps	• Would you like to know about ____? • May I _____? • What do you know already about _____________? • What would you like to know about? • Is there any information I can help you with today?
Provide	• Prioritize information • Be clear and concise • Elicit – Provide-Elicit • Support autonomy •	What to provide… • What the person most wants and needs to know • Avoid jargon; use everyday language • Offer small amounts with time to reflect • Acknowledge freedom to disagree with or ignore what is offered • Present what you know without interpreting the meaning for the client
Elicit	• Ask for the client's interpretation, understanding, or response	• Ask open-ended questions • Reflect reactions that you see • Allow time to process and respond to the information

Source: Exchanging information, Miller & Rollnick 2013

[Grab your reader's attention with a great quote from the document or use this space to emphasize a key point. To place this text box anywhere on the page, just drag it.]

ADAPT: Five Steps to Solving Life's Problems

A	**Attitude** ▪ Adopt a **positive, optimistic attitude** toward the problem and *your ability to cope* with it, before you attempt to solve a problem
D	**Define** ▪ Define the problem by … o getting **all the facts** o selecting a **realistic goal** o identifying the **obstacles**
A	**Alternatives** ▪ Generate a list of possible **solutions or alternatives** for overcoming the obstacles and achieving your goal
P	**Predict** ▪ Predict the consequences (+/-) that might happen for each possible solution ▪ Choose the best solution (more + than -)
T	**Try It Out** ▪ Try out the solution and see if it works. ▪ If it worked, then problem solved!' ▪ If not, try another (an alternative solution)

Think of problems as challenges, not as threats.

A problem well-defined is a problem half-solved.

Source: Nezu A, et al. Solving Life's Problems, 2007

PRACTICE (1.5 hours) HANDOUTS provided

Practice: **Activity #1 and #2**
Listening | Starting the Conversation

- Counseling Practice (In-Person - Home Visits)
- Counseling Practice (Phone Contact - Booster Calls)

- Training Wrap-up & Evaluation

CHW Training | Day 4 Outline

Training time for this segment: **~ 8 hours** including time for practice of appropriate skills. Day 4 should take place at least a week after the initial training, to give the CHW time to learn the CHANGE program material, practice the skills learned in the initial training, and to allow the guided practice to be more valuable.

Participant Recruitment

Inviting people to participate in the CHANGE program:

- Review recruitment strategies the community health worker can use to reach individuals to participate in the program
    - This can involve prioritizing recruitment of existing members of the agency to reach those that would benefit most from the program
- Discuss how community health workers will receive referrals from others in the organization
- Discuss how the community health worker can reach out to participants, either within the organization or in the community

Guided Practice | CHANGE Program Delivery & Data Collection

- Practice the first home visit. Include telling participants about the program, enrollment, initial paperwork, and data collection using the health behavior questionnaires.
    - Practice building rapport, collecting health behavior questionnaire data vs. therapeutic counseling skills
    - Administration of health behavior questionnaire
    - Measuring blood pressure and weight

- Delivery of the CHANGE intervention
    - Reviewing intervention material with participants
    - Helping set goals
    - Community resource referrals

- Data Collection, Entry, and Management
  - Data collected from participants
    - Baseline survey, blood pressure, weight
    - Material covered
    - Goals set
    - Referrals made

APPENDIX 6:

Protocols — Delivering CHANGE Program Contacts

CHANGE Participant Appointment CALL LOG

Participant Name: (First, Last)	
Phone Number:	
Address: (if applicable)	

Call No.	Staff (Initials)	Date	Time	Result Code	Comments
1.		____/____/____ MM DD YY	_ _: _ _ am/pm		
2.		____/____/____ MM DD YY	_ _: _ _ am/pm		
3.		____/____/____ MM DD YY	_ _: _ _ am/pm		
4.		____/____/____ MM DD YY	_ _: _ _ am/pm		
5.		____/____/____ MM DD YY	_ _: _ _ am/pm		
6.		____/____/____ MM DD YY	_ _: _ _ am/pm		
7.		____/____/____ MM DD YY	_ _: _ _ am/pm		
8.		____/____/____ MM DD YY	_ _: _ _ am/pm		

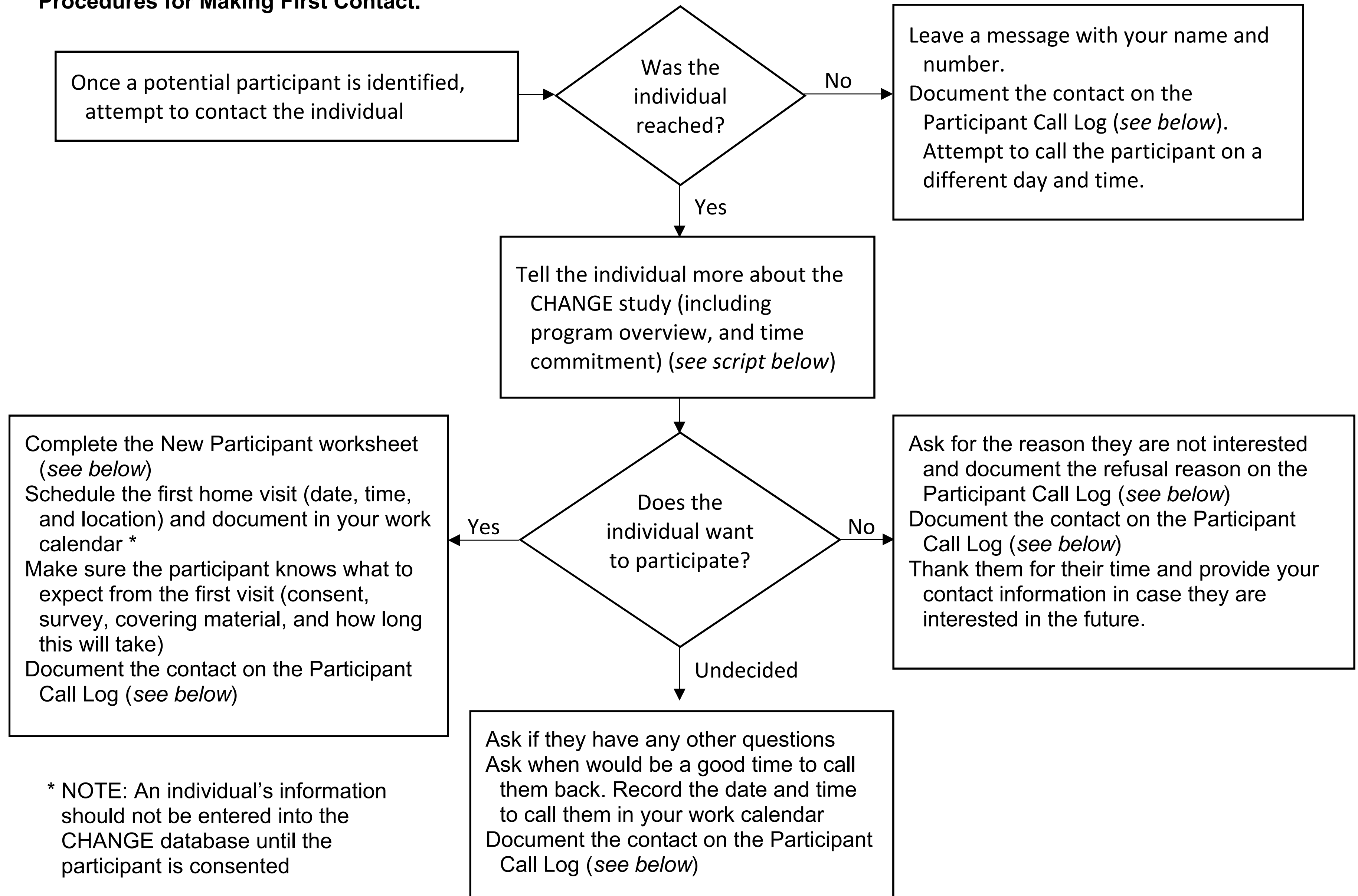
Participant **not contacted**	
01	Answering machine
02	Phone Busy
03	Ring; no answer
04	Number not in service
05	High-pitch screech (i.e. fax)

Contact made but **meeting** appointment time **not** set:	
06	Participant identified; appointment made to call back
07	Participant identified; no appointment made to call back
08	Participant not identified; appointment made to call back
09	Participant not identified; no appointment made to call back
10	Participant not at this number
11	Other:

Participant **Contacted / Outcome**	
12	Refusal (e.g. is not interested)
13	Complete (will meet for session/appt.)
14	Other: (specify in comments)
Comments	

Decision Tree for Making First Contact

Procedures for Making First Contact.



CHANGE INTRODUCTORY TELEPHONE SCRIPT

Before scheduling an in-person visit, be sure that the patient meets eligibility criteria (either by reviewing medical records, or at the initial phone call):

- ☐ Ages 18-80 years old
- ☐ Resident of either Edgecombe or Nash County, NC or receive public health or healthcare services in Edgecombe or Nash County
- ☐ Speaks English
- ☐ Not currently pregnant
- ☐ OIC: Participants should be receiving services from OIC. If not, individuals should be referred to Edgecombe County HD.
- ☐ ECHD: Participants should not be patients at OIC. If they are, refer these individuals to OIC

REMEMBER TO COMPLETE the "CHANGE Participant Appointment CALL LOG" to DOCUMENT PHONE CALLS

Telephone Script

May I please speak with ____?

[If not available…]
Thank you. Is there a better time that I could call to reach him/her? [Document call attempt on the Call Log and Note Time to call back for next contact.]

[If participant is there…]

Hello ____,

My name is ______________________and I am the Community Health Worker at _______________________________________. I'm calling to speak with you about the CHANGE study. I learned of your interest from _____________________________________. Is this a good time to talk?

[If yes…]
A primary goal of the CHANGE Program is preventing heart disease. CHANGE focuses on ***helping people to make healthier food choices*** and to ***become more physically active***. The program also ***works with participants to quit smoking if they use tobacco products***. If a participant takes medicines to lower blood cholesterol or blood pressure, the CHANGE program ***helps them work more closely with a doctor to take their meds as they should.*** If you are interested in this study to lower your risk of getting heart disease, I can tell you more about what to expect. Would you like me to continue?

[If no…]
My apologies for any inconvenience. Would you mind telling me why you are not interested in participating in the study? Thank you and have a nice day.

[If yes…]
Thank you. I am going to ask you a few questions to make sure you are eligible to participate in the CHANGE program. *[NOTE to interviewer: At the point, make sure the participant meets the eligibility criteria below. NOTE: If the person is female, check to be sure she is not pregnant..]*

- ☐ What is your age? *[to be eligible, the individual must be between the age of 18-80]*
- ☐ Are you a resident of Edgecombe or Nash County? If not, do you receive public health or healthcare services in Edgecombe or Nash County? *[to be eligible, the participant must answer yes to ONE of these questions]*

Introductory Telephone Script

- ☐ Do you speak English *[to be eligible, the participant must speak English]*
- ☐ *[FOR FEMALES ONLY]* Are you currently pregnant? *[to be eligible, participants cannot be pregnant at the time of enrollment]*
- ☐ Are you at patient at or are you receiving care at OIC?
  - *[FOR OIC – to be eligible, individuals SHOULD be receiving care at OIC. If not, refer them to the CHWs at Edgecombe County Health Department]*
  - *[For Edgecombe County HD – to be eligible, individuals SHOULD NOT be receiving care at OIC. If they are, refer them to the CHW at OIC]*

[If not eligible…]
My apologies, but based on your answers to my questions you are not eligible to participate in the program. Thank you for your time have a nice day.

[If eligible but needs to be referred to the other agency…]
Thank you for answering my questions. We are offering this program both through Edgecombe County Health Department and OIC. Since you [are/are not] at patient at OIC, I will give your contact information to that program and someone will contact you about participating in the program. Can I answer any questions for you before passing on your contact information?

[If eligible…]
As someone who is both eligible and interested in the CHANGE Program, here's what you can expect. Your part in this study would last about 4-5 months. During this time, you would meet with me four times at your home or another place that you choose. These meetings would take place about once a month for about one hour. We would also check in on the phone 3 times between these monthly meetings. At the end of the program, we will ask you to complete a short survey (10-20 minutes) over the phone. You will receive a $10 incentive for your time completing the survey. Additional, you may be selected for an in-person interview following your participation in the study. If you agree to participate in this, you will receive a $20 gift card for your time completing the interview.

It will not cost you anything to take part in this study. You may not benefit from being in this study, but your part in this study may help us obtain knowledge that could help people in the future. Being a part of this study is absolutely voluntary. You may refuse to join, or you may withdraw at any time and for any reason without penalty or any effect on your relationship with your health care providers at _________________________.

Do you think you would be interested in enrolling in the CHANGE study?

[If no…]
May I ask why you are not interested?

- ☐ ***Code and record response on "CHANGE Participant Appointment CALL LOG"***
- ☐ ***Answer any questions they may have***

Thank you for your time and consideration. If you have additional questions, feel free to call me at ________________.

[If yes…]
Great. If it is okay with you, I would like to schedule a meeting for us to talk further about participation in the study participation and possible enrollment. If you do enroll, we can begin our first program session then. The first session should take between 1 hour to 1 ½ hours. Is there a day of the week that would work best for you?

Can you meet on _________ (***date***) at _____ (***time***) at ____________________ (***location***)?

If you need to contact me before then, you can call me at (____) _____-_____(***phone number***). I'm looking forward to talking with you.

I'll see you on _________ (***date***) at ______ (***time***) at _______________________ (***location***).

Date Script Updated: Nov 15, 2017

Site: ☐ ECHD ☐ OIC	CHANGE Study	Study # 15-2822

CHANGE Participant Appointment CALL LOG

Participant Name: (First, Last)	
Phone Number:	
Address: (if applicable)	

Call No.	Staff (Initials)	Date	Time	Result Code	Comments
1.		______/______/______ MM DD YY	_ _: _ _ am/pm		
2.		______/______/______ MM DD YY	_ _: _ _ am/pm		
3.		______/______/______ MM DD YY	_ _: _ _ am/pm		
4.		______/______/______ MM DD YY	_ _: _ _ am/pm		
5.		______/______/______ MM DD YY	_ _: _ _ am/pm		
6.		______/______/______ MM DD YY	_ _: _ _ am/pm		
7.		______/______/______ MM DD YY	_ _: _ _ am/pm		
8.		______/______/______ MM DD YY	_ _: _ _ am/pm		

Participant **not contacted**	
01	Answering machine
02	Phone Busy
03	Ring; no answer
04	Number not in service
05	High-pitch screech (i.e. fax)

Contact made but **meeting** appointment time **not** set:	
06	Participant identified; appointment made to call back
07	Participant identified; no appointment made to call back
08	Participant not identified; appointment made to call back
09	Participant not identified; no appointment made to call back
10	Participant not at this number
11	Other: (specify in comments)

Participant **Contacted / Outcome**	
12	Refusal (is not interested, document refusal reason)
13	Complete (will meet for session/appt.)
14	Other: (specify in comments)

Refusal Reasons: a) I don't have enough time; **b)** I need to focus on other health concerns right now; **c)** other things, not related to my health, are more important to me right now; **d)** I do not want to share this type of information with others; e) I do not have a reliable phone number; **f)** I do not like the idea of meeting at my house or any other nearby places that come to mind; **g)** I already am doing everything I can to take care of my heart health; **h)** I already know what I need to know to take care of my heart health; **i)** I am too young to worry about my heart health; **j)** I am too old to worry about my heart health; **k)** other (describe in comments)

CHANGE
New Participant

Pt ID | | | | |

Date: __ __ - __ __ - __ __ __ __
M M D D Y Y Y Y

Interviewer Initials: ____ ____ ____

Participant (Study ID #:__ __ __ __)

Name: First: ________ Middle: ________ Last: ________

Date of Birth: __ __ __ __ - __ __ - __ __
Y Y Y Y M M D D

Gender: (Check One) ☐ **Male** ☐ **Female**

Site: (Check One) ☐ **OIC Family Medical Center** ☐ **Edgecombe County Health Department**

Address

Street: ________

Street 2: ________

City: ________ **State:** ________ **Zip:** ________

Phone number (type): ________

Alternate Phone (type): ________

Email: ________

Alternative Contact Information: (ask the participant for an alternative contact to have in case the participant moves or changes their phone number)

Name: ______________________________

Phone: ______________________________

Email: ______________________________

Notes (include relationship to participant)**:** ______________________________
____

How did you hear about and become interested in participating in the CHANGE program?

- ☐ Heard about the program from medical staff (e.g. physician, provider, nurse)
- ☐ Newspaper advertisement

  Specify newspaper

  ____
- ☐ Attended a community event where the CHW talked about the program

  Specify location

  ____
- ☐ Church bulletin/newsletter

  Specify church

  ____
- ☐ Flyer in the community

  Specify location

  ____
- ☐ Word of mouth (e.g. friend, family)
- ☐ Other ______________________________

Counseling Session Content | Protocol

Overview: The topics (also called 'modules') covered in the CHANGE Program include:

1. **Medication Adherence**
2. **Smoking Cessation**
3. **Healthy Eating** – 4 areas (also called 'sessions')
   a. Nuts, Oils, Dressings and Spreads
   b. Vegetables, Fruits, Beans and Whole Grains
   c. Drinks, Desserts, Snacks, and Eating Out
   d. Fish, Meat, Dairy and Eggs
4. **Physical Activity** – 4 areas (also called 'sessions')
   a. Walking
   b. Keep Walking and Moving More
   c. Staying on Track
   d. Add Muscle Strengthening

Procedure:

- The participant will determine the topic of highest priority.
- After that topic is covered, address the remaining topics in the following order:

Medication Adherence → Smoking Cessation → Healthy Eating → Physical Activity

- If a topic is not relevant (for example, a participant does not smoke), move on to the next topic in the sequence.
- For 'Healthy Eating' and 'Physical Activity' the order of the **4 areas** listed is the order of importance and the order in which they should be covered. For Example, in 'Physical Activity', cover 'Walking' before 'Keep Walking and Moving More'.
- Cover no **more than 2 topics in a single home visit** (counseling session). Within each of the topic areas you should only cover ONE area. For example: you **should not** cover "Nuts, Oils, Dressings and Spreads" and "Fish, Meat, Dairy and Eggs." **You may cover**, for example, "Nuts, Oils, Dressings and Spreads" and "Walking."
- If a participant selects "Healthy Eating" as their priority, after covering "Nuts, Oils, Dressings and Spreads", continue with the next topic (i.e., Medication Adherence) and follow the priority above.
- At the next counseling visit, you can cover another topic area in "Healthy Eating" **along with one of the other 4 topics**.
- By the end of the 4th home visit, you should have covered ALL topics that are relevant for the participant. For "Healthy Eating" and "Physical Activity" you don't have to cover all 4 topic areas. Simply cover those most important to the participant.

Reminders Calls:

- Give participants a reminder call **no later than the day before** your scheduled home visit or booster call. If you find that the participant is no longer available at the time of the scheduled contact, reschedule right away.

Booster Calls:

- These calls are for checking in after the counseling/home visit.
- Make your booster call **about 10 days to two weeks** after the in-person home visit.

Data Collection with Paper Forms

NOTE: Use only the **Participant ID#** in **ALL** communications regarding study participants.

Paper Data Forms

- Paper data forms should be used at any home visit or booster phone call where there is no Internet access and the online data collection form cannot be used.
- The paper data collection form includes the following:
  - Home Visit forms, which include:
    - new participant form
    - heart health profile
    - making first contact
    - consent documentation
    - baseline survey
    - CVD risk calculator – data collection form
    - Priority selection
    - home visit summary sheets (for visits 1-4)
    - module specific data collection forms for medication adherence, stopping smoking, healthy eating (modules 1-4), and physical activity (modules 1-4)
    - follow-up survey
  - Booster Call forms, which include forms for booster call 1-3
  - Communication Log
  - Withdrawal Form

Completing Home Visit Paper Data Forms: Home Visit 1

- For home visit 1: complete the following forms:
  1. new participant form
  2. heart health profile
  3. making first contact
  4. consent
  5. baseline survey
  6. CVD risk calculator – data collection form
  7. priority selection
  8. home visit summary sheets (for visits 1)
  9. the appropriate module specific data collection forms
- After enrolling the participant, and collecting data on forms 1-7 listed above, proceed to the "Home Visit 1 – Summary Sheet" (pg. Home Visit 1-1) and collect the Medication adherence data.
- Proceed with the participant's priority area, as selected on the "priority selection form" (pg 1-16), and cover the content in the participant manual. Following this, fill out both:
  - the appropriate module specific data collection form
  - the information on which modules were covered (pg. Home Visit 1-2).
- After completing the first module, check in with the participant about competing an additional module.

- Modules should be covered in the following order:
    1. Participant's priority topic
    2. Medication Adherence
    3. Stopping Smoking
    4. Healthy Eating
    5. Physical Activity
- If you complete a second module, cover the content in the participant manual. Following this, fill out both:
    - the appropriate module specific data collection form
    - the information on which modules were covered (pg. Home Visit 1-2).

Completing Home Visit Paper Data Forms: Home Visit 2-3

- For home visit 2 and 3: complete the following forms:
    1. home visit summary sheets (for visits 2 or 3, as appropriate)
    2. the appropriate module specific data collection forms
- **Before arriving at the visit, be sure to review referrals and goals set at prior visits. Enter in the name of each referral made into "Checking in" section of the "Home Visit 2/3 – Summary Sheet" (pg. Home Visit 2-1 or 3-1).**
- Begin with to the "Home Visit 2/3 – Summary Sheet" (pg. Home Visit 2-1 or 3-1) and collect the Medication adherence data.
- Next review goals set and referrals made at the last visit, beginning with the participant's priority topic, and then use the following order:
    1. Medication Adherence
    2. Stopping Smoking
    3. Healthy Eating
    4. Physical Activity

  Make sure to complete the data collection related to referrals made (i.e.: Were the referrals acted on? And are services being received?)
- Proceed with the participant's priority area (if there are modules still to cover), as selected on the "priority selection form" (pg 1-16), and cover the content in the participant manual. Following this, fill out both:
    - the appropriate module specific data collection form
    - the information on which modules were covered (pg. Home Visit 1-2).
- After completing the first module, check in with the participant about competing an additional module.
    - Modules should be covered in the following order:
        1. Participant's priority topic
        2. Medication Adherence
        3. Stopping Smoking
        4. Healthy Eating
        5. Physical Activity
- If you complete a second module, cover the content in the participant manual. Following this, fill out both:
    - the appropriate module specific data collection form
    - the information on which modules were covered (pg. Home Visit 1-2).

Completing Home Visit Paper Data Forms: Home Visit 4

- For home visit 4: Follow the instructions above for home visits 2-3, making sure you save 10 minutes at the end of the visit to complete the final study measures.
- Following covering the module information, and documentation as noted above, proceed to the follow-up survey (pg. Follow up Survey 1, located at the end of the data collection PDF document).
    - Make sure blood pressure and weight measurements are also collected.

Completing Booster Call Paper Data Forms

- To complete the Booster call form, first review previously set goals and referrals. If these were not collected on a paper form, and you don't have access to the online database, reschedule the booster call.
    - Before completing the call, be sure to fill out referrals offered at previous sessions in item 4 (pg. Booster Call ##-3
- Use the data collections forms to guide the call, documenting as you go along so you are able to follow up on topics discussed at the next home visit.
- If you provide new referrals, you can access information about referrals in the participant notebook, or on the individual module specific data collection forms.

Sending Completed Data Forms

- Whenever study data is collected from participants on a paper form, that document should be immediately entered into the online Data System. Transferring the data from the paper form to the online system should happen the **same day or within 24 hours.**
- If for some reason the data cannot be entered within this time frame, follow the instructions below for scanning the data forms.
- NOTE: All participant data collected on paper before the online system opened should be **scanned** if not already entered into the Data System.
- **Scan** the following forms to create a second copy of the data before filing the paper forms. Only forms that **do NOT have the participant's name or other personal identifiers** should be scanned.
    - Visit 1 (baseline) data forms
    - All other visit forms (if participant was seen before the online data system was operational)
- Do NOT scan the consent form or any form with the participant's name, address, phone number, etc. These forms should be FAXED with a cover page to the CHANGE Project Manager at UNC. The secure fax number is: (919) 966-3811.
- Scanned documents should be uploaded to the CHANGE database within 24 hours and entered into the database within 24 hours. To upload the documents into the CHANGE database:
    - Click on the "documents" link at the top of the database page
    - Click on "New File Upload" to add a file
    - Enter the name of the file
        - files should be named as follows: YYMMDD_PtID_VisitType, where YY is the two digit year, MM is the two digit month and DD is the two digit day.

        - ex: 170504_1205_HV1 would be the file name for participant 1205 who completed home visit 1 on May 4, 2017
    - Click on “Choose File” to locate the document on your desktop (NOTE: please name files in the same way as described above)
    - Then click on “Upload” to upload the document to the CHANGE database.
- Store all paper forms in a secure (locked file cabinet) at your site. The UNC staff will make arrangements to collect all paper forms.

Follow-up to a Missed Contact | Protocol

Overview: Participants in the CHANGE Program have a total of **seven planned contacts** – 4 in-person monthly counseling visits (at their home or other selected site) + 3 booster phone calls. In order to get the full benefits of this program, it is important for participants to receive the full program. Missed contacts/visits are to be expected and the CHWs are asked to follow the steps below when they occur.

Missed Monthly Contacts or Booster Calls:

1. Encourage participants to let the CHW know when they plan to miss a scheduled visit or a planned phone contact. Provide participants with staff numbers or email addresses for these contacts.
2. CHWs should make a reminder call before planned home visits and phone contacts. If a participant indicates (s)he will miss a contact, make a note of this and schedule a new appointment. Missed contacts should be documented in the online system according to the "**Missed Contact Documentation** Protocol."

3. If a **monthly counseling session/visit** is missed and unplanned:
    a. **Contact** the participant the same day to say that you missed seeing them at your scheduled visit and you would like to reschedule within the next 7 days if possible. NOTE: There is a 2-week window between home visits and the booster calls, so you want to **reschedule the visit within one week if possible**.
    b. **If you do not reach (speak with) the participant** on the day of the missed contact, leave a voice message and say that you will contact them again with a goal of rescheduling the visit within a week's time.
    c. **Make at least 3 attempts** to contact the participant **within 1 week** of the missed visit, and if necessary, 3 additional contacts the following week, for a total of at least 6 attempts. Try a different time of the day with each attempt. NOTE: If you have 'alternate' contact information, use it to reach the participant.
    d. If you cannot reach the participant by phone, **send a letter to the participant** with a request to provide new contact information. [See letter template.]
    e. If you cannot reschedule and complete the counseling visit within a **2-week period**, the visit should be documented as 'missed' and you will move on to scheduling the next monthly contact. NOTE: Booster calls are designed to follow-up on the goals set during the counseling visit. If a counseling visit after the first home visit is missed, **you can still make the booster call**. You will be following up on the goals set during the previously completed visit. For example, if a participant has booster call #1 after the 1st home visit but misses the 2nd home visit, you can still make booster call #2. You won't be able to cover new content, but can follow-up with progress made

toward initial goals and set new goals. If referrals were made, you can follow-up on those as well and make new referrals.

f. Record your attempts to reach the participant and the outcome of each attempt in the online system (Communication with Participant). You may also use the **Participant Follow-Up Contact Sheet** to record your contacts. Submit your contact sheet after the participant has completed the program.

4. If a booster call is missed and unplanned:
    a. **Leave a voice message** to say you missed talking with them and you would like to reschedule as soon as possible.
    b. **Make at least 3 attempts** to contact the participant within 1 week of the missed visit, and <u>if necessary</u>, <u>3 additional contacts the following week</u>, for a total of at least 6 attempts. Try a different time of the day with each attempt. NOTE: If you have 'alternate' contact information, use it to reach the participant.
    c. If you cannot reschedule and make the booster call within a 2-week period, the contact should be documented as 'missed' and you will move on to the next contact.
    d. Record your attempts to reach the participant and the outcome of each attempt in the online system (Communication with Participant). You may also use the **Participant Follow-Up Contact Sheet** to record your contacts. Submit your contact sheet after the participant has completed the program.

LETTERHEAD

Date

Dear _______________,

I hope all is well with you. I have been trying to get in contact with you to reschedule your appointment for the CHANGE program and have not been able to reach you. Could you please give me a call and let me know how you can be reached? You can reach me at XXX-XXX-XXXX or XXX-XXX-XXXX.

If for some reason I do not answer the phone when you call, please leave a message with a good number to return your call. I hope to hear from you soon, so that you and I can continue to make better choices together for a heart healthy life. If you are no longer interested in participating in the CHANGE Program, you can call and let me know that too. I hope that's not the case and look forward to scheduling our next visit.

Have a wonderful day,

Community Health Care Worker
CHANGE Program

CHANGE Participant Appointment CALL LOG

Participant Name: (First, Last)	
Phone Number:	
Address: (if applicable)	

Call No.	Staff (Initials)	Date	Time	Result Code	Comments
1.		____/____/____ MM DD YY	_ _: _ _ am/pm		
2.		____/____/____ MM DD YY	_ _: _ _ am/pm		
3.		____/____/____ MM DD YY	_ _: _ _ am/pm		
4.		____/____/____ MM DD YY	_ _: _ _ am/pm		
5.		____/____/____ MM DD YY	_ _: _ _ am/pm		
6.		____/____/____ MM DD YY	_ _: _ _ am/pm		
7.		____/____/____ MM DD YY	_ _: _ _ am/pm		

Participant **not contacted**	
01	Answering machine
02	Phone Busy
03	Ring; no answer
04	Number not in service
05	High-pitch screech (i.e. fax)

Contact made but **meeting** appointment time **not** set:	
06	Participant identified; appointment made to call back
07	Participant identified; no appointment made to call back
08	Participant not identified; appointment made to call back
09	Participant not identified; no appointment made to call back
10	Participant not at this number
11	Other:

Participant **Contacted / Outcome**	
12	Refusal (e.g. is not interested)
13	Complete (will meet for session/appt.)
14	Other: (specify in comments)
Comments	

Data Collection:
General Guidelines for Survey Administration

These guidelines provide information on how to deliver the baseline and follow-up surveys, in order to track individuals progress in the program. Surveys should collect information about individual's health behaviors that are covered in the CHANGE program like eating habits, physical activity, smoking habits, and medication use. ***Note****: these guidelines are specific for data collection and are not the same as the skills used in delivering the intervention.*

BUILDING/MAINTAINING RAPPORT

Building rapport does not end with the respondent's agreement to begin the interview. Rapport needs to be maintained. While you are reading the questions neutrally, recalling information from your manual, and listening to and recording answers, you must also track your respondent's reaction to the interview. Is he or she still interested? Are you asking questions that are too personal for this respondent?

If you detect that the respondent is bored with repetitive questions, concerned about confidentiality, or concerned about how long the survey is taking, it is usually better to diffuse the situation than to ignore it. This may take the form of acknowledging the respondent's concern and attempting to answer them (for example, stressing the confidential nature of the survey). If you take the lead in establishing an open, friendly atmosphere from the start, you will feel comfortable enough to address the respondent's concerns.

At the beginning of the interview you should ask respondent to reduce any distractions (cell phone, pagers, etc.).

It is important to remember that in order to remain neutral, you must maintain a professional and objective attitude at all times. Some questions in this survey may be about very personal and/or distressing topics, and for some respondents, the interview experience can become emotionally overwhelming. You will need to distinguish between "establishing an open, friendly atmosphere" and allowing yourself to become involved.

LISTENING

Listening is an important part of the social interaction in an interview -- both on the part of the interviewer and the respondent. It is very important that you listen carefully to what the respondent says in answer to each question and decide if it is a usable response.

The ideal respondent also listens carefully to the questions and then gives accurate and complete answers to the best of his or her ability, without digressing to irrelevant topics. Not surprisingly, not all respondents behave in this ideal way, and only a few behave this way all of the time. Often a respondent will give a response that sounds like an answer to the question but really is not. The respondent may not have listened to the question carefully.

Or, the question may have set off an association with some experience that the respondent is interested in having a chance to talk about, even though it is a little “off the mark.”

In any case, a good interviewer needs to listen carefully to the responses to know when the respondent has given an acceptable answer and when the interviewer needs to clarify the response.

PROPER INTERVIEWING

Interviewers (I) should:

- be able to state the purpose of each questionnaire briefly and clearly
- be able to explain why participation is important
- understand the purpose of each question
- have a strategy to deal with reluctance
- know the responses to commonly asked questions

Your approach should be:

- **neutral**--think of yourself as a reporter, recording information without stating an opinion about what you hear
- **confident**--don't be apologetic. The information you are collecting is important.
- **casual**--put your respondent (R) at ease. The burden of 'not knowing' is ours, not the respondents.

Conducting the interview:

- **Always read the question exactly as written at a fairly slow pace.**
    - If R does not understand, repeat it again with a different emphasis.
    - If R still does not understand or responds "I don't know," try one of the probes outlined below.
    - If you repeat any of the response choices, repeat <u>all</u> of them in the same order.
- **Do NOT offer your own interpretation or examples**, except where pre-determined examples are provided.
- **Do <u>not</u> to respond to a R's choice of answers in such a way as to provide biased feedback.** Examples of phrases to avoid are:

  "good"
  "great"
  "I agree"
  "all right" etc.
- **Use neutral words of encouragement** such as:

  "I see"
  "Yes, . . yes"
  Silence works too!
- **For ambiguous answers** (i.e. "Oh, I don't know." "Two or three I guess."):
    - A good interviewer will say, "I can only enter one number. Which is more accurate, two or three?"
    - Or when R answers "Yes," to a question that requires an agree/disagree response, repeat the possible responses.

- Remember what has been said and **summarize a long-winded answer.** ("So, you fell down the stairs and hurt your ankle after you started the CHANGE program?")

Probing:

- Older Rs take longer to complete surveys, have much less experience with standardized scales, and tend to have more complex answers. Therefore, probing may be needed.
- Never make a R feel that the question is too difficult for her to answer. She may perceive it as too difficult because:
    - the wording of the question is complicated
    - some questions are asking about something that happened in the past
    - some questions provoke thoughts the R has never considered
- The following probes might be helpful tools in situations such as these:
  "You can take your time thinking about it."
  "Some of these questions are hard. Let me repeat this one."
  "Would you say then that . . . (repeat the question)."
  "There is no right or wrong answer to this question. Just give me you opinion."
  "What the question is asking is . . . (repeat the question with a slightly different emphasis)."

Prodding:

- Listen patiently and carefully. If you **hear information that conflicts with earlier responses**, clarify by saying: "I want to make sure I record your information correctly. Earlier you said you did not do any physical activity. But now I thought you said you work in your garden. Is that correct?"
- If R is reluctant to answer a question, reassure her that **there is no right or wrong answer**--only she knows the answer for her.
- If R **gets off the subject**, direct her back to the interview politely:
  "Now here's the next question. . ."
  "If we keep going we can finish in __ minutes."
  "There are some questions about that later. I'd like you to hold that thought for a minute or two."
  "I don't want to take up too much of your time."

Refusals:

- If R objects to completing the interview, try to find out why. Some possible replies to a refusal are outlined below:

R objection:	**I response:**
I don't have time. . . I'm too busy.	I know people are busy these days. My questions will only take __ minutes. It's very important we talk to the people who are involved in this program.

R objection:	I response:
R is insistent that she doesn't have time	When would be a good time to call back? We really want to talk to everyone we are supposed to, otherwise our information is not very accurate.
R wants to know what kind of questions you will ask	Read one or two questions as an example and reassure her you will skip over a question if it makes her feel uncomfortable to answer it.
R asks what you are going to do with the information	The information is used to learn what better ways to help diabetic patients. Reassure her that the information is seen only by the UNC researchers and not by the staff at her medical center.
R questions why she needs to answer questions	Everyone who agreed to participate is being called and is answering the same questions. Our information won't be complete if she doesn't answer the questions.
R seems rushed and hostile	If I've caught you at a bad time, I'll be glad to call back in a few days. (NOTE: this is a statement and not a question.)
R absolutely refuses and/or hangs up	Don't take it personally. If you get an opportunity, thank her for her time and end the call. Make a note on the questionnaire that the R refused to comply.

Call backs:

- Document at least 6 attempts to reach a patient to complete a telephone interview. (Record all attempts on the R's phone log.)
- Some attempts should be made at the R's preferred time.

Disconnected numbers:

- Check the file for alternate numbers. Whenever possible, try to secure another number for the R. If the alternate refuses to give out a number, ask them if they will have the R call us.
- Call Directory Assistance

Patient Refusals

	Date (MM/DD/YYY)	Race*	Age**	Gender	**Reason Refused** (notate specific quotes from patient)
1.	/ /				
2.	/ /				
3.	/ /				
4.	/ /				
5.	/ /				
6.	/ /				
7.	/ /				
8.	/ /				
9.	/ /				
10.	/ /				
11.	/ /				
12.	/ /				
13.	/ /				
14.	/ /				
15.	/ /				
16.	/ /				
17.	/ /				
18.	/ /				
19.	/ /				
20.	/ /				
21.	/ /				
22.	/ /				

Race*	
B	Black
W	White
HL	Hispanic/Latino
A	Asian
NA	Native American
O	Other
M	Mixed

****NOTE:** Only provide age if given (i.e. in patient's medical records, clinical notes, etc.). Do NOT ask patient for age.

	Date (MM/DD/YYY)	Race*	Age**	Gender	**Reason Refused** (notate specific quotes from patient)
23.	/ /				
24.	/ /				
25.	/ /				
26.	/ /				
27.	/ /				
28.	/ /				
29.	/ /				
30.	/ /				
31.	/ /				
32.	/ /				
33.	/ /				
34.	/ /				
35.	/ /				
36.	/ /				
37.	/ /				
38.	/ /				
39.	/ /				
40.	/ /				
41.	/ /				
42.	/ /				
43.	/ /				
44.	/ /				

Race*	
B	Black
W	White
HL	Hispanic/Latino
A	Asian
NA	Native American
O	Other
M	Mixed

****NOTE:** Only provide age if given (i.e. in patient's medical records, clinical notes, etc.). Do NOT ask patient for age.

Weekly Update Form

***Please fill in this form weekly and send to the Project Manager at audrina_bunton@unc.edu* by COB on Monday.**

1. **Site:** (Check One) ☐ ECHD ☐ OIC

2. **Community Health Worker Name:** ______________________________

3. **Week of** (*Monday's date of previous week*): ______________________________

4. Participant Recruitment	
Task	**Number**
# of **individuals contacted** about the study	
• # of **individuals consented** this week	
• # of **refusals** this week	
• # of **individuals contacted, but did not make a decision this week**	
# of **individuals interviewed (started/completed)** session 1 this week	
5. Number of scheduled/potential interviews for this week	
6. Social Network participants Recruitment	
Task	**Number**
# Social Network individuals **consented** this week	
# Social Network individuals **interviewed (started/completed)** this week	

7. **As of Today** (Enter today's date): ______________________________

8. Participant Recruitment	
Task	**Number**
TOTAL # of **individuals consented** to-date	
TOTAL # of **refusals** to-date	
TOTAL # of **individuals contacted, but did not make a decision** to-date	

9. Comments:

Weekly Update Form

Procedure

Complete Weekly Update Form each Monday

Forward completed form (via email) to Project Manager each Monday

Instructions to Complete the Form

1. **Site**: Check appropriate site (double click on box, click on the "checked" field, hit "ok")
2. **Community Health Worker Name:** Fill in Community Health Worker's name.
3. **Week of (Monday's date of previous week):** Fill in date for week being reported (i.e. Monday's date of previous week).
4. **Participant Recruitment**
   For the previous week:
   a. Enter the number of individuals contacted about the study. (***NOTE**: The total number of individuals contacted should be the sum of consented + refusals + contacted but did not make a decision*)
      i. Enter the number of individuals consented.
      ii. Enter the number refusals.
      iii. Enter the number of individuals contacted, but did not make a decision
   b. Enter the number of individuals interviewed (started/completed) session
5. **Number of scheduled or potential interviews for this week:** Enter the number of any scheduled or potential participant interviews for the current week.
6. **Social Network Participants Recruitment:**
   a. Enter the number of Social Network participants consented for the previous week. [***NOTE:** Natural Supports (i.e. Family or friends) can be involved in the session without consenting to be a study participant.*
   b. Enter the number of Social Network participants interviewed for that week only.
7. **As of Today:** Enter today's date (i.e. the date the form is being completed, which should standardly fall on a Monday).
8. **Participant Recruitment:**
   a. Enter the **total** number of participants consented **to-date**.
   b. Enter the **total** number of participants interviewed **to-date**.
   c. Enter the **total** number of participant refusals **to-date**.
9. **Comments**: Any comments about the week that made it unusual (e.g. no participants met eligibility criteria, doctor on vacation, CHW on vacation, etc.)

APPENDIX 7:

Program Enrollment and Evaluation Forms

CHANGE
New Participant

Pt ID | | | |

Date: __ __ - __ __ - __ __ __ __
M M D D Y Y Y Y

Interviewer Initials: ____ ____ ____

Participant (Study ID #:__ __ __ __)

Name: First: ________________ Middle: ____________ Last: ______________

Date of Birth: __ __ __ __ - __ __ - __ __
Y Y Y Y M M D D

Gender: (Check One) ☐ **Male** ☐ **Female**

Site: (Check One) ☐ **OIC Family Medical Center** ☐ **Edgecombe County Health Department**

Address

Street: ____

Street 2: ____

City: ____________________ **State:** ______________ **Zip:** __________

Phone number (type): ____

Alternate Phone (type): ____

Email: ____

CHANGE
New Participant

Pt ID | | | |

Alternative Contact Information: (ask the participant for an alternative contact to have in case the participant moves or changes their phone number)

Name: ______________________________

Phone: ______________________________

Email: ______________________________

Notes (include relationship to participant)**:** ______________________________
____

How did you hear about and become interested in participating in the CHANGE program?

- ☐ Heard about the program from medical staff (e.g. physician, provider, nurse)
- ☐ Newspaper advertisement
  - Specify newspaper ______________________________
- ☐ Attended a community event where the CHW talked about the program
  - Specify location ______________________________
- ☐ Church bulletin/newsletter
  - Specify church ______________________________
- ☐ Flyer in the community
  - Specify location ______________________________
- ☐ Word of mouth (e.g. friend, family)
- ☐ Other ______________________________

CHANGE
Heart Health Profile

Pt ID | | | | |

Height:		ft.			in.

Weight: __________________ lbs.

Visit 1: __________ lbs.

Visit 2: __________ lbs.

Visit 3: __________ lbs.

Visit 4: __________ lbs.

Blood Pressure:

sbp: _______ / dbp _____ mm Hg

Visit 1: _______ / _____ mm Hg

Visit 2: _______ / _____ mm Hg

Visit 3: _______ / _____ mm Hg

Visit 4: _______ / _____ mm Hg

Total Cholesterol: _______________ mg/dl

HDL Cholesterol: _______________ mg/dl

Has Diabetes: ☐ **Yes** ☐ **No**

Smokes: ☐ **Yes** ☐ **No**

Takes High Blood Pressure Meds: ☐ **Yes** ☐ **No**

Takes Cholesterol Meds: ☐ Yes ☐ No

Has Cardiovascular Disease: ☐ **Yes** ☐ **No**

Primary Care Provider:: ____
First Last

CHANGE
Make First Contact

Pt ID ☐☐☐☐

Did you make first contact?

☐ **Yes** ☐ **No**

Is the participant interested in joining the study?

☐ **Yes** ☐ **No**

Refusal Reason

- ☐ I don’t have enough time
- ☐ I need to focus on other health concerns right now
- ☐ Other things, not related to my health, are more important to me right now
- ☐ I do not want to share this type of information with others
- ☐ I do not have a reliable phone number
- ☐ I do not like the idea of meeting at my house or any other nearby places that come to mind
- ☐ I already am doing everything I can to take care of my heart health
- ☐ I already know what I need to know to take care of my heart health
- ☐ I am too young to worry about my heart health
- ☐ I am too old to worry about my heart health
- ☐ Other ____
- ☐ Could not be reached

CHANGE
Home Visit 1 – Consent

Pt ID ☐☐☐☐

Date: ____________________________________ **Time:** ______________ (AM / PM)

Does the patient consent to be in the study or refuse?

☐ **Consent** ☐ **Refuse**

Say: *There are many reasons why someone might not want to participate in the CHANGE study. Would you tell me about your reasons?*

Refusal Reason

- ☐ I don't have enough time
- ☐ I need to focus on other health concerns right now
- ☐ Other things, not related to my health, are more important to me right now
- ☐ I do not want to share this type of information with others
- ☐ I do not have a reliable phone number
- ☐ I do not like the idea of meeting at my house or any other nearby places that come to mind
- ☐ I already am doing everything I can to take care of my heart health
- ☐ I already know what I need to know to take care of my heart health
- ☐ I am too young to worry about my heart health
- ☐ I am too old to worry about my heart health
- ☐ Other ____

CHANGE
Carolina Heart Alliance
Networking for Greater Equity

CHANGE
Baseline Survey

Pt ID

SECTION I: INTRODUCTION

Before we get started, I'd like to take a few minutes to ask you some questions about what kinds of foods you eat, your physical activity and other health habits. These survey questions will only take about 5 minutes. I'll ask you the same questions again at the end of our last session a few months from today.

My first questions are about foods that you eat.

SECTION II: FRUITS AND VEGETABLES

Think about your eating habits over the past month. About how often do you eat or drink each of the following foods? Remember breakfast, lunch, dinner, snacks and eating out. Answer for each of these foods:

[Read each answer choice (except "No Answer") aloud before selecting the participant's answer.]

	Less than 1 WEEK	Once a WEEK	2-3 times a WEEK	4-6 times a WEEK	Once a DAY	2+ a DAY	No answer
1. Fruit juice, like orange, apple, grape, fresh frozen or canned (Not sodas or other drinks.)	O	O	O	O	O	O	O
2. Any fruit, fresh or canned? (Not counting juice.)	O	O	O	O	O	O	O
3. Vegetable juice, like tomato juice, V-8, carrot	O	O	O	O	O	O	O
4. Green salad	O	O	O	O	O	O	O
5. Potatoes, any kind, including baked, mashed or French fried	O	O	O	O	O	O	O
6. Vegetable soup or stew with vegetables	O	O	O	O	O	O	O
7. Any other vegetables, including string beans, peas, corn, broccoli or any other kind	O	O	O	O	O	O	O

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Section III: BEVERAGES

I'd also like to ask you…

8. On an average day, how many 12-ounce servings of sugar-sweetened beverages do you drink with meals or in between meals? One regular can of beverage is 12 ounces. Sugar-sweetened beverages include regular non-diet sodas, bottled fruit drinks, Kool-Aid, iced or hot coffee or tea that has been sweetened with sugar (including drinks like Coke, Pepsi, Sprite, Snapple, lemonade, or Fruitade and sports or energy drinks).

Would you say:

O 0	O 1	O 2+	O No answer

Section IV: FATS

9. In an average week, how many servings of peanut butter or nuts (like almond, pecans, walnuts, or cashews) do you usually eat?

Would you say:

O 0-1	O 2	O 3+	O No answer

10. What type of butter or margarine do you usually use?

Is it:

O Tub margarine or other trans-fat free	O Butter	O Stick margarine	O No answer

Section V: PHYSICAL ACTIVITY - PART A

My next questions are about walking and any other physical activities.

11. In a **usual week**, do you walk to get to or from somewhere (such as walking to a store or bus stop), for recreation, health or fitness (including walking your dog)?

O Yes   O No → **If No, skip to Q. 18**   O No answer

I'd like to ask you about two types of walking. First there is walking for transportation (for example, walking to the store or work). Second there is walking for recreation, health and fitness.

12. The first questions are about **walking for transportation**. In a usual week, how many times do you walk **as a means of transportation**, such as going to and from work, walking to the store, or walking to a bus stop?

☐☐ Number of Times → **If 0, skip to Q. 15**   O No answer

Walking for Transportation

13. Please estimate the total time you spend walking as **a means of transportation** in a **usual week**.

[If needed, use the physical activity worksheet to collect information. Then enter answers under each day of the week. If participant does not walk on any given day, enter 0.]

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total

That totals ___ **minutes /** ___ **hour(s) and** ___ **minutes**. Does that sound about right?

☐ Yes   ☐ No   ☐ No answer

14. Let me know which of the following places you walk to as a **means of transportation** in a **usual week.** *[Mark all that apply.]*

- ☐ To or from work (or school)
- ☐ To or from bus stop
- ☐ To or from store
- ☐ To or from restaurant
- ☐ To or from a friend's house
- ☐ Other #1 ____
- ☐ Other #2 ____
- ☐ No answer

Walking for Recreation, Health or Fitness

If you already reported recreational walking, please do not report it again for the following questions.

15. In a usual week, how many times do you walk for **recreation, health** or **fitness** (including walking your dog)?

☐☐ Number of Times → **If 0, skip to Q. 18**	O No answer

16. Please estimate the total time you spend walking for **recreation, health** or **fitness** in a usual week.

[*If needed, use the physical activity worksheet to collect information. Then enter participant answers below under each day of the week. If participant does not walk on any given day, enter 0.]*

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total

That totals ___ **minutes / ___ hour(s) and ___ minutes**. Does that sound about right?

☐ Yes ☐ No ☐ No answer

17. Could you tell me where you walk for recreation, health or fitness in a usual week? *[Mark all that apply.]*

- ☐ Park
- ☐ Neighborhood
- ☐ School
- ☐ Fitness center
- ☐ To or from restaurant
- ☐ To or from a store
- ☐ Other #1 ____________________
- ☐ Other #2 ____________________
- ☐ No answer

Section VI: PHYSICAL ACTIVITY - PART B

The next set of questions is about **other leisure time physical activities** that you do in a **usual week**, besides what you have already mentioned. Do not include walking.

18. In a **usual week**, do you do any other **vigorous or moderate intensity** physical activity during your leisure time? Do not include any walking.

O Yes O No → **If No, skip to Q. 26** O No answer

19. Can you tell me where you do **vigorous or moderate intensity** physical activities in a **usual week**? [*Mark all that apply.]*

- ☐ Park
- ☐ Neighborhood
- ☐ School
- ☐ Fitness center
- ☐ Other #1 ____
- ☐ Other #2 ____
- ☐ No answer

I'm going to ask you more about **vigorous intensity** leisure activities first. Then, I'll ask you about moderate intensity leisure activities. Vigorous intensity physical activities cause a large increase in breathing and heart rate.

(a). Vigorous Leisure Activities

20. In a **usual week** do you do any **vigorous intensity** leisure time physical activities like jogging, aerobics, swimming laps, or competitive tennis? Do not include walking or moderate intensity physical activities.

O Yes O No → **If No, skip to Q. 23** O No answer

21. In a **usual week**, how many times do you do **vigorous intensity** leisure time physical activities which cause a large increase in breathing and heart rate?

☐☐ Number of Times → **If 0, skip to Q. 23** | O No answer

22. What do you estimate is the total time you spend doing **vigorous intensity** leisure time physical activities in a **usual week**?

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total

The total time you spend doing vigorous intensity physical activity is ___ **minutes /** ___ **hour(s) and** ___ **minutes**. Does that sound about right?

☐ Yes ☐ No ☐ No answer

(b). Moderate Leisure Activities

23. Apart from what you have already mentioned, in a **usual week** do you do any other moderate intensity leisure time physical activities like dancing, cycling, golf, or gardening?

O Yes O No → **If No, skip to Q. 26** | O No answer

24. In a **usual week**, how many times do you do **moderate intensity** leisure time physical activities?

☐☐ Number of Times → **If 0, skip to Q. 26** | O No answer

25. What do you estimate is the total time you spend doing **moderate intensity** leisure time physical activities in a **usual week**?

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total

That totals ___ **minutes /** ___ **hour(s) and** ___ **minutes**. Does that sound about right?

☐ Yes ☐ No ☐ No answer

Section VII: SMOKING

I would like to ask you about smoking.

26. Do you currently smoke cigarettes?

O Yes → **If Yes, continue to Q. 27**	O No → **If No, skip to Q. 28**	O No answer→ **Skip to Q. 28**

27. Do you smoke more than 10 cigarettes a day?

O Yes → **skip to Q. 30**	O No→ **skip to Q. 30**	O No answer→ **skip to Q. 30**

28. Have you ever smoked cigarettes?

O Yes→ **If Yes, continue to Q. 29**	O No → **If No, skip to Q. 30**	O No answer→ **skip to Q. 30**

29. How long ago did you smoke your last cigarette?

O Less than 1 month ago	O 1 month ago or longer	O No answer

Section VIII: ASK-12 Taking Medicine

How much do you agree/disagree with the following statements?

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
30. I just forget to take my medicines some of the time.	O	O	O	O	O
31. I run out of my medicine because I don't get refills on time.	O	O	O	O	O
32. Taking medicines more than once a day is inconvenient	O	O	O	O	O
33. I feel confident that each one of my medicines will help me.	O	O	O	O	O
34. I know if I am reaching my health goals.	O	O	O	O	O
35. I have someone I can call with questions about my medicines.	O	O	O	O	O
36. My doctor/nurse and I work together to make decisions.	O	O	O	O	O

Have you…

	In the last week	In the last month	In the last 3 months	More than 3 months ago	Never
37. Taken a medicine more or less often than prescribed?	O	O	O	O	O
38. Skipped or stopped taking a medicine because you didn't think it was working?	O	O	O	O	O
39. Skipped or stopped taking a medicine becuase it made you feel bad?	O	O	O	O	O
40. Skipped, stopped, not refilled, or taken less medicine becuase of the cost?	O	O	O	O	O
41. Not had medicine with you when it was time to take it?	O	O	O	O	O

Section IX: DEMOGRAPHIC AND HEALTH BACKGROUND

Thank you for sharing information about your diet and other health activities. This information will be very helpful for planning our sessions together. I have just a few more questions about your background and your health.

Has a health care provider ever told you that you have:

42.	Diabetes?	O Yes	O No	O No answer
43.	High cholesterol?	O Yes	O No	O No answer
44.	High blood pressure?	O Yes	O No	O No answer
45.	Cardiovascular disease?	O Yes	O No	O No answer
46.	Enlarged Heart?	O Yes	O No	O No answer
47.	Atrial Fibrillation?	O Yes	O No	O No answer

48. Do you take any medicines for high blood pressure?

O Yes O No O No answer

49. Do you take any medicines for high cholesterol?

O Yes O No O No answer

50. Do you take at least one aspirin a day?

O Yes O No O No answer

51. Do you take at least one aspirin a week?

O Yes O No O No answer

52. Registered in electronic patient messaging system for the clinic?

O Yes O No O No answer

53. How would you describe the health insurance plan(s) that you've had in the past 12 months? [*Check all that apply.*]

☐ No insurance or self-pay

☐ Medicaid

☐ Medicare

☐ Partners Medicare Choice

☐ Private insurance, such as Blue Cross Blue Shield, Aetna, United Healthcare, Cigna and so on

☐ No answer

54. What is your date of birth? ____/____/______
mm dd yyyy

55. How do you describe your sex? Do you describe yourself as:

O Female O Male O Other O No answer

56. What is the highest grade of school you have completed?

O Less than high school

O High school or GED

O Some college

O 2-yr college degree

O 4-yr college degree

O Masters or doctoral degree

O No answer

57. Would you describe yourself as Hispanic or Latino?

O Yes O No O No answer

58. What is your race? [*Check all that apply]*

☐ American Indian or Alaskan Native

☐ Asian

☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander

☐ White

☐ Unknown

☐ No answer

59. Are you currently living with a spouse or someone like a spouse or partner?

O Yes O No O No answer

Thank you for answering the questions on this survey.

CHANGE
Home Visit 1 –
Priority Selection

Pt ID ☐☐☐☐

Everyone can take steps to lower their chance of heart disease. For example:

- Choosing healthy foods more often
- Getting more physical activity
- Quitting smoking if you are a smoker
- Or taking cholesterol or blood pressure medicine that your doctor has prescribed (only for eligible participants enrolled by the RCCHC CHW)

During our sessions together, we will talk about a plan for heart health that includes topics and strategies that are important to you.

1. Which of these topics is most important to you right now?

O Healthy Eating

O Physical Activity

O Stopping Smoking

O Medication

Great! You've made a decision about how to lower your chances of heart disease. During this session we can talk about:

☐ How to work with your doctor to take medicines-to lower your heart disease risk
☐ How to have a healthy eating plan
☐ How to be more physically active
☐ How to get support to stop smoking

Continue to Modules

CHANGE
Home Visit 1 –
Summary Sheet

Pt ID | | | | |

Date: _______________
(mm/dd/yyyy)

Start time: **______:______ (AM or PM)** ***End Time:*** **______:______ (AM or PM)**

All questions on pages 1-2 should be answered (items 1-4). Transferring data from module worksheets to this data collection form are optional (items 5-8)

1. Medication adherence: Say to Participant: *Medications can really help to control your blood pressure and cholesterol.*

a. Would you say that you take all of your medications as prescribed?
- ☐ Always
- ☐ Most of the Time
- ☐ Sometimes
- ☐ Never

b. About how many pills are you supposed to take each week? ____________

c. During the last week, how many pills **do** you estimate that you actually were able to take? ____________

CHANGE
Home Visit 1 – Summary Sheet

Pt ID | | | | |

2. Indicate below which modules were covered:

	Medication	Smoking	Healthy Eating	Physical Activity
Which modules were covered?	☐	☐	☐	☐

If the information was *NOT* covered, indicate why the module was skipped

	Medication	Smoking	Healthy Eating	Physical Activity
Participant not eligible ***or*** not a smoker	☐	☐		
Not enough time	☐	☐	☐	☐
Participant not interested today	☐	☐	☐	☐
Other: (include reason below)	☐	☐	☐	☐

Other Reason(s)____

List below the order in which the modules were covered in this session.

Module 1: ____

Module 2: ____

3. Weight and Blood Pressure measurement:

Weight (average of 2 measurements): _____________________

Systolic BP (average of 3 measurements): _____________________

Diastolic BP (average of 3 measurements): _____________________

4. Other Attendees: ***Did anyone else attend the session with the participant?***

- ☐ Spouse or Partner
- ☐ Friend or Acquaintance
- ☐ Daughter or Son
- ☐ Parent
- ☐ Grandparent
- ☐ Aunt or Uncle
- ☐ Cousin
- ☐ Other relative

Indicate if they: Previously attended _______ Were referred to PCP_______

CHANGE
Home Visit 1 –
Summary Sheet

Pt ID | | | | |

5. Goals set for Session 1, Module 1:

Goal 1: ____

Goal 2: ____

6. Referrals made for Session 1, Module 1:

Referrals: ____

7. Goals set for Session 1, Module 2:

Goal 1: ____

Goal 2: ____

8. Referrals made for Session 1, Module 2:

Referrals: ____

At the End of the Session:

- ☐ Thank participant
- ☐ Review and summarize session
  - o Ask participant to describe specific goals that they will focus on during the coming weeks and any actions that will help them move toward accomplishing those goals
  - o Review referrals if needed
- ☐ Describe any action steps that you will take on participant's behalf
- ☐ Provide information about what to expect for the remainder of their participation in CHANGE
- ☐ Schedule next appointment
- ☐ Remind participant about how to reach you if needed
- ☐ Confirm date, time, purpose, and place of next contact

CHANGE
Carolina Heart Alliance
Networking for Greater Equity

CHANGE
Home Visit 1 –
Summary Sheet

Pt ID | | | |

Notes:

CHANGE
Home Visit 2 – Summary Sheet

Pt ID ☐☐☐☐

Date: ____________________
(mm/dd/yyyy)

Start time: ______:______ **(AM or PM)** ***End Time:*** ______:______ **(AM or PM)**

Prior to beginning the session, referrals made in session 1 and booster call 1 should be noted below in item 2 below. All questions on pages 1-2 should be answered (items 1-5). Transferring data from module worksheets to this data collection form are optional (items 6-9)

1. Medication adherence: Say to Participant: *Medications can really help to control your blood pressure and cholesterol.*

a. Would you say that you take all of your medications as prescribed?
- ☐ Always
- ☐ Most of the Time
- ☐ Sometimes
- ☐ Never

b. About how many pills are you supposed to take each week? ____________

c. During the last week, how many pills **do** you estimate that you actually were able to take? ____________

2. Checking in:
- ☐ Review goals set at the last session
- ☐ Review referrals made at last session (***List each referral and whether acted on***)

Referral 1: ________________________
Acted on?
☐ Yes ☐ No
Services being received?
☐ Yes ☐ No ☐ Not Sure

Referral 2: ________________________
Acted on?
☐ Yes ☐ No
Services being received?
☐ Yes ☐ No ☐ Not Sure

CHANGE
Home Visit 2 –
Summary Sheet

Pt ID ☐☐☐☐

3. Indicate below which modules were covered:

	Medication	Smoking	Healthy Eating	Physical Activity
Which modules were covered?	☐	☐	☐	☐

If the information was *NOT* covered, indicate why the module was skipped

	Medication	Smoking	Healthy Eating	Physical Activity
Participant not eligible ***or*** not a smoker	☐	☐		
Not enough time	☐	☐	☐	☐
Participant not interested today	☐	☐	☐	☐
Other: (include reason below)	☐	☐	☐	☐

Other Reason(s)____

List below the order in which the modules were covered in this session.

Module 1: ____

Module 2: ____

4. Weight and Blood Pressure measurement:

Weight (average of 2 measurements): _____________________

Systolic BP (average of 3 measurements): _____________________

Diastolic BP (average of 3 measurements): _____________________

5. Other Attendees: ***Did anyone else attend the session with the participant?***

- ☐ Spouse or Partner
- ☐ Friend or Acquaintance
- ☐ Daughter or Son
- ☐ Parent
- ☐ Grandparent
- ☐ Aunt or Uncle
- ☐ Cousin
- ☐ Other relative

Indicate if they: Previously attended _______ Were referred to PCP_______

6. Goals set for Session 2, Module 1:

Goal 1: ____

Goal 2: ____

7. Referrals made for Session 2, Module 1:

Referrals: ____

8. Goals set for Session 2, Module 2:

Goal 1: ____

Goal 2: ____

9. Referrals made for Session 2, Module 2:

Referrals: ____

At the End of the Session:

- ☐ Thank participant
- ☐ Review and summarize session
  - o Ask participant to describe specific goals that they will focus on during the coming weeks and any actions that will help them move toward accomplishing those goals
  - o Review referrals if needed
- ☐ Describe any action steps that you will take on participant's behalf
- ☐ Provide information about what to expect for the remainder of their participation in CHANGE
- ☐ Schedule next appointment
- ☐ Remind participant about how to reach you if needed
- ☐ Confirm date, time, purpose, and place of next contact

CHANGE
Carolina Heart Alliance
Networking for Greater Equity

CHANGE
Home Visit 2 –
Summary Sheet

Pt ID | | | | |

Notes:

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CHANGE
Home Visit 3 – Summary Sheet

Pt ID | | | | |

Date: ___________________
(mm/dd/yyyy)

Start time: ______:______ **(AM or PM)** ***End Time:*** ______:______ **(AM or PM)**

Prior to beginning the session, referrals made in sessions 1-2 and booster call 1-2 should be noted below in item 2. All questions on pages 1-2 should be answered (items 1-5). Transferring data from module worksheets to this data collection form are optional (items 6-9)

1. Medication adherence: Say to Participant: *Medications can really help to control your blood pressure and cholesterol.*

a. Would you say that you take all of your medications as prescribed?
- ☐ Always
- ☐ Most of the Time
- ☐ Sometimes
- ☐ Never

b. About how many pills are you supposed to take each week? ____________

c. During the last week, how many pills **do** you estimate that you actually were able to take? ____________

2. Checking in:

☐ Review goals set at the last session

☐ Review referrals made at last session (***List each referral and whether acted on***)

Referral 1: ______________________
Acted on?
☐ Yes ☐ No
Services being received?
☐ Yes ☐ No ☐ Not Sure

Referral 2: ______________________
Acted on?
☐ Yes ☐ No
Services being received?
☐ Yes ☐ No ☐ Not Sure

Referral 3: ______________________
Acted on?
☐ Yes ☐ No
Services being received?
☐ Yes ☐ No ☐ Not Sure

Referral 4: ______________________
Acted on?
☐ Yes ☐ No
Services being received?
☐ Yes ☐ No ☐ Not Sure

CHANGE
Home Visit 3 –
Summary Sheet

Pt ID ☐☐☐☐

3. Indicate below which modules were covered:

	Medication	Smoking	Healthy Eating	Physical Activity
Which modules were covered?	☐	☐	☐	☐

If the information was *NOT* covered, indicate why the module was skipped

	Medication	Smoking	Healthy Eating	Physical Activity
Participant not eligible ***or*** not a smoker	☐	☐		
Not enough time	☐	☐	☐	☐
Participant not interested today	☐	☐	☐	☐
Other: (include reason below)	☐	☐	☐	☐

Other Reason(s)____

List below the order in which the modules were covered in this session.

Module 1: ____

Module 2: ____

4. Weight and Blood Pressure measurement:

Weight (average of 2 measurements): _____________________

Systolic BP (average of 3 measurements): _____________________

Diastolic BP (average of 3 measurements): _____________________

5. Other Attendees: ***Did anyone else attend the session with the participant?***

- ☐ Spouse or Partner
- ☐ Friend or Acquaintance
- ☐ Daughter or Son
- ☐ Parent
- ☐ Grandparent
- ☐ Aunt or Uncle
- ☐ Cousin
- ☐ Other relative

Indicate if they: Previously attended _______ Were referred to PCP_______

6. Goals set for Session 3, Module 1:

Goal 1: ____

Goal 2: ____

7. Referrals made for Session 3, Module 1:

Referrals: ____

8. Goals set for Session 3, Module 2:

Goal 1: ____

Goal 2: ____

9. Referrals made for Session 3, Module 2:

Referrals: ____

At the End of the Session:

- ☐ Thank participant
- ☐ Review and summarize session
    - o Ask participant to describe specific goals that they will focus on during the coming weeks and any actions that will help them move toward accomplishing those goals
    - o Review referrals if needed
- ☐ Describe any action steps that you will take on participant's behalf
- ☐ Provide information about what to expect for the remainder of their participation in CHANGE
- ☐ Schedule next appointment
- ☐ Remind participant about how to reach you if needed
- ☐ Confirm date, time, purpose, and place of next contact

CHANGE
Carolina Heart Alliance
Networking for Greater Equity

CHANGE
Home Visit 3 –
Summary Sheet

Pt ID | | | | |

Notes:

CHANGE
Home Visit 4 –
Summary Sheet

Pt ID ☐☐☐☐

Date: ____________________
(mm/dd/yyyy)

Start time: **______:______ (AM or PM)** ***End Time:*** **______:______ (AM or PM)**

Prior to beginning the session, referrals made in sessions 1-3 and booster calls 1-3 should be noted below in item 2. All questions on pages 1-2 should be answered (items 1-5). Transferring data from module worksheets to this data collection form are optional (items 6-9)

1. Medication adherence: Say to Participant: *Medications can really help to control your blood pressure and cholesterol.*

a. Would you say that you take all of your medications as prescribed?
- ☐ Always
- ☐ Most of the Time
- ☐ Sometimes
- ☐ Never

b. About how many pills are you supposed to take each week? _____________

c. During the last week, how many pills **do** you estimate that you actually were able to take? _____________

2. Checking in:

☐ Review goals set at the last session

☐ Review referrals made at last session (***List each referral and whether acted on***)

Referral 1: _________________________

Acted on?
☐ Yes ☐ No

Services being received?
☐ Yes ☐ No ☐ Not Sure

Referral 2: _________________________

Acted on?
☐ Yes ☐ No

Services being received?
☐ Yes ☐ No ☐ Not Sure

Referral 3: _________________________

Acted on?
☐ Yes ☐ No

Services being received?
☐ Yes ☐ No ☐ Not Sure

Referral 4: _________________________

Acted on?
☐ Yes ☐ No

Services being received?
☐ Yes ☐ No ☐ Not Sure

CHANGE
Home Visit 4 –
Summary Sheet

Pt ID ☐☐☐☐

3. Indicate below which modules were covered:

	Medication	Smoking	Healthy Eating	Physical Activity
Which modules were covered?	☐	☐	☐	☐

If the information was *NOT* covered, indicate why the module was skipped

	Medication	Smoking	Healthy Eating	Physical Activity
Participant not eligible ***or*** not a smoker	☐	☐		
Not enough time	☐	☐	☐	☐
Participant not interested today	☐	☐	☐	☐
Other: (include reason below)	☐	☐	☐	☐

Other Reason(s)____

List below the order in which the modules were covered in this session.

Module 1: ____

Module 2: ____

4. Weight and Blood Pressure measurement:

Weight (average of 2 measurements): _____________________

Systolic BP (average of 3 measurements): _____________________

Diastolic BP (average of 3 measurements): _____________________

5. Other Attendees: ***Did anyone else attend the session with the participant?***

- ☐ Spouse or Partner
- ☐ Friend or Acquaintance
- ☐ Daughter or Son
- ☐ Parent
- ☐ Grandparent
- ☐ Aunt or Uncle
- ☐ Cousin
- ☐ Other relative

Indicate if they: Previously attended _______ Were referred to PCP_______

6. Goals set for Session 4, Module 1:

Goal 1: ____

Goal 2: ____

7. Referrals made for Session 4, Module 1:

Referrals: ____

8. Goals set for Session 4, Module 2:

Goal 1: ____

Goal 2: ____

9. Referrals made for Session 4, Module 2:

Referrals: ____

At the End of the Session:

- ☐ ***Complete the follow-up survey***
- ☐ Thank participant
- ☐ Review and summarize session
  - o Ask participant to describe specific goals that they will focus on during the coming weeks and any actions that will help them move toward accomplishing those goals
  - o Review referrals if needed
- ☐ Describe any action steps that you will take on participant's behalf
- ☐ Provide information to the participant about ending their participation in the study and remind them of the resources available in the community.

- ☐ ***Let the participant know someone from UNC Chapel Hill will be calling in the next week to ask some follow-up questions about their experience with the CHANGE program and they will receive $10 for their time.***
- ☐ ***Thank the participant for their thoughtful responses, and time and commitment in participating in the CHANGE study.***

CHANGE
Home Visit 4 –
Summary Sheet

Pt ID | | | |

Notes:

CHANGE
Medication Adherence

Pt ID | | | |

Date: ___________ **Study Visit Number:** __________

Home Visit Records are filled out by the CHW.

FOR CLINIC PATIENTS ONLY: Say to Participant:
Medications can really help to control your blood pressure and cholesterol. I brought a list of medicines that your doctor has prescribed for you.

Can we take a few minutes to compare this list with medicines that you are taking each day?

☐ Yes ☐ No, not interested or unable

Instructions: Review Quitting Smoking Session

Explore with Participant:
- What makes it hard for them to keep their goals?
- What supports them in keeping their goals

---

1. Discuss reasons why it may be hard to take medicines as prescribed. *Check each reason the participant listed as a problem.*

☐ Forget to take medicine
☐ Worried about side effects
☐ Need to get medicine refills
☐ Medicine costs too much or do not have insurance to cover medicine costs
☐ Not sure when or how to contact doctor's office
☐ Other____
☐ No problems taking medicines as prescribed

2. Did you use an electronic patient messaging system for the clinic to describe problems with side effects to the doctor?

☐ Yes→ **If Yes, go to Q.4** ☐ No→ **If No, continue to Q. 3**

3. We skipped using eClinical Works (eCW) because:

☐ Not enough time
☐ Participant not interested today
☐ No internet connection
☐ Other ____

4. Was this a new registration?

☐ Yes ☐ No

5. Is the participant willing to set one or two goals today?

☐ Yes→ **If Yes, continue to Q.6** ☐ No→ **If No, go to Q.7**

6. Which goal(s) did the participant set? *Check all that apply.*

☐ Buy a pillbox to help organize my medicines
☐ Set a timer to remind me to take medicines on schedule
☐ Fill out my medication calendar, so I can start tracking my medicine use tonight
☐ Make a list of my medicines to take to my next doctor appointment
☐ Other ____________________
☐ Other ____________________

7. Did you give any referrals for medication?

☐ Yes→ **If Yes, continue to Q.8** ☐ No→ **If No, go to Q.9**

8. What referrals did you make? *Choose from the list below or write in referrals.*

☐ Cardiopulmonary Connections, Rocky Mount Senior Center
☐ Chronic Disease Self-Management Program, Edgecombe County HD
☐ Diabetes Support Group, Edgecombe County HD
☐ Edgecombe Health Access, Vidant Edgecombe Hospital
☐ Walmart Pharmacy
☐ Freedom Hill Community Health Center
☐ Group Classes for Diabetes Support, Boice-Willis Clinic
☐ Men's Christian Fellowship Home
☐ NC Breast and Cervical Cancer Control Program, Edgecombe & Nash County HD
☐ OIC Family Medical Center
☐ Perdue Health Improvement Program, Perdue Farms
☐ Rocky Mount Senior Center
☐ Senior Transportation
☐ The Wright's Adult Day Health Care Center
☐ Vidant Multispecialty Clinic
☐ Women, Infants and Children (WIC), Edgecombe County HD
☐ Good Neighbor Pharmacy Prescription Savings Club, Thorne Drug Company
☐ Nash County Medicaid Transportation
☐ Perdue Associate Wellness Center, Perdue Farms
☐ Ride Tar River Transit
☐ Rite Aid Pharmacy
☐ Seniors Health Insurance Information
☐ Walgreens Pharmacy
☐ Walmart Pharmacy
☐ Other____________________
☐ Other____________________

9. Describe why no referrals were offered. *Choose from the list below or write in other reason.*

☐ Participant not interested ☐ Not enough time ☐ I need to do some research
☐ Other ____________________

CHANGE
Stopping Smoking

Pt ID ☐☐☐☐

Date: ___________ **Study Visit Number:** __________

Home Visit Records are filled out by the CHW

Instructions: Review Quitting Smoking Session

Explore with Participant:
- What makes it hard for them to keep their goals?
- What supports them in keeping their goals?

---

1. Is participant willing to make a plan to quit smoking?

☐ Yes ☐ No

2. Is the participant willing to set one or two goals today?

☐ Yes→ **If Yes, continue to Q.3** ☐ No→ **If No, go to Q.4**

3. Which goal(s) did the participant set? *Check all that apply.*

☐ Ask for a referral to QuitLineNC

☐ Call the QuitLineNC at 800-QUIT-NOW or 800-784-8669

☐ Talk to my doctor about Nicotine Replacement Therapy to help me quit smoking.

☐ Other ____

4. Did you give any referrals for smoking today?

☐ Yes → **If Yes, continue to Q.5** ☐ No→ **If No, go to Q.6**

5. What referrals did you make? *Choose from the list below or write in other.*

☐ Edgecombe Health Access, Vidant Edgecombe Hospital
☐ Fresh Start Tobacco Program
☐ NC Breast and Cervical Cancer Control Program - Edgecombe & Nash County HD
☐ OIC Family Medical Center
☐ Perdue Health Improvement Program, Perdue Farms
☐ QuitlineNC
☐ Vidant Multispecialty Clinic
☐ Women, Infants and Children (WIC), Edgecombe County Health Department
☐ Other____
☐ Other____

6. Describe why no referrals were offered. *Choose from the list below or write in other reason.*

☐ Participant not interested
☐ Not enough time
☐ I need to do some research
☐ Other____

CHANGE Carolina Heart Alliance Networking for Greater Equity

CHANGE
Healthy Eating – Module 1

ID | | | |

Date: ___________ **Study Visit Number:** __________

Home Visit Records are filled out by the CHW

Review Healthy Eating Session 1 (Nuts, Oils, Dressing and Spreads)

Explore with Participant:
- What makes it hard for them to keep their healthy eating goals?
- What supports them in keeping their healthy eating goals?

1. Is participant willing to set one or two goals today?

☐ Yes → **If Yes, continue to Q.2** ☐ No→ **If No, go to Q.3**

2. Which goal(s) did the participant set? *Check all that apply.*

☐ Eat three or more servings of nuts or peanut butter each week

☐ Choose trans free fat margarine

☐ Cook with healthy oils

☐ Eat three or more servings of healthy salad dressing each week

☐ Other ____

☐ Other ____

3. Did you give any referrals for healthy eating today?

☐ Yes → **If Yes, continue to Q.4** ☐ No→ **If No, go to Q.5**

4. What referrals did you make? *Choose from the list below or write in other referral.*

- ☐ Abundant Life Ministries
- ☐ Cardiopulmonary Connections, Rocky Mount Senior Center
- ☐ Chronic Disease Self-Management Program, Edgecombe County HD
- ☐ Edgecombe Health Access, Vidant Edgecombe Hospital
- ☐ Freedom Hill Community Health Center
- ☐ Group Classes for Diabetes Support, Boice-Willis Clinic
- ☐ Harrison Family YMCA
- ☐ Hobgood Citizens Group
- ☐ Men's Christian Fellowship Home
- ☐ NC Breast and Cervical Cancer Control Program - Edgecombe & Nash County HD
- ☐ OIC Family Medical Center
- ☐ Our Lady of Perpetual Help
- ☐ Perdue Health Improvement Program, Perdue Farms
- ☐ Project Hope Ministries
- ☐ Rocky Mount Farmers Market
- ☐ Rocky Mount Senior Center
- ☐ Senior Transportation
- ☐ Tarboro Community Outreach, Inc.
- ☐ Tarboro-Edgecombe Farmers Market
- ☐ Vidant Multispecialty Clinic
- ☐ Weight Loss Management, Health First Rehabilitation and Fitness Center
- ☐ Women, Infants and Children (WIC), Edgecombe County Health Department
- ☐ Other ____
- ☐ Other ____

5. Describe why no referrals were offered. *Choose from the list or write in other reason.*

- ☐ Participant not interested
- ☐ Not enough time
- ☐ I need to do some research
- ☐ Other _________________

CHANGE Carolina Heart Alliance Networking for Greater Equity

CHANGE
Healthy Eating – Module 2

ID | | | | |

Date: ___________ **Study Visit Number:** __________

Home Visit Records are filled out by the CHW

Review Healthy Eating Session 2 (Vegetables, Fruits, Beans and Whole Grains)

Explore with Participant:

- What makes it hard for them to keep their healthy eating goals?
- What supports them in keeping their healthy eating goals?

1. Is participant willing to set one or two goals today?

☐ Yes → **If Yes, continue to Q.2** ☐ No→ **If No, go to Q.3**

2. Which goal(s) did the participant set? *Check all that apply.*

☐ Eat 4 or more servings of vegetables each day

☐ Try to eat 3 servings of fruit each day

☐ Try to eat beans 3 or more times each week

☐ Choose whole grain breads

☐ Try more whole grain foods (brown rice, whole wheat pasta, etc)

☐ Eat more whole grains for breakfast

☐ Other____

☐ Other____

3. Did you give any referrals for healthy eating today?

☐ Yes → **If Yes, continue to Q.4** ☐ No→ **If No, go to Q.5**

4. What referrals did you make? *Choose from the list below or write in other referral.*

- ☐ Abundant Life Ministries
- ☐ Cardiopulmonary Connections, Rocky Mount Senior Center
- ☐ Chronic Disease Self-Management Program, Edgecombe County HD
- ☐ Edgecombe Health Access, Vidant Edgecombe Hospital
- ☐ Freedom Hill Community Health Center
- ☐ Group Classes for Diabetes Support, Boice-Willis Clinic
- ☐ Harrison Family YMCA
- ☐ Hobgood Citizens Group
- ☐ Men's Christian Fellowship Home
- ☐ NC Breast and Cervical Cancer Control Program - Edgecombe & Nash County HD
- ☐ OIC Family Medical Center
- ☐ Our Lady of Perpetual Help
- ☐ Perdue Health Improvement Program, Perdue Farms
- ☐ Project Hope Ministries
- ☐ Rocky Mount Farmers Market
- ☐ Rocky Mount Senior Center
- ☐ Senior Transportation
- ☐ Tarboro Community Outreach, Inc.
- ☐ Tarboro-Edgecombe Farmers Market
- ☐ Vidant Multispecialty Clinic
- ☐ Weight Loss Management, Health First Rehabilitation and Fitness Center
- ☐ Women, Infants and Children (WIC), Edgecombe County Health Department
- ☐ Other ____
- ☐ Other ____

5. Describe why no referrals were offered. *Choose from the list or write in other reason.*

- ☐ Participant not interested
- ☐ Not enough time
- ☐ I need to do some research
- ☐ Other _________________

CHANGE
Carolina Heart Alliance
Networking for Greater Equity

CHANGE
Healthy Eating – Module 3

ID | | | |

Date: ___________ **Study Visit Number:** __________

Home Visit Records are filled out by the CHW

Review Healthy Eating Session 3 (Drinks, Desserts, Snacks and Eating Out)

Explore with Participant:
- What makes it hard for them to keep their healthy eating goals?
- What supports them in keeping their healthy eating goals?

1. Is participant willing to set one or two goals today?

☐ Yes → **If Yes, continue to Q.2** ☐ No→ **If No, go to Q.3**

2. Which goal(s) did the participant set? *Check all that apply.*

☐ Choose healthy drinks

☐ Watch out for unhealthy sweets desserts and snacks

☐ Be careful with snack chips and crackers

☐ Make good choices when you eat at restaurants

☐ Other ___________________________________

☐ Other ___________________________________

3. Did you give any referrals for healthy eating today?

☐ Yes → **If Yes, continue to Q.4** ☐ No→ **If No, go to Q.5**

4. What referrals did you make? *Choose from the list below or write in other referral.*

- ☐ Abundant Life Ministries
- ☐ Cardiopulmonary Connections, Rocky Mount Senior Center
- ☐ Chronic Disease Self-Management Program, Edgecombe County HD
- ☐ Edgecombe Health Access, Vidant Edgecombe Hospital
- ☐ Freedom Hill Community Health Center
- ☐ Group Classes for Diabetes Support, Boice-Willis Clinic
- ☐ Harrison Family YMCA
- ☐ Hobgood Citizens Group
- ☐ Men's Christian Fellowship Home
- ☐ NC Breast and Cervical Cancer Control Program - Edgecombe & Nash County HD
- ☐ OIC Family Medical Center
- ☐ Our Lady of Perpetual Help
- ☐ Perdue Health Improvement Program, Perdue Farms
- ☐ Project Hope Ministries
- ☐ Rocky Mount Farmers Market
- ☐ Rocky Mount Senior Center
- ☐ Senior Transportation
- ☐ Tarboro Community Outreach, Inc.
- ☐ Tarboro-Edgecombe Farmers Market
- ☐ Vidant Multispecialty Clinic
- ☐ Weight Loss Management, Health First Rehabilitation and Fitness Center
- ☐ Women, Infants and Children (WIC), Edgecombe County Health Department
- ☐ Other ____
- ☐ Other ____

5. Describe why no referrals were offered. *Choose from the list or write in other reason.*

- ☐ Participant not interested
- ☐ Not enough time
- ☐ I need to do some research
- ☐ Other ________________

CHANGE
Carolina Heart Alliance
Networking for Greater Equity

CHANGE
Healthy Eating – Module 4

ID | | | | |

Date: ____________ **Study Visit Number:** ___________

Home Visit Records are filled out by the CHW

Review Healthy Eating Session 4 (Fish, Meat, Dairy and Eggs)

Explore with Participant:
- What makes it hard for them to keep their healthy eating goals?
- What supports them in keeping their healthy eating goals?

1. Is participant willing to set one or two goals today?

☐ Yes → **If Yes, continue to Q.2** ☐ No→ **If No, go to Q.3**

2. Which goal(s) did the participant set? *Check all that apply.*

☐ Eat fish 1 or more times each week

☐ Cut down on bacon sausage, hot dogs and cold cuts

☐ Choose chicken and turkey more often

☐ Cut down on red meat

☐ Choose dairy products like milk, cheese and yogurt to replace less healthy meats

☐ Eggs are a good choice

☐ Other _____________________________________

☐ Other _____________________________________

3. Did you give any referrals for healthy eating today?

☐ Yes → **If Yes, continue to Q.4** ☐ No→ **If No, go to Q.5**

4. What referrals did you make? *Choose from the list below or write in other referral.*

- ☐ Abundant Life Ministries
- ☐ Cardiopulmonary Connections, Rocky Mount Senior Center
- ☐ Chronic Disease Self-Management Program, Edgecombe County HD
- ☐ Edgecombe Health Access, Vidant Edgecombe Hospital
- ☐ Freedom Hill Community Health Center
- ☐ Group Classes for Diabetes Support, Boice-Willis Clinic
- ☐ Harrison Family YMCA
- ☐ Hobgood Citizens Group
- ☐ Men's Christian Fellowship Home
- ☐ NC Breast and Cervical Cancer Control Program - Edgecombe & Nash County HD
- ☐ OIC Family Medical Center
- ☐ Our Lady of Perpetual Help
- ☐ Perdue Health Improvement Program, Perdue Farms
- ☐ Project Hope Ministries
- ☐ Rocky Mount Farmers Market
- ☐ Rocky Mount Senior Center
- ☐ Senior Transportation
- ☐ Tarboro Community Outreach, Inc.
- ☐ Tarboro-Edgecombe Farmers Market
- ☐ Vidant Multispecialty Clinic
- ☐ Weight Loss Management, Health First Rehabilitation and Fitness Center
- ☐ Women, Infants and Children (WIC), Edgecombe County Health Department
- ☐ Other ____
- ☐ Other ____

5. Describe why no referrals were offered. *Choose from the list or write in other reason.*

- ☐ Participant not interested
- ☐ Not enough time
- ☐ I need to do some research
- ☐ Other ________________

CHANGE
Carolina Heart Alliance
Networking for Greater Equity

CHANGE
Physical Activity – Module 1

Pt ID

Date: ___________ **Study Visit Number:** __________

Home Visit Records are filled out by the CHW

Instructions: Review Physical Activity Module 1 (*Walking*)

Explore with Participant:

- What makes it hard for them to keep their goals?
- What supports them in keeping their goals?

---

1. Is participant willing to set one or two goals today?

☐ Yes → **If Yes, continue to Q.2** ☐ No→ **If No, go to Q.6**

2. Is participant ready to set a goal of walking more each week?

☐ Yes → **If Yes, continue to Q.3** ☐ No→ **If No, go to Q.4**

3. Participant plans to take a ____ minute walk at least ____ times per week.

4. Would the participant like to set another goal for the coming month?

☐ Yes → **If Yes, continue to Q.5** ☐ No→ **If No, go to Q.6**

5. Which goal(s) did the participant set? *Check all that apply.*

☐ Do errands or visit neighbors "on foot"
☐ Use stairs instead of elevators
☐ Use the farthest safe parking space when you drive, instead of the closest
☐ Go for a few 10-minute walking breaks during the day
☐ Other____
☐ Other____

6. Did you give any referrals for physical activity today?

☐ Yes → **If Yes, continue to Q.7** ☐ No→ **If No, go to Q.8**

7. What referrals did you make? *Choose from the list below or write in referrals.*

- ☐ Bailey-Middlesex Park
- ☐ Cardiopulmonary Connections, Rocky Mount Senior Center
- ☐ Chronic Disease Self-Management Program, Edgecombe County HD
- ☐ City Lake
- ☐ Diabetes Support Group, Edgecombe County Health Department
- ☐ Edgecombe Health Access, Vidant Edgecombe Hospital
- ☐ Freedom Hill Community Health Center
- ☐ Group Classes for Diabetes Support, Boice-Willis Clinic
- ☐ Harrison Family YMCA
- ☐ Indian Lake Sports Complex
- ☐ J.W. Glover Memorial Park & Complex
- ☐ Nash Community College LiveWell & Learn Trail
- ☐ OIC Family Medical Center
- ☐ Perdue Health Improvement Program, Perdue Farms
- ☐ Princeville Heritage Park
- ☐ Rocky Mount Farmers Market
- ☐ Rocky Mount Senior Center
- ☐ Rocky Mount Sports Complex
- ☐ South Rocky Mount Community Center, Rocky Mount Parks & Recreation
- ☐ Spring Hope Park
- ☐ Sunset Park
- ☐ Tarboro Recreation Center
- ☐ The Wright's Adult Day Health Care Center
- ☐ Vidant Multispecialty Clinic
- ☐ W.B. Ennis Memorial Park
- ☐ Weight Loss Management, Health First Rehabilitation and Fitness Center
- ☐ Whitakers Town Park
- ☐ Women, Infants and Children (WIC), Edgecombe County Health Department
- ☐ Other ______________________
- ☐ Other ______________________

8. Describe why no referrals were offered. *Choose from the list below or write in other reason.*

☐ Participant not interested ☐ Not enough time ☐ I need to do some research

☐ Other____

CHANGE Carolina Heart Alliance Networking for Greater Equity

CHANGE
Physical Activity – Module 2

ID | | | |

Date: ___________ **Study Visit Number:** __________

Home Visit Records are filled out by the CHW

Instructions: Review Physical Activity Module 2 (*Keep Walking! And increase Other Physical Activities)*

Explore with Participant:
- What makes it hard for them to keep their goals?
- What supports them in keeping their goals?

---

1. Is participant willing to set one or two goals today?

☐ Yes → **If Yes, continue to Q.2** ☐ No→ **If No, go to Q.3**

2. Which goal(s) did the participant set? *Check all that apply.*

☐ Increase the pace of my chores or housework

☐ Increase the pace of my yardwork

☐ Play with children more

☐ When I am working at my desk or watching TV, take short breaks every 30 minutes or so to walk around

☐ Add a new type of physical activity to my exercise routine
- ☐ An exercise class
- ☐ Dancing
- ☐ Chair exercises (see handout)
- ☐ Strengthening exercises (see handout)
- ☐ Other ____

☐ Other___________________________________

☐ Other ___________________________________

3. Did you give any referrals for physical activity today?

☐ Yes → **If Yes, continue to Q.7** ☐ No→ **If No, go to Q.8**

4. What referrals did you make? *Choose from the list below or write in referrals.*

- ☐ Bailey-Middlesex Park
- ☐ Cardiopulmonary Connections, Rocky Mount Senior Center
- ☐ Chronic Disease Self-Management Program, Edgecombe County HD
- ☐ City Lake
- ☐ Diabetes Support Group, Edgecombe County Health Department
- ☐ Edgecombe Health Access, Vidant Edgecombe Hospital
- ☐ Freedom Hill Community Health Center
- ☐ Group Classes for Diabetes Support, Boice-Willis Clinic
- ☐ Harrison Family YMCA
- ☐ Indian Lake Sports Complex
- ☐ J.W. Glover Memorial Park & Complex
- ☐ Nash Community College LiveWell & Learn Trail
- ☐ OIC Family Medical Center
- ☐ Perdue Health Improvement Program, Perdue Farms
- ☐ Princeville Heritage Park
- ☐ Rocky Mount Farmers Market
- ☐ Rocky Mount Senior Center
- ☐ Rocky Mount Sports Complex
- ☐ South Rocky Mount Community Center, Rocky Mount Parks & Recreation
- ☐ Spring Hope Park
- ☐ Sunset Park
- ☐ Tarboro Recreation Center
- ☐ The Wright's Adult Day Health Care Center
- ☐ Vidant Multispecialty Clinic
- ☐ W.B. Ennis Memorial Park
- ☐ Weight Loss Management, Health First Rehabilitation and Fitness Center
- ☐ Whitakers Town Park
- ☐ Women, Infants and Children (WIC), Edgecombe County Health Department
- ☐ Other ______________________
- ☐ Other ______________________

5. Describe why no referrals were offered. *Choose from the list below or write in other reason.*

☐ Participant not interested ☐ Not enough time ☐ I need to do some research

☐ Other____

CHANGE Carolina Heart Alliance Networking for Greater Equity

CHANGE
Physical Activity – Module 3

ID | | | | |

Date: ___________ **Study Visit Number:** __________

Home Visit Records are filled out by the CHW

Instructions: Review Physical Activity Module 3 (*Staying on Track)*

Explore with Participant:
- What makes it hard for them to keep their goals?
- What supports them in keeping their goals?

---

1. Is participant willing to set one or two goals today?

☐ Yes → **If Yes, continue to Q.2** ☐ No→ **If No, go to Q.3**

2. Which goal(s) did the participant set? *Check all that apply.*

☐ Goals to help cope with feeling tired

☐ Goals to help cope with not having enough time

☐ Goals to help cope with my concerns about the weather

☐ Goals to help cope with not liking exercising by myself

☐ Goals to help cope with getting bored by exercise

☐ Goals to help cope with feeling sore or uncomfortable

☐ Goals to help cope with concerns about how much exercise costs

☐ Goals to help cope with forgetting to be physically active

☐ Other___________________________________

☐ Other _________________________________

3. Did you give any referrals for physical activity today?

☐ Yes → **If Yes, continue to Q.7** ☐ No→ **If No, go to Q.8**

4. What referrals did you make? *Choose from the list below or write in referrals.*

- ☐ Bailey-Middlesex Park
- ☐ Cardiopulmonary Connections, Rocky Mount Senior Center
- ☐ Chronic Disease Self-Management Program, Edgecombe County HD
- ☐ City Lake
- ☐ Diabetes Support Group, Edgecombe County Health Department
- ☐ Edgecombe Health Access, Vidant Edgecombe Hospital
- ☐ Freedom Hill Community Health Center
- ☐ Group Classes for Diabetes Support, Boice-Willis Clinic
- ☐ Harrison Family YMCA
- ☐ Indian Lake Sports Complex
- ☐ J.W. Glover Memorial Park & Complex
- ☐ Nash Community College LiveWell & Learn Trail
- ☐ OIC Family Medical Center
- ☐ Perdue Health Improvement Program, Perdue Farms
- ☐ Princeville Heritage Park
- ☐ Rocky Mount Farmers Market
- ☐ Rocky Mount Senior Center
- ☐ Rocky Mount Sports Complex
- ☐ South Rocky Mount Community Center, Rocky Mount Parks & Recreation
- ☐ Spring Hope Park
- ☐ Sunset Park
- ☐ Tarboro Recreation Center
- ☐ The Wright's Adult Day Health Care Center
- ☐ Vidant Multispecialty Clinic
- ☐ W.B. Ennis Memorial Park
- ☐ Weight Loss Management, Health First Rehabilitation and Fitness Center
- ☐ Whitakers Town Park
- ☐ Women, Infants and Children (WIC), Edgecombe County Health Department
- ☐ Other ______________________
- ☐ Other ______________________

5. Describe why no referrals were offered. *Choose from the list below or write in other reason.*

☐ Participant not interested ☐ Not enough time ☐ I need to do some research

☐ Other____

CHANGE Carolina Heart Alliance Networking for Greater Equity

CHANGE
Physical Activity 4

ID ☐☐☐☐

Date: ___________ **Study Visit Number:** __________

Home Visit Records are filled out by the CHW

Instructions: Review Physical Activity Module 4 (*Add Muscle Strengthening and Stay Active*)

Explore with Participant:
- What makes it hard for them to keep their goals?
- What supports them in keeping their goals?

---

1. Is participant willing to set one or two goals today?

☐ Yes → **If Yes, continue to Q.2** ☐ No→ **If No, go to Q.3**

2. Which goal(s) did the participant set? *Check all that apply.*

☐ Find places where I can be active

☐ Find small ways to increase the pace or time with activities I am already doing

☐ Find a walking buddy or a walking group

☐ Plan activities with children

☐ Invite friends and family to join me

☐ Keep an activity log or diary

☐ Share my progress with family and friends

☐ Other___________________________________

☐ Other __________________________________

3. Did you give any referrals for physical activity today?

☐ Yes → **If Yes, continue to Q.7** ☐ No→ **If No, go to Q.8**

4. What referrals did you make? *Choose from the list below or write in referrals.*

- ☐ Bailey-Middlesex Park
- ☐ Cardiopulmonary Connections, Rocky Mount Senior Center
- ☐ Chronic Disease Self-Management Program, Edgecombe County HD
- ☐ City Lake
- ☐ Diabetes Support Group, Edgecombe County Health Department
- ☐ Edgecombe Health Access, Vidant Edgecombe Hospital
- ☐ Freedom Hill Community Health Center
- ☐ Group Classes for Diabetes Support, Boice-Willis Clinic
- ☐ Harrison Family YMCA
- ☐ Indian Lake Sports Complex
- ☐ J.W. Glover Memorial Park & Complex
- ☐ Nash Community College LiveWell & Learn Trail
- ☐ OIC Family Medical Center
- ☐ Perdue Health Improvement Program, Perdue Farms
- ☐ Princeville Heritage Park
- ☐ Rocky Mount Farmers Market
- ☐ Rocky Mount Senior Center
- ☐ Rocky Mount Sports Complex
- ☐ South Rocky Mount Community Center, Rocky Mount Parks & Recreation
- ☐ Spring Hope Park
- ☐ Sunset Park
- ☐ Tarboro Recreation Center
- ☐ The Wright's Adult Day Health Care Center
- ☐ Vidant Multispecialty Clinic
- ☐ W.B. Ennis Memorial Park
- ☐ Weight Loss Management, Health First Rehabilitation and Fitness Center
- ☐ Whitakers Town Park
- ☐ Women, Infants and Children (WIC), Edgecombe County Health Department
- ☐ Other ______________________
- ☐ Other ______________________

5. Describe why no referrals were offered. *Choose from the list below or write in other reason.*

☐ Participant not interested ☐ Not enough time ☐ I need to do some research

☐ Other____

CHANGE Carolina Heart Alliance Networking for Greater Equity	**CHANGE** Follow-up Survey	*Pt ID* ☐☐☐☐

Date: __ __ - __ __ - __ __ __ __
M M D D Y Y Y Y

SECTION I: INTRODUCTION

Before we end, I'd like to take a few minutes to ask you some survey questions about what kinds of foods you eat, your physical activity and other health habits. These survey questions are the same questions I asked you at the start of our first session a few months ago.

My first questions are about foods that you eat.

SECTION II: FRUITS AND VEGETABLES

Think about your eating habits over the past month. About how often do you eat or drink each of the following foods? Remember breakfast, lunch, dinner, snacks and eating out. Answer for each of these foods:

[Read each answer choice (except "No Answer") aloud before selecting the participant's answer.]

	Less than 1 WEEK	Once a WEEK	2-3 times a WEEK	4-6 times a WEEK	Once a DAY	2+ a DAY	No answer
1. Fruit juice, like orange, apple, grape, fresh frozen or canned (Not sodas or other drinks.)	O	O	O	O	O	O	O
2. Any fruit, fresh or canned (Not counting juice.)	O	O	O	O	O	O	O
3. Vegetable juice, like tomato juice, V-8, carrot	O	O	O	O	O	O	O
4. Green salad	O	O	O	O	O	O	O
5. Potatoes, any kind, including baked, mashed or French fried	O	O	O	O	O	O	O
6. Vegetable soup or stew with vegetables	O	O	O	O	O	O	O
7. Any other vegetables, including string beans, peas, corn, broccoli or any other kind	O	O	O	O	O	O	O

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Section III: BEVERAGES

I'd also like to ask you…

8. On an average day, how many 12-ounce servings of sugar-sweetened beverages do you drink with meals or in between meals? One regular can of beverage is 12 ounces. Sugar-sweetened beverages include regular non-diet sodas, bottled fruit drinks, Kool-Aid, iced or hot coffee or tea that has been sweetened with sugar (including drinks like Coke, Pepsi, Sprite, Snapple, lemonade, or Fruitade and sports or energy drinks).

Would you say:

O 0	O 1	O 2+	O No answer

Section IV: FATS

9. In an average week, how many servings of peanut butter or nuts (like almond, pecans, walnuts, or cashews) do you usually eat?

Would you say:

O 0-1	O 2	O 3+	O No answer

10. What type of butter or margarine do you usually use?

Is it:

O Tub margarine or other trans-fat free	O Butter	O Stick margarine	O No answer

Section V: PHYSICAL ACTIVITY - PART A

My next questions are about walking and any other physical activities.

11. In a **usual week**, do you walk to get to or from somewhere (such as walking to a store or bus stop), for recreation, health or fitness (including walking your dog)?

O Yes O No → **If No, skip to Q. 18** O No answer

I'd like to ask you about two types of walking. First there is walking for transportation (for example, walking to the store or work). Second there is walking for recreation, health and fitness.

12. The first questions are about **walking for transportation**. In a usual week, how many times do you walk **as a means of transportation**, such as going to and from work, walking to the store, or walking to a bus stop?

☐☐ Number of Times → **If 0, skip to Q. 15** O No answer

Walking for Transportation

13. Please estimate the total time you spend walking as **a means of transportation** in a **usual week**.

[If needed, use the physical activity worksheet to collect information. Then enter answers under each day of the week. If participant does not walk on any given day, enter 0.]

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total

That totals ___ **minutes /** ___ **hour(s) and** ___ **minutes**. Does that sound about right?

O Yes O No O No answer

14. Let me know which of the following places you walk to as a **means of transportation** in a **usual week.** *[Mark all that apply.]*

☐ To or from work (or school)

☐ To or from bus stop

☐ To or from store

☐ To or from restaurant

☐ To or from a friend's house

☐ Other #1 ______________________________

☐ Other #2 ______________________________

☐ No answer

Walking for Recreation, Health or Fitness

If you already reported recreational walking, please do not report it again for the following questions.

15. In a usual week, how many times do you walk for **recreation, health** or **fitness** (including walking your dog)?

☐☐ Number of Times → **If 0, skip to Q. 18** O No answer

16. Please estimate the total time you spend walking for **recreation, health or fitness** in a usual week.

[*If needed, use the physical activity worksheet to collect information. Then enter participant answers below under each day of the week. If participant does not walk on any given day, enter 0.]*

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total

That totals ___ **minutes / ___ hour(s) and ___ minutes**. Does that sound about right?

O Yes O No O No answer

17. Could you tell me where you walk for recreation, health or fitness in a usual week? *[Mark all that apply.]*

☐ Park

☐ Neighborhood

☐ School

☐ Fitness center

☐ To or from restaurant

☐ To or from a store

☐ Other #1 ____

☐ Other #2 ____

☐ No answer

Section VI: PHYSICAL ACTIVITY - PART B

The next set of questions is about **other leisure time physical activities** that you do in a **usual week**, besides what you have already mentioned. **Do not include walking.**

18. In a **usual week**, do you do any other **vigorous or moderate intensity** physical activity during your leisure time?

O Yes	O No → **If No, skip to Q. 26**	O No answer

19. Can you tell me where you do **vigorous or moderate intensity** physical activities in a **usual week**? [*Mark all that apply.]*

☐ Park

☐ Neighborhood

☐ School

☐ Fitness center

☐ Other #1 ____

☐ Other #2 ____

☐ No answer

I'm going to ask you more about **vigorous intensity** leisure activities first. Then, I'll ask you about moderate intensity leisure activities. Vigorous intensity physical activities cause a large increase in breathing and heart rate.

(a). Vigorous Leisure Activities

20. In a **usual week** do you do any **vigorous intensity** leisure time physical activities like jogging, aerobics, swimming laps, or competitive tennis? Do not include walking or moderate intensity physical activities.

O Yes	O No → **If No, skip to Q. 23**	O No answer

21. In a **usual week**, how many times do you do **vigorous intensity** leisure time physical activities which cause a large increase in breathing and heart rate?

☐☐ Number of Times → **If 0, skip to Q. 23** | O No answer

22. What do you estimate is the total time you spend doing **vigorous intensity** leisure time physical activities in a **usual week**?

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total

The total time you spend doing vigorous intensity physical activity is ___ **minutes / ___ hour(s) and ___ minutes**. Does that sound about right?

O Yes O No | O No answer

(b). Moderate Leisure Activities

23. Apart from what you have already mentioned, in a **usual week** do you do any other moderate intensity leisure time physical activities like dancing, cycling, golf, or gardening?

O Yes O No → **If No, skip to Q. 26** | O No answer

24. In a **usual week**, how many times do you do **moderate intensity** leisure time physical activities?

☐☐ Number of Times → **If 0, skip to Q. 26** | O No answer

25. What do you estimate is the total time you spend doing **moderate intensity** leisure time physical activities in a **usual week**?

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total

That totals ___ **minutes / ___ hour(s) and ___ minutes**. Does that sound about right?

O Yes O No | O No answer

Section VII: SMOKING

I would like to ask you about smoking.

26. Do you currently smoke cigarettes?

O Yes → **If Yes, continue to Q. 27**	O No → **If No, skip to Q. 28**	O No answer→ **Skip to Q. 28**

27. Do you smoke more than 10 cigarettes a day?

O Yes → **skip to Q. 30**	O No→ **skip to Q. 30**	O No answer→ **skip to Q. 30**

28. Have you ever smoked cigarettes?

O Yes→ **If Yes, continue to Q. 29**	O No → **If No, skip to Q. 30**	O No answer→ **skip to Q. 30**

29. How long ago did you smoke your last cigarette?

O Less than 1 month ago	O 1 month ago or longer	O No answer

Section VIII: ASK-12 Taking Medicine

How much do you agree/disagree with the following statements?

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
30. I just forget to take my medicines some of the time.	O	O	O	O	O
31. I run out of my medicine because I don't get refills on time.	O	O	O	O	O
32. Taking medicines more than once a day is inconvenient	O	O	O	O	O
33. I feel confident that each one of my medicines will help me.	O	O	O	O	O
34. I know if I am reaching my health goals.	O	O	O	O	O
35. I have someone I can call with questions about my medicines.	O	O	O	O	O
36. My doctor/nurse and I work together to make decisions.	O	O	O	O	O

Have you…

	In the last week	In the last month	In the last 3 months	More than 3 months ago	Never
37. Taken a medicine more or less often than prescribed?	O	O	O	O	O
38. Skipped or stopped taking a medicine because you didn't think it was working?	O	O	O	O	O
39. Skipped or stopped taking a medicine becuase it made you feel bad?	O	O	O	O	O
40. Skipped, stopped, not refilled, or taken less medicine becuase of the cost?	O	O	O	O	O
41. Not had medicine with you when it was time to take it?	O	O	O	O	O

Section IX: DEMOGRAPHIC AND HEALTH BACKGROUND

42. Do you take any medicines for high blood pressure?

O Yes O No O No answer

43. Do you take any medicines for high cholesterol?

O Yes O No O No answer

44. Do you take at least one aspirin a day?

O Yes O No O No answer

44. Do you take at least one aspirin a week?

O Yes O No O No answer

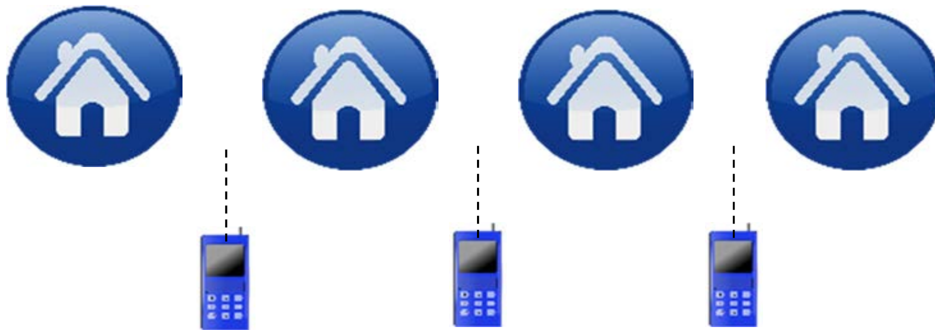
Thank you for answering the questions on this survey.

Participant Flow Diagram

Taking part in the CHANGE Program means you can expect these things to happen:

- You have **4 monthly in-person visits** with your 'coach'. These visits can happen **at your home** or at another place that you choose.

- Your 'coach' will **call you between these monthly visits** to check in and see how you are doing with your goals. There are 3 calls in the program.



At your **first in-person visit**, here is what will happen:

Your coach will …

- Tell you about the CHANGE program and have you fill out paperwork as needed.

- Give you a CHANGE program handbook with lots of information about how to make healthy changes for a healthy heart.

- Ask you some questions about your eating, physical activity, and medication use habits

- Measure your blood pressure, weight, and height

At **every in-person visit**, we will take your blood pressure and weight.

At the **4th in-person visit**, we will ask you some follow-up questions about your eating, physical activity, and medication use habits.

APPENDIX 8:

Participant Manual

PARTICIPANT MANUAL

Center for Health Promotion and Disease Prevention
University of North Carolina at Chapel Hill

Welcome to CHANGE

What is CHANGE?

CHANGE is a new program to…

- prevent heart disease, an important health concern for you and many people in Edgecombe and Nash Counties.
- connect you to care and services that will help you be healthy
- support you in making lifestyle changes for a healthy heart

About CHANGE Community Health Workers

In the CHANGE program, you will meet with a community health worker. Your community health worker will visit you in person and check in with you by phone to…

- learn what is important to you
- help you think about ways to improve your health
- support you in setting and following through on your goals
- link you to resources that can help you reach your goals

During your sessions, you might talk about eating well, being physically active and taking medicine. If you smoke cigarettes, your community health worker will help you find ways to quit smoking.

Your community health worker will spend time with you to help you create a plan just for you.

Bring this notebook to each session

Information in this notebook will help you and your community health worker talk about the best way to reach your health goals.

Important contacts

Your Community Health Worker: ______________________ (name) ________________ (phone)

Your Doctor: ______________________________________ (name) ________________ (phone)

CHANGE Study Leaders: Dr. Sam Cykert - 919-966-2461
Dr. Carmen Samuel-Hodge - 919-966-0360

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- *Heart to Health. A tool to Help You to Your Best Heart Health*
- *Heart Healthy Lenoir Project. A Lifestyle Program to Improve Your Health*
- *A New Leaf… Choices for Healthy Living*

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Center for Health Promotion and Disease Prevention

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To access the rest of the participant manual, visit

change.web.unc/tools-and-resources

Center for Health Promotion and Disease Prevention
University of North Carolina at Chapel Hill

APPENDIX 9:

Resource Manual

Heart Healthy Resource Guide

Edgecombe and Nash Counties

Updated: January 2018

UNC
CENTER FOR HEALTH
PROMOTION AND
DISEASE PREVENTION

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Drug discount programs

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<tr><td>Thorne Drug Company
2900 North Main Street
Tarboro, NC, 27886-1921</td><td colspan="2">Features: Save on more than 5,000 name brand and generic medications at your locally-owned participating Good Neighbor Pharmacy. And it’s ideal for people without prescription drug benefits or those with inadequate coverage. No prior authorization is required; simply show your card and enjoy great savings.
Hours: Mon - Fri: 7:00am - 8:00pm; Sat: 9:00am - 6:00pm; Sun: Closed
Contact: Join online or in-store. Call: (252) 823-5655
Eligibility: Open to people of all ages. People who receive healthcare benefits from Medicare, Medicaid or TRICARE are not eligible.
Cost: 30-Day Supply: $4.99|90-Day Supply: $10.99|Membership Fee: $9.99</td></tr>
<tr><td colspan="2">Perdue Associate Wellness Center
perduehealthworks.net/perdue-wellness-centers/</td><td>Nash</td></tr>
<tr><td>Perdue Farms
1835 US Highway 64A
Nashville, NC 27856</td><td colspan="2">Features: Low-cost, onsite primary care and occupational health services through the fully-staffed Perdue Wellness Center. Services offered include medical check-ups and exams, treatment for cold, flu, allergies and infections, ongoing treatment for chronic high blood pressure, diabetes, cholesterol and additional issues, OB/GYN services, family planning and prenatal care, pediatric care, physical therapy and referral to specialists. A prescription drug benefit plan and free generic drug samples are also available.
Hours: 6am-9pm Monday through Friday and occasional weekend hours. Wellness Center is open whenever the Perdue plant is.
Contact: Michelle Jones, Regional Nurse Manager: (252)648-4344
Joanne/Wellness Center staff: (252)348-4235
Eligibility: All employees of Perdue Farms and their dependents who enroll in the Perdue health insurance plan are automatically enrolled in the Wellness Center. Those who opt out may still visit the Center.
Cost: $15 co-pay for employees and dependents enrolled in Perdue health insurance plan; $30/visit for employees who opt out. $5 for lab tests. One free visit is offered within the initial 90 days or employment. Employees remain on payroll and do not clock out during their visit. Payment is deducted from employee's payroll.</td></tr>
</table>

Rite Aid Pharmacy		Rocky Mount
824 W Raleigh Blvd Rocky Mount, NC 27803 3590 Sunset Avenue Rocky Mount, NC 27804 1123 E Raleigh Blvd Rocky Mount, NC27801	**Features:** Rx Savings Program offers discounts on generic prescription medications. Wellness 65+ is a free program for seniors, which offers a free pharmacist consultation and blood pressure screening; seniors also receive 20% discount on all non-prescription purchases the first Wednesday of every month. **Hours:** Monday through Friday 8am-9pm, Saturday 8am-6pm, Sunday 10am-6pm **Contact:** (252) 446-0391| (252) 443-5101 | (252) 977-0066 **Eligibility**: Rx Savings Program is open to all; Wellness 65+ to seniors 65 years and older. **Cost**: Free of charge	
Walgreens Pharmacy		North Carolina
2624 Sunset Ave Rocky Mount, NC 27804 1519 N Main St Tarboro, NC 27886 703 E Washington St Nashville, NC 27856	**Features:** The Prescription Savings Club offers discounts off of thousands of brand-name and generic medications. **Hours:** Monday through Friday 8am-8pm, Saturday 9am-6pm, Sun 10am-6pm. **Contact:** Nash: (252) 459–2639 | Rocky Mount: (252) 937-4999 | Tarboro: (252) 824-0342 **Eligibility:** Open to all. **Cost:** $20 individual membership; $35 for family plan.	
Walmart Pharmacy **http://i.walmartimages.com/i/if/hmp/fusion/ genericdruglist.pdf**		North Carolina
1511 Benvenue Rd Rocky Mount, NC 27804 110 River Oaks Drive Tarboro, NC 27886 1205 Eastern Ave Nashville, NC 27856	**Features:** Walmart Pharmacy offers $4 prescription refills for generic drugs including a variety of medications. The Free Rx Saver prescription card is also accepted for discounts in both generic and brand name prescriptions (to download unique, printable card: http://www.freerxsaver.com/ walmart.php#.VYm2gPlViko). *Other discounts may apply. Please check with your pharmacist.* **Hours:** Monday through Friday 9am-9pm, Saturday 9am-7pm, Sunday 10am-6pm (Sat/Sun break from 1:30-2pm). **Contact:** Edgecombe: (252) 985-2753 | Nash: (252) 459-2223 | Rocky Mount: (252) 985-2753 **Eligibility:** Open to all—no membership, fee or pre-existing exclusions **Cost:** Walmart Pharmacy: free shipping/home delivery included and no membership required. Free Rx Saver: no deductible, membership or fee required.	

Reminder tools

Medication Reminder Service	North Carolina
→ *MyMedSchedule*: http://mymedschedule.com/ → *Pill Reminder:* http://www.drugs.com/apps/ → *MedCoach Medication Reminder*: http://www.greatcall.com/medical-apps/medcoach → *Medisafe*: http://www.medisafe.com/ → *Pill Reminder - All in One:* https://itunes.apple.com/us/app/pill-reminder-all-in-one-rx/id816347839?mt=8 → *OnTimeRx*: http://www.ontimerx.com/	**Features:** Free, secure mobile applications that send medication and prescription reorder reminders to consumers via phone alarms, SMS/text and email notifications including times, quantity, purpose and pictures of the medications to take according to the schedule(s) consumers create on the website and/or mobile app. Tracking for medical and lab records also available. Applications are available in several languages for iPhone, iPad and Android and require an internet connection. Personal health information is protected by SSL encryption and will not be redistributed or resold. Free, web-based program for email and text that does not require installation on a Smartphone available on MyMedSchedule. **Cost:** Free Additional programs are available for a monthly cost. OnTimeRx can call your phone for a monthly plan starting at $9.95 per month.

STOPPING SMOKING AND TOBACCO USE

Fresh Start Tobacco Program — North Carolina

www.acsworkplacesolutions.com/freshstart.asp

Features: An American Cancer Society Tobacco Cessation program that lasts four weeks and is designed to help smokers quit the habit for good. One on one counseling available.
Hours: New sessions available twice a year
Contact: For more information, please call 252-962-3473
Cost: Free of charge

Perdue Health Improvement Program — North Carolina

www.perduefarms.com/careers/benefits/

Perdue Farms 1835 US Highway 64A Nashville, NC 27856	**Features:** Program of health education, coaching and counseling by a health improvement specialist and wellness nursing staff to address areas of exercise, nutrition and smoking cessation to eliminate lifestyle risk factors and manage controllable diseases. HIP leads employee initiatives such as "Walk Across America": an on-site, employee walking group. Individual health screening, assessment and chronic disease treatment for hypertension, diabetes, cholesterol, weight, eating, exercise and smoking also available. **Contact:** Michelle Jones, Regional Nurse Manager: (252)348-4344 | Joanne/Wellness Center staff: (252)348-4235 **Eligibility:** All Perdue employees and their dependents. **Cost:** Free of charge

QuitlineNC — North Carolina

www.quitlinenc.com

Features: Professional and confidential telephone counseling, coaching and web-based services for individuals to reduce and quit smoking and tobacco use (including smokeless tobacco). Services are flexible and numerous languages available.
Hours: English and Spanish language counseling available 24/7; additional languages available with a translation appointment. Clients may call in anytime or request that Quitline proactively call them via the webpage.
Contact: **"Expert Quit Coaches":** 1-800-784-8669 (1-800-Quit-Now); Spanish speakers call 1-855-335-3569 (1-855-Dejelo-Ya)
Fax referrals: 1-800-483-3114
Eligibility: North Carolina residents (no insurance or income necessary).
To enroll, call main line or visit website (https://www.quitnow.net/northcarolina/ProgramLookup/).
Cost: Free counseling services for all NC residents. Free two-week starter kit of nicotine replacement patch and gum available for recipients of NC State Health Plan for Teachers and State Employees (dependents and retirees), Medicare and Medicaid (18 years and older) with active program enrollment and participation.

HEALTHY EATING

Individual counseling **(see SUPPORT GROUPS AND GROUP EDUCATION FOR HEALTH on page 1)**

Women, Infants and Children (WIC)

Women, Infants and Children (WIC) **www.edgecombecountync.gov/departments/health_department/wic.php**	Edgecombe
Edgecombe County Health Department 122 E. St. James Street Tarboro, NC 27886	**Features:** Supplemental healthy foods, nutrition education and counseling, breastfeeding support, health care and social service referrals to low-income, pregnant, breastfeeding and postpartum. **Hours:** Walk-in or appointment, Site: M-F, 8:30-5pm **Contact:** 252-641-7550 or 252-641-7561 (Tarboro) | 252-985-1067 (Rocky Mount) **Eligibility**: North Carolina resident women. **Cost:** Free of charge

Food pantries and food banks

Abundant Life Ministries **abundantlm.org**	Rocky Mount
500 Peachtree Street Rocky Mount NC 27804	**Features:** They have a food pantry and offer financial assistance with rent and utilities in emergency situations. **Contact:** (252) 557-1333 **Cost:** Free of charge
Hobgood Citizens Group **www.nhc.fns.usda.gov/nhc/85616**	Edgecombe
401 Beech St., Tarboro, NC 27886	**Features:** Offers emergency food boxes, clothing, and other basic needs. **Contact:** (252) 826-0970 **Cost:** Free of charge
Living Waters Ministries of Pinetops, Inc. **https://www.facebook.com/pages/Living-Waters/120162848000652**	Edgecombe
7421 US-258 South Pinetops, NC 27864	**Features:** Runs a free food pantry in Pinetops. **Contact:** (252) 827-4592 **Cost:** Free of charge

Men's Christian Fellowship Home **cfhrockymountnc.com**		Rocky Mount
301 South Grace St. Rocky Mount, NC	**Features:** Beyond basic life necessities, 3 meals a day, and shelter. Also offer our residents basic transportation, in-house volunteer opportunities, and peer community support. Provide referrals to critical support services for employment, counseling services, medical services, food and nutrition services, and disability determination services. **Contact:** (252) 977-1273 **Eligibility**: Recovering from substance abuse or mental health issues. **Cost:** Free of charge	
Our Lady of Perpetual Help **www.olphrm.org** | **www.facebook.com/olphrm/**		Rocky Mount
315 Hammond Street Rocky Mount NC 27804	**Features:** They have a food pantry and offer financial assistance with rent and utilities in emergency situations. **Contact**: (252) 972-1971 **Cost:** Free of charge	
Project Hope Ministries **www.project-hope-ministries.org/**		Rocky Mount
209 South Grace Street Rocky Mount, NC 27802	**Features:** Offers a few forms of assistance. Funds may be offered for paying rent, utility bills, or security deposits. Free food, clothing, and holiday meals may be served as well to struggling families. Or get referrals to loan programs or benefits such as food stamps. **Contact:** (252) 985-1041 **Cost:** Free of charge	
Tarboro Community Outreach, Inc. **https://www.facebook.com/pages/Tarboro-Community-Outreach/165028343522666**		Edgecombe
701 Cedar Lane Tarboro, NC 27886	**Features:** They are part of the Emergency Food & Shelter Program. Some rent, mortgage, and utility bill grants may be offered in order to prevent or reverse homelessness. Other resources include shelter, food, and groceries. Case managers work to prevent evictions. **Contact:** (252) 823-8801 **Cost:** Free of charge	

Local fruits and vegetables

Rocky Mount Farmers Market **https://www.facebook.com/Farmers-Market-Rocky-Mount-201494653195167/**		Rocky Mount
1006 Peachtree Street Rocky Mount, NC 27804	**Features:** Sells fresh produce cultivated by local farmers. Open to both consumers looking by to produce, as well as farmers looking to sell what they have grown. **Hours:** April-November, Saturdays, 8 am - 1 pm **Contact:** 252-407-7920 **Eligibility**: Any adult. **Cost:** Varies	
Tarboro-Edgecombe Farmers Market **www.facebook.com/HandHMarketTarboro/**		Edgecombe
500 N. Main Street Tarboro, NC 27858	**Features:** Locally grown beans, broccoli, cabbage, cantaloupe, collards, corn, eggplant, gourds, greens, hay bales, honey, onions, peanuts, pecans, peppers, potatoes, squash, sweet potatoes, tomatoes, watermelons, zucchini & produce in season. **Hours:** Spring: May-August, Tuesday & Friday 7 am-10 am Fall Hours: Sept-December, Saturday 8 am - 11 am **Eligibility:** Open to all. **Cost:** Varies	

Fitness centers

Harrison Family YMCA **www.harrisonfamilyy.org**		Rocky Mount
1000 Independence Drive Rocky Mount, NC 27804	**Features:** Swimming programs, summer camps, sports and recreation, fitness and group exercise, health and wellness lessons **Hours:** 5:00am-9:00pm **Contact:** 252-972-9622 **Eligibility**: Ages 5+ **Cost:** Gym membership Young Adult/Student Rate: Ages 19-29 monthly rate: $31 joining fee: 25 Adult: Ages 30-59 monthly rate: $42 joining fee: $25 Senior: Ages 60 and over monthly rate: $38 joining fee: $25	
Indian Lake Sports Complex **www.tarboro-nc.com/visitors/indian_lake_sports_complex/index.php**		Edgecombe
3300 Western Boulevard Tarboro, NC	**Features:** A baseball field, four softball fields, two soccer fields, four tennis courts, and a playground. **Contact:** Thomas Perkins, Indian Lake Sports Complex Manager 252-641-4202 **Eligibility:** Open to all **Cost:** Free to all	
Rocky Mount Sports Complex **rockymountsportscomplex.com**		Edgecombe
600 Independence Drive Rocky Mount, NC 27804	**Features:** Hosts a variety of recreational facilities such as, baseball fields, softball fields, soccer fields, football fields, disc golf courses, outdoor basketball and volleyball courts, picnic shelters, and a walking trail. **Hours:** "Sun up, Sun down" hours policy, 5:00 pm start for league play on weekdays, 1 hour before start of first game for league play on weekends. **Contact:** Kelvin Yarrell: 252-972-1154 **Eligibility:** Any adult/youth interested **Cost:** Tournament Prices: $6.00 for Adults (13 years and over), $4.00 for Seniors (55+) and Children (6-12 years), free for Younger Children (5 years and under)	

South Rocky Mount Community Center **https://www.facebook.com/South-Rocky-Mount-Community-Center-929654233785645/**		Rocky Mount
Rocky Mount Parks & Recreation 719 Recreation Drive Rocky Mount, NC	**Features:** The community center is equipped with a gym, kitchen, game room, exercise rooms, walking track, arts and crafts room, media room, and meeting rooms. The park contains 2 lighted softball fields with dugouts, little league field and multiplay field with dugouts, 4 lighted tennis courts, a lighted basketball court, volleyball court, and playground equipment. **Hours:** Monday thru Friday: 10:00am - 8:00pm. Saturday: 1:00pm - 5:00pm **Contact:** Main: 252-972-1169 |Chris Allen (Recreation Coordinator) - 252-972-1170 **Cost:** Free of charge	
Tarboro Recreation Center **www.facebook.com/TarboroParksandRecreation/**		Edgecombe
1501 Western Blvd Tarboro, NC 27886	**Features:** Strength and cardio equipment, aerobics room and basketball gym. **Hours:** Mon to Fri- 8:00am-9:00pm, Sat- 8:00am-4:00pm, Sun- Closed **Contact:** 252-641-4200 **Cost:** Free of charge	

Local Parks

Bailey-Middlesex Park		Nash
8104 Stoney Hill Church Rd Bailey, NC 27807	**Features:** ADA accessible, playground, soccer fields, volleyball, walking trails. **Contact:** 252-462-2628 **Eligibility:** Open to all **Cost:** Free of charge	
City Lake		Rocky Mount
Off Sunset Avenue at the Tar River	**Features**: A half-mile concrete path surrounding the lake. **Cost:** Free of charge	
J.W. Glover Memorial Park & Complex		Nash
1782 North Carolina Hwy 58 Nashville, NC 27856	**Features:** Four baseball fields, football field, soccer field, basketball courts, walking/jogging trail, playground, grill and passive area, batting cage, field house **Contact:** 252-459-4511 **Eligibility**: Open to all **Cost:** Free of charge	
Nash Community College LiveWell & Learn Trail		Nash
522 N. Old Carriage Road Rocky Mount, NC 27804	**Features:** 2.5-mile fitness and nature trail that winds through the wooded area of campus with learning stations along the way. **Contact:** 252-443-4011 **Eligibility:** Open to all **Cost:** Free of charge	
Princeville Heritage Park		Edgecombe
425 Mutual Blvd Princeville, NC 27886	**Features:** Fishing, Wheelchair Accessible, Mountain Biking, Walking **Eligibility:** Open to all **Cost:** Free of charge	

Spring Hope Park		Nash
401 McLean Street Spring Hope, NC 27882	**Features:** multipurpose park with ball fields, tennis courts, basketball court, shelters, playground and restroom facilities. **Eligibility:** Open to all **Cost:** Free of charge	
Stoney Creek Environmental Park		Nash
455 W Washington St Nashville, NC 27856	**Features:** multipurpose field, tennis court, picnic shelter, nature trail, adult exercise equipment, and playground. **Contact:** 252-459-9796 **Eligibility:** Open to all **Cost:** Free of charge	
Sunset Park		Rocky Mount
1550 River Drive Rocky Mount NC 27804	**Features:** Offers a mini train, walking trail, basketball courts, tennis courts, and water park **Contact**: (252) 972-1151 **Cost:** Free of charge	
W.B. Ennis Memorial Park		Nash
4605 N. Old Carriage Road Rocky Mount, NC 27804	**Features:** Baseball fields, basketball courts, picnic shelters, playground, soccer fields, tennis courts, walking trail. **Contact:** 252-462-262 **Eligibility:** Open to all **Cost:** Free of charge	
Whitakers Town Park		Nash/ Edgecombe
302 NW Railroad St., Whitakers NC 27891	**Features:** Basketball Court, Volleyball Court, Playground, Gazebo Picnic Shelter, Walking Trail .25 mil **Eligibility:** Open to all **Cost:** Free of charge	

SUPPORT GROUPS AND GROUP EDUCATION FOR HEALTH

Groups for healthy eating, chronic disease prevention and weight loss

Cardiopulmonary Connections **www.active.com/rocky-mount-nc/classes/senior-cardiopulmonary-connections-l-and-amp-l-2017**		Rocky Mount
Rocky Mount Senior Center 427 S. Church St Rocky Mount, NC 27804	**Features:** For those interested in heart and lung health, this group meets monthly at the Rocky Mount Senior Center. **Hours:** Monday - Thursday: 8:00 am - 7:00 pm. Friday: 8:00 am - 5:00 pm **Contact:** (252) 443-8000 **Eligibility:** open to individuals age 55 or older **Cost:** Free of charge	
Chronic Disease Self-Management Program **www.edgecombecountync.gov/departments/health_department**		Edgecombe
Edgecombe County Health Department 122 East St. James Street Tarboro, NC 27886	**Features:** Classes offered each month with focus on prediabetes, diabetes and high blood pressure management. Also offers one-to-one sessions with a Certified Diabetes Educator at convenient time for participants. Opportunity to participate in no cost exercise at Vidant Edgecombe Hospital Community exercise program. **Contact:** Cheryl Fisher (252) 641-7588 **Eligibility:** A referral from medical provider required **Cost:** Free of charge	
EXERCISE IS MEDICINE **www.harrisonfamilyy.org/programs/post-rehab-program**		Rocky Mount
Harrison Family YMCA 1000 Independence Drive Rocky Mount, NC 27804	**Features:** Intended for clients who suffer from chronic diseases, disabilities and potentially debilitating medical conditions **Eligibility:** Open to all. For clients that have been released from physical therapy, as advised by their doctor. **Contact**: Sharon Simons at (252) 972-9622 x.246 or ssimons@rmymca.org **Cost:** Free of charge	
Weight Loss Management **www.wellness.com/dir/3086134/weight-loss-consultant/nc/rocky-mount/healthfirst-rehabilitation-and-fitness-center#referrer**		Rocky Mount
Health First Rehabilitation and Fitness Center 1771 Jeffreys Road Rocky Mount, NC 27804	**Features:** Supplies a weight-loss consultant who aids in developing a weight-loss program, and provides counseling in weight-loss, dieting, exercise, and obesity management. **Contact:** (252) 451-3468 **Cost:** Free of charge	

Diabetes education and support groups

Diabetes Support Group **www.edgecombecountync.gov/departments/health_department/**	Edgecombe
Edgecombe County Health Department 122 East St. James Street Tarboro, NC 27886	**Features:** Classes offered each month with focus on diabetes. Provides education, activities, nutritional information, and support. **Hours:** First Monday of each month, 6-7 pm **Contact:** Cheryl Fisher (252) 641-7588 **Eligibility:** No referral required **Cost:** Free of charge
Group Classes for Diabetes Support **www.boice-willis.com/services/health-education-diabetes-center**	Rocky Mount
Boice-Willis Clinic 901 N Winstead Ave. Rocky Mount, NC 27804	**Features:** group classes to help patients better understand and manage diabetes. Many patients who have completed the group classes have seen a decrease in their hemoglobin A1c, or their average blood sugar control. Through a series of three classes, patients explore how to live a healthy and vibrant life with diabetes. **Hours:** Monday - Thursday: 8:00 am - 5:00 pm Friday: 8:00 am - 12:00 pm **Contact:** (252) 937-0289 **Cost:** Free of charge

Disease screening and follow up

NC Breast and Cervical Cancer Control Program **bcccp.ncdhhs.gov**	North Carolina
Edgecombe & Nash County Health Departments **Edgecombe:** 122 E. St. James Street Tarboro, NC 27886 **Nash:** 214 South Barnes St. Nashville, NC 27856	**Features:** Free and low-cost breast and cervical cancer screening and follow-up to eligible women. Services may include clinical breast exams, mammogram and pap testing, diagnostic testing for abnormal results and referrals to treatment. **Contact:** Edgecombe- (252) 641-7511 | Nash- (252) 459-9819 **Eligibility**: Women 40 and 64 years old who are under or uninsured and with a household income at or below 200% of the FPL. Women must be BCCCP patients prior to cancer diagnosis to be eligible for treatment funding. Additional funding may be available for mammograms for those who do not fall into eligibility criteria. **Cost:** Free or reduced cost according to eligibility.

EMPLOYEE WELLNESS

Perdue Health Improvement Program

www.perduefarms.com/careers/benefits/ — North Carolina

Perdue Farms
1835 US Highway 64A
Nashville, NC 27856

Features: Program of health education, coaching and counseling by a health improvement specialist and wellness nursing staff to address areas of exercise, nutrition and smoking cessation to eliminate lifestyle risk factors and manage controllable diseases. HIP leads employee initiatives such as "Walk Across America": an on-site, employee walking group. Individual health screening, assessment and chronic disease treatment for hypertension, diabetes, cholesterol, weight, eating, exercise and smoking also available.
Contact: Michelle Jones, Regional Nurse Manager: (252) 348-4344
Eligibility: All Perdue employees and their dependents.
Cost: Free of charge

Vidant Employee Assistance Program

www.vidanthealth.com/Team-Members/Benefit-Information/Health-Wellness — Edgecombe

Vidant Health
111 Hospital Dr.
Tarboro, NC 27886

Features: Offers confidential health coaching, programs for smoking cessation and weight loss, free medication under certain conditions, coordinated care with primary physician, and wellness seminars
Hours: Open 24 Hours
Contact: 252-847-5590
Eligibility: Employees of Vidant Hospital
Cost: Free of charge

Health Insurance and Primary Care

Edgecombe Health Access **www.vidanthealth.com**		Edgecombe
Vidant Edgecombe Hospital 111 Hospital Dr. Tarboro, NC 27886	**Features:** A variety of services includes oncology, ultrasound, digital mammography, nuclear medicine, MRI and CT. Cardiopulmonary, inpatient, outpatient rehabilitation services, and a certified pathology laboratory, etc. **Hours:** Open 24 Hours **Contact:** 252-641-7700 **Eligibility:** Open to everyone	
Freedom Hill Community Health Center **www.cfhcnc.org**		Edgecombe
162 NC Highway 33 East Princeville, NC 27886	**Features:** The clinic will arrange for medical, dental, pharmacy services to low to middle income families as well as the uninsured in Edgecombe. **Contact:** Phone: 252-641-0514 | Fax: 252-641-1668 | After Hours: 888-648-7229 **Eligibility:** Edgecombe County residents	
OIC Family Medical Center **www.oicone.org**		Rocky Mount
At Happy Hill: 300 North Grace Street Rocky Mount NC 27804 **At Fairview:** 111 S. Fairview Road Rocky Mount, NC 27801 **At Community Health Plaza:** **Medical Plaza B** 1041 Noell Lane Rocky Mount, NC 27804	**Features:** offer in-depth healthcare services to regions that receive inadequate assistance. Full primary care assistance is available here at the Family Medical Center. We also cater to pharmaceutical, behavioral health and dental care requirements. **Contact:** Happy Hill: (252) 210-9856 Fairview: (252) 446-3333 Community Health Plaza: (252) 962-3450	

Rocky Mount Senior Center **www.rockymountnc.gov/departments__services/parks__recreation/recreation_services/senior_programs/**	Rocky Mount
427 S Church St Rocky Mount, NC 27804	**Features:** The Division of Senior Programs provides endless learning and recreational/leisure opportunities for adults 55 or older to age actively. In addition, they serve as an information and referral service hub for the older adult community. Programs and services are broken up into the following categories: Health/Wellness, Day and Overnight Trips, Special Events, Athletic Leagues and Tournaments, Educational Classes/Workshops, Information and Referral Services. **Contact**: Senior Center Supervisor at 252-972-1564 or by email at julie.watson@rockymountnc.gov. **Cost:** Activities are free to all participants, some classes/activities do require a small monthly, daily, or one-time registration fee.
Seniors Health Insurance Information **www.ncdoi.com/SHIIP/Default.aspx**	North Carolina
Features: Counseling and information about Medicare (including Advantage, Part D and supplements) and long-term care insurance. The counselors on toll-free line offer free and unbiased information regarding Medicare health care products. Also help people recognize and prevent Medicare billing errors and possible fraud and abuse through NC SMP Program. **Hours:** Monday through Friday 8am-5pm (toll free service) **Contact:** Barry Mowbray (DOI): (855) 408-1212, barry.mowbray@ncdoi.gov **Eligibility:** Seniors and their caregivers **Cost:** Free to seniors 60 years and older	
The Wright's Adult Day Health Care Center **www.thewrightscenter.com**	Edgecombe /Nash
513 W Raleigh Blvd, Rocky Mount NC 27803	**Features**: A supervised program of activities, health monitoring, meals/snacks and transportation are provided. **Eligibility**: Elders age 60 and older, disabled adults and veterans **Contact:** 252-442-8363 Email: wrightscenter.inc@embarqmail.com **Hours:** Mon-Fri 07:00 AM - 05:00 PM Sat-Sun – Closed

Vidant Multispecialty Clinic **www.vidanthealth.com/Locations/Facilities/Vidant-Multispecialty-Clinic-Tarboro**	Edgecombe
101 Clinic Dr. Tarboro, NC 27886	**Features**: This clinic includes family medicine, internal medicine, pediatrics, immediate care, geriatrics, general surgery, cardiology, pulmonology and urology. **Hours:** Primary & Specialty Care: Monday - Friday 8:00 am - 5:00 pm **Contact**: 252-823-2105 **Cost:** Serves all patients regardless of inability to pay. Discounts for essential services are offered based on family size and income. Accept insurance, including Medicaid, Medicare and Children's Health Insurance Program (CHIP).

Worksite-based health services

Perdue Associate Wellness Center **perduehealthworks.net/perdue-wellness-centers/**	North Carolina
Perdue Farms 1835 US Highway 64A Nashville, NC 27856	**Features:** Low-cost, onsite primary care and occupational health services. Services include medical check-ups and exams, treatment for cold, flu, allergies and infections, ongoing treatment for chronic high blood pressure, diabetes, cholesterol, OB/GYN services, family planning and prenatal care, pediatric care, physical therapy and referral to specialists. A prescription drug benefit plan and free generic drug samples also available. **Hours:** 6am-9pm Monday through Friday and occasional weekend hours. *Wellness Center is open whenever the Perdue plant is.* **Contact:** Michelle Jones, Regional Nurse Manager: (252) 648-4344 | Joanne/Wellness Center staff: (252) 348-4235 **Eligibility:** All employees of Perdue Farms and their dependents who enroll in the Perdue health insurance plan are automatically enrolled in the Wellness Center. Those who opt out may still visit the Center. **Cost:** $15 co-pay for employees and dependents enrolled in Perdue health insurance plan; $30/visit for employees who opt out. $5 for lab tests. One free visit is offered within the initial 90 days or employ1ment. Employees remain on payroll and do not clock out during their visit. Payment is deducted from employee's payroll.

TRANSPORTATION

Public transit/Medical Transportation

Nash County Medicaid Transportation		Nash
	Features: Provides transportation to medical appointments for individuals who have Medicaid **Contact:** (252) 462-2731 **Cost:** Free of charge	
Ride Tar River Transit **www.tarrivertransit.org/index.asp**		Edgecombe
100 Coastline Street, Suite 315 Rocky Mount, NC 27802	**Features:** Tar River Transit is a public transportation service providing affordable fixed-route bus service throughout the City of Rocky Mount, North Carolina and Rural General Public para-transit transportation for Nash and Edgecombe counties. **Hours:** Monday - Friday: 6:45 a.m. to 6:45 p.m. Saturday: 9:15 a.m. to 5:45 p.m. **Contact:** 252-972-1174 **Cost: Varies by plan** http://www.tarrivertransit.org/index.asp?page=tickets	
Senior Transportation **www.tarrivertransit.org/index.asp**		Edgecombe
Edgecombe County Office of Aging: Senior Tar Heel 100 Coastline Street, Suite 315 Rocky Mount, NC 27802	**Features:** Non-emergency transportation available as needed to medical appointments within the County (can pick up and transport anywhere within Edgecombe County). Limited transport to nutrition sites and shopping centers also available. The program allows the individuals to ride the regular fixed-route system for half the regular fare. **Hours:** By appointment only; please call the Senior Center office one week in advance to schedule transport. **Contact:** (252) 972-1174 TRT@rockymountnc.gov **Eligibility:** Seniors of Edgecombe County 60 years of age and older. Clients must be mobile and able to get in and out of the vehicle and appointment without assistance. **Cost:** Free of charge	

APPENDIX 10:

Success Stories

CHANGE is Good

Mrs. Hattie Blythe has been taking care of people her entire life. She not only has taken care of her husband of 43 years, 3 children and 9 grandchildren, but she also worked in a nursing home for many years.

Mrs. Blythe is also a survivor. She's overcome leukemia and a heart attack, as well as her husband's illness which led him to move into a nursing home a few years ago.

All these changes could be overwhelming to many, but to Mrs. Blythe, it was an inspiration to become healthier and stronger.

"My goal is to be a role model for my family," she said. "I need to be healthy to be able to keep taking care of people. When your health is good, age doesn't have anything to do with what you do; if you're fit to do it, you can do it."

She first heard about the CHANGE program at a cancer survivor's luncheon at her church, but didn't live in the area where the project was recruiting participants. Mrs. Blythe's questions and interest in the program led to a phone call from the community health worker a few days later, and she enrolled in the program. She said just being offered the program and taking advantage of it was important first step.

"It's important to know that there's somebody out there that's concerned about the people," she said. "They have a program that would help to enhance our lives if they would take the opportunity. If she hadn't had the information that day, I would never have known. Just knowing it's possible is the main thing, to know that somebody cares about you."

CHANGE teaches participants about how to incorporate heart-healthy foods and exercise into their lifestyles. Mrs. Blythe said learning about which foods were healthy for her and how to make small changes led her to weight loss and better health.

"I learned what's healthy for me, it's ok to try things and get a taste, but you can't consume it more than the healthy stuff," she said. "Fix it up in a different way, and you'll see changes come eventually. I had clothes I couldn't even wear, and now I can button the blouse up and you do feel better, you really do. It takes work, but you will feel better about yourself."

Mrs. Blythe said learning about how to replace salt with other seasonings was important in her health changes. She also learned to enjoy walking for exercise.

"At first I really wasn't interested in going out for a walk; I was doing other things around the house. I know cutting the grass, pushing the lawn mower was walking, too. But walking and thinking was good for your mental health, too. When you walk, you can just feel free and take time to look at the sky and look around. Getting motivation is good. Get up and go do, and enjoy what you're doing."

All these healthy changes have led Mrs. Blythe to take up a new mantra, which combines her new perspective and her deep faith in God.

"My slogan now is I'm going to live until I die. Worry, stress, give it to Him, and He'll take care of it. Life is a journey and you have to do it day to day."

Mrs. Hattie Blythe was a participant in the CHANGE project in 2017. She lives in Woodland, NC.

Listening to the angel on her shoulder

Community Health Workers (CHWs) are an important part of the Carolina Heart Alliance Networking for Equity (CHANGE) project. CHWs recruit participants, meet with them in their homes and guide them through modules to improve their diet, physical activity and quit smoking. They are the most important link between the research project and the community, but they also make individual relationships that can change lives.

Cheryl Amey calls her CHANGE CHW an angel.

“She was my motivator and my good angel,” Amey said of Ms. Eley, her CHW. “There’s a good angel and a bad angel on my shoulder, and she was my voice of reason. When I wanted to give up, she would say no, that’s not an option.”

Amey was ready for a big change when she realized her weight and eating habits were threatening her life. At age 49, she was overweight and had uncontrolled diabetes.

“A lightbulb went off, that well, you haven’t seen your first grandchild yet and you’re going to miss everything,” she said.

Amey attends a breast cancer awareness fair near her home in Murfreesboro every year, and met the CHANGE team at the fair. She told them about her health issues, and they said she should try the CHANGE program.

Amey said she enjoyed utilizing the CHANGE modules, which focus on different parts of the program. The exercise module gives examples of short exercises for both cardiovascular and strengthening activities that are easy to do at home.

“I don’t have to walk for an hour like I thought previously, or walk five or seven days a week. I could just walk three days a week and do weightlifting. I had an 8lb hand weight sitting in my house that I’ve never picked up, and Ms. Eley said to pick it up.”

Amey also made big changes to her eating habits by following the CHANGE guidelines. She learned to increase her vegetable intake, utilize smaller portions and read labels for fat and sugar content. She said her CHW helped her make small changes that led to bigger ones.

“Even at my age I was willing to learn, and she’s the one who taught me,” said Amey.

Amey said she is most proud of her weight loss through the program, but that sticking to the dietary guidelines consistently was also her biggest challenge. She started using a smaller plate and watching her portions for every meal, and her work is paying off.

“The numbers don’t lie,” she said. “The numbers show that I’m doing something. That’s encouraging me to keep doing what I’m doing.”

But, she said the key to her success was having a CHW who encouraged and believed in her throughout the program. She still hears Ms. Eley’s voice in her head when she’s tempted to have a soda or eat something unhealthy telling her to put it down and just keep heading to her goal.

“Get a mentor,” Amey advised to others looking to improve their health. “Get someone that is going to encourage you and say they’re happy with what you’re doing. It makes a difference. Get someone on your side.”

Living a Better, Healthy Life

For Nancy Lambertson, the need to make a change in her diet and exercise was quick and certain.

She was admitted to the hospital in January 2017 with blood clots in her legs and her lungs. It was an unexpected event, and Ms. Lambertson got help from her sister and nephew while she recovered. Doctors sent her home from the hospital with a diet limited to 2,000 mg of sodium a day, and Ms. Lambertson was determined to follow their guidance.

Ms. Lambertson's personal motto is "I can do all things through Christ who strengthens me" and remembering this has given her strength to seek out ways to make these changes.

Making a drastic diet change is often difficult, and Ms. Lambertson wanted to find ways to make her food tasty but still low in sodium. She asked her doctor if she could meet with a nutritionist to help her find ways to make good, low-sodium food, and he suggested she join the CHANGE project.

One of the things Ms. Lambertson enjoyed most was working with her CHANGE Community Health Worker, Denita.

"Working with Denita and the CHANGE program helped to refresh my mind, and the materials were a great help to me," said Lambertson. "Her talking to me and sharing some recipes and different things she tried were very helpful. She was always positive, and that helped a lot, too."

The CHANGE program helped Ms. Lambertson find foods and recipes that she enjoyed while still keeping her salt levels low. She even surprised herself at the foods she started to eat.

"I despise whole wheat anything, but started eating it for my health," she said. "Brown bread, brown rice, more vegetables, I drink more juice, I eat more nuts. Not a lot of French fries, fried foods and I just changed because I have to and I know it's better for me. That's just the way I've got to live."

Ms. Lambertson's efforts have led to weight loss. Her experience with CHANGE has also led her family to make healthy changes. They are all eating less salt and fried foods. Lambertson said she would recommend anyone with the opportunity to enroll in the CHANGE program.

"Think positive, get in the CHANGE program, remember that you're doing it for yourself and you can do it to help your family, also, so you can all live a better, healthy life."

Nancy Lambertson lives in Rich Square, NC

CENTER FOR HEALTH PROMOTION AND DISEASE PREVENTION

If you want to make a change, this is where to start

Grady Hall loves to hunt and fish, but he was having trouble getting around in the woods.

"I was smoking a pack and a half a day, sometimes two packs, and I couldn't walk to the end of the driveway without getting out of breath," he said. "I had to stop and rest when I was hunting."

He knew he needed to cut back on smoking, but hadn't been successful until he encountered a CHANGE Community Health Worker at the local bank.

"I met Shanta at the State Employee Credit Union," he laughed. "We were both there and started talking. I told her I wanted to stop smoking, so she said to join the program and she could help."

CHANGE includes tools to help improve nutrition and increase physical activity, but it also includes tools to help cut back and stop smoking. Hall knew he needed help, and he attributes Shanta as the source of his success.

"Her pushing me along made the difference," he said. "She'd say 'Come on, you can do it, you can do it.'"

Shanta called Hall twice a week while he was participating in the program, and in addition to providing him with tools and encouragement to stop smoking, she also helped him to establish a routine to take his medications regularly. She also had a solution when his cut back of cigarettes led to weight gain.

"When I tried to stop smoking, I started eating more, so she said, 'Now you need to exercise,'" remembers Hall. He started riding a bike three miles a day, and used the exercise band provided by CHANGE to do exercise at home while watching television. He started losing weight again.

Hall hasn't stopped smoking, but he has cut back from 1-2 packs a day to 1 pack a month. He can feel the difference in his stamina and ability to exercise without losing his breath, and he's back to hunting.

"I can feel my wind coming back and I can exercise, and I feel a whole lot better," he said.

He advises anyone interested in improving their heart health to sign up for CHANGE.

"I would tell people to come down and sign up, if they want to do something to change their life, this would be the place."

Grady Hall lives in Cofield, NC.

CENTER FOR HEALTH PROMOTION
AND DISEASE PREVENTION

I'm Living Better, I Made a Change

Richard White had already started to take his health into his own hands when he joined the CHANGE program, but with the help of his Community Health Worker (CHW) he is now seeing "concrete benefits."

With his regularly scheduled doctor visits sometimes being as much as 3 to 6 months apart, Mr. White bought a kit for checking his vitals at home between visits.

Mr. White notes, "I was health conscious before [CHANGE], watching UNC-TV programs about health [and] some of the cooking shows that highlight a balanced diet."

His motivation for joining the CHANGE program was simply, "opportunity." He explained, the decision is clear "when somebody offers you an opportunity to do something in the spirit of what you're already doing."

One of the things Mr. White enjoyed most was the knowledge he gained to support his health goals. He praises the CHANGE manual and his CHW for helping him achieve a better quality of life. "Accurate knowledge of the subject" of healthy living was Mr. White's most important goal for his time with CHANGE, and he is sure he has gained that. "It's cheaper to keep people healthy than to make them well" he explained.

Since the CHANGE program, he has been able to make significant changes to his eating habits, noting portion size as a major change. "Ms. Murray was great in helping me appreciate I need to be balanced…When [I] go out, [I] use a to-go box and eat the serving size and bring the rest home for later."

Mr. White expresses that being conscious and having self-control are his keys to change. He advises, "get in the program and use it! It's no good to you if you don't use it."

Mr. White's favorite quote reads, "to deny the facts, doesn't change the facts. The facts are the facts." He notes, "I've gotten the facts through this program."

Living Beyond Hope

As a Direct Care Professional, *Therese Andrews* spends her days making sure her patients are living healthy and independent lives. But when her own health started to affect her ability to care for others, she decided she wanted to make a change.

Diagnosed with hypertension and high cholesterol, Ms. Andrews was on multiple medications for blood pressure management, high cholesterol and asthma.

Ms. Andrews explained her passion for taking care of others led to her decision to participate in the CHANGE program, expressing "here I am trying to help someone else live an independent life…and I was neglecting myself."

Change is never easy, and Ms. Andrews admits that making changes to her routine was one of the hardest parts of committing to the program. Even though it was hard, with the help of her Community Health Worker and the knowledge she gained, she began with small attainable goals to change her food and exercise habits.

Prior to the program, she described herself as an "emotional eater," but since CHANGE she has replaced many of her old food choices with healthier options. "I went from consuming a lot of soda to consuming a gallon of water…from fried food to grilled and boiled…[and] from no servings of fruits and vegetables to eating at least 4 servings per day!"

Ms. Andrew's determination has enabled her to stop taking high cholesterol medication altogether and reduced her high blood pressure pills to one. She did this in just four months.

Ms. Andrews advises that "if you come in with an open mind and…you embrace what it is that you want to change about yourself, it will be a success. But if you don't want it and you don't embrace the change or if you don't want to implement any changes, then don't look for results..." Ms. Andrews advocates that the way to get the most out of CHANGE is to embrace the process while implementing the changes, because it won't be easy.

"The best thing that's happened because of the CHANGE program is that my overall view of my life has changed," she says. "I went from no hope, to living beyond hope."

I Want to Live Healthy - I Don't Just Want to Live

During the first week of December 2017, ***Don Pollard*** was diagnosed with diabetes. When his doctor suggested getting involved with the Diabetes Support Group at Edgecombe County's Health Department, he jumped at the chance.

Mr. Pollard says, "I wanted to be as healthy as possible," so shortly after joining the Diabetes Support Group, he expressed interest in making more lifestyle changes and was referred to the CHANGE Program.

During his visits with his Community Health Worker (CHW), Mr. Pollard expressed "You can see it in her eyes that she cares… She was very helpful and very informative." Mr. Pollard shared especially enjoying the conversations with the CHW relating to reading labels, portion sizes, adding fresh produce options, and switching his oil, saying, "I love chicken breast... and she said, 'Don you can still eat the skin, you just have to eat moderately depending on what type of oil you use.'"

Mr. Pollard shared many successes with CHANGE, but he is especially proud of his change in eating habits. Since the program, he says "I eat a whole lot more vegetables. I cut out all the cookies, [and] the cakes." He expressed switching from white rice, bread and cereal to all whole grain versions. He says he has even replaced chips with carrots to satisfy his love of crunchy foods.

Through referrals from his CHW Mr. Pollard was also able to receive free nicotine patches and quit smoking after 30 years, one of his primary goals for CHANGE. "I want to live healthy. I don't *just* want to live" he explained.

He has also made some major changes to his physical activity routine, going from periodically riding his bicycle to more consistent activity. First by committing to walk the 30 minutes to his appointments at the Health Department, to eventually increasing his 30-minute walks to an hour every other day.

Mr. Pollard shared that he not only wants to make changes for himself but also for his family so when he began caring for his granddaughter, he traded his usual hour walks to 45-minute dances with her. He hopes that his success with CHANGE will also be a motivator for his wife to live a healthier life, both with eating and increased physical activity.

Today, Mr. Pollard is excited his weight and blood pressure are down because he eats healthier, exercises by using the weight room at his church, and no longer smokes. He says that the CHANGE program helped to strengthen his "will to do better."