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## **Barbershops and Preventative Health: A Case of Embedded Education**

Deloris Wilson, Linda Kaboolian, Jorrit de Jong, and Guy Stuart

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January 2017



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## **SUMMARY**

This is a case study of the Colorado Black Health Collaborative (CBHC) Barbershop/Salon Health Outreach Program, a community-based initiative that targeted disproportionate rates of hypertension and other health problems within the African American community. The program, which began as a grassroots operation in 2008 and was formally incorporated into the CBHC (a network of organizations providing health-related resources for Colorado's African American community) in 2012, serves as an example of a healthcare intervention making continuous strides with limited resources and dedicated community workers. The operations of the CBHC program are contrasted with the nationwide Black Barbershop Health Outreach Program (BBHOP), which was the most expansive barbershop-based operation at the time the case research was conducted.

This case begins by providing background information on health disparities faced by the African American community. It then discusses the social significance of the Black barbershop setting and presents the strategic and design elements of the program. The paper concludes with a discussion of challenges in the governance and operation of the CBHC's program, as well as the nationwide Barbershop Health Outreach Program.

*Note on language:* This case study uses “African American” and “Black” interchangeably in reference to the population both implementing and targeted by the referenced barbershop interventions. As a heterogeneous population, comprising individuals of various ethnic, multiracial, and religious backgrounds, persons identifying as Black/African American face particular health challenges and disparities addressed by barbershop interventions.

## **BACKGROUND**

African Americans are the second-largest minority population in the United States, but there are significant health disparities between African Americans and the majority population.<sup>1</sup> African Americans are almost twice as likely as non-Hispanic whites to be diagnosed with diabetes and are more likely to suffer from diabetes-related complications.<sup>2</sup> Although African Americans are 40% more likely to have high blood pressure, they are less likely to have their blood pressure under control.<sup>3</sup> Nearly 44% of African American men have some form of cardiovascular disease,<sup>4</sup> and Black men are 60% more likely to die from a stroke than their white male counterparts.<sup>5</sup>

Various factors influence health disparities among and within racial groups. “Diet-related disparities” play a large role; socioeconomic, cultural, and geographical factors contribute to diets that are higher in salt and saturated fat and lower in fresh produce and whole grains.<sup>6</sup> Socioeconomic status also affects access to quality health-care services and availability of resources to support physical activity and healthy living. However, even controlling for socioeconomic status, hypertension rates among African American men remain significantly higher than other groups.<sup>7</sup> Although the Affordable Care Act has lowered the uninsured rate among African Americans aged 18–64 by 6.8%,<sup>8</sup> alleviating financial barriers without addressing cultural norms may not adequately address the issue(s) at hand.

One study of health interventions in Black barbershops noted that “compared to Black women, men have less frequent physical contact for preventive care and thus substantially lower rates of HTN [hypertension] detection, medical treatment and control.”<sup>9</sup> This tendency may signal a cultural mistrust of the medical community among African

American men. A historical legacy of deliberate medical mistreatment of African Americans is well documented and increasingly well known.<sup>10</sup> Researchers found increases in medical mistrust and mortality and decreases in interactions between physicians and Black men following the 1972 disclosure of the Tuskegee Study of Untreated Syphilis in the Negro Male.<sup>11</sup> From 1932–1972, the U.S. Public Health Service, in partnership with Tuskegee University, studied the natural progression of untreated syphilis in infected African American men in rural Alabama. During the course of the study, researchers denied available and effective treatment to these patients, allowing them to suffer the full progress of the disease and, in some cases, to infect their wives and children.<sup>12</sup>

In *Medical Apartheid*, a landmark study of America’s long history of unscrupulous medical experimentation on and treatment of African Americans, Harriet A. Washington asserts that “. . . although the heightened African American wariness of medical research and institutions reflects a situational hyper-vigilance, it is neither a *baseless* fear of harm nor a fear of imaginary harms.” Moreover, racial bias in health care remains a source of concern. An overview of research commissioned by the National Academies’ Institute of Medicine cited multiple studies showing bias in health care based on stereotypes and (often unconscious) prejudice on the part of medical practitioners.<sup>13</sup> Finally, treatment standards that take white men as the norm can result in incompetent care. Byron Conner, MD, founder of the Black Barbershop/Salon Health Outreach Program at the Colorado Black Health Collaborative (CBHC) pointed out that, for example, “some doctors don’t know that Black people are salt sensitive” and that typical dietary guidelines may therefore not apply.<sup>14</sup>

Bill Releford, MD, founder of the Black Barbershop Health Outreach Program (BBHOP) noted that “some of the men [who came into the barbershops] had never been to a doctor in their adult lives.”<sup>15</sup> Others had seen a doctor but still lacked the communication, basic trust, and/or follow-up care to make informed decisions about their health. One Chicago barbershop client, believing that his prescribed medication was ineffective and “they were just out for the money,” chose to stop the regimen, which ultimately caused kidney damage.<sup>16</sup>

It is within this context of genetic predispositions, socioeconomic conditions, and cultural norms that founders of the CBHC Barbershop/Salon Health Outreach Program—Byron Conner, MD; Alfredia Conner, RN; and Terri Richardson, MD—brought

health education and the promotion of ongoing medical care to the barbershop environment. The program sought to empower African American men to take charge of their own health through blood pressure and glucose screenings, as well as health education and counseling, all within an existing trusted environment: the barbershop.

Though it operates as a grooming station, the Black barbershop also serves as a pillar of the Black community, connecting Black men and their families in a place of historical significance. The venue has served as a “nerve center” where people conducted voter registration campaigns, discussed politics, sports, [and] relationship[s]; now, it [is] used to talk about health and how to make healthy lifestyle choices.”<sup>17</sup>

In a 2016 TED talk, Dr. Joseph Ravenell discussed how the barbershop operated as a “safe haven” that allowed Black men to “fearlessly be [them]selves and just... talk.” Ravenell, a medical doctor with extensive experience in barbershop interventions, cited two reasons why the barbershop environment was ideal for discussion, action, and partnerships around improving health: they were (1) non-medical settings, free of “negative psychological baggage”; and (2) places of connection, loyalty, and trust where patrons already discussed topics associated with high blood pressure (stress, food, relationships, and being a Black man in America).<sup>18</sup>

## **CASE**

Founded in 2008 as a grassroots nonprofit and formally incorporated as a 501(c)(3) organization in 2009, the Colorado Black Health Collaborative (CBHC) is a network of organizations providing health-related resources for the African American community. As a hub for collaborative partnerships and health/wellness initiatives, the CBHC’s guiding mantra was to make their community “the healthiest Black folks in the nation.”<sup>19</sup> CBHC held quarterly community forums and operated through a committee-based structure, which allowed it to remain responsive to community concerns and actively involved in the community it served.<sup>20</sup>

In 2008, Dr. Byron Conner, a member of the CBHC and active community servant, learned about barbershop interventions while attending the National Medical Association Annual Convention.<sup>21</sup> Inspired by existing practices and committed to achieving

health equity within his own community, Dr. Conner returned to Denver and, with the help of his wife, Alfredia Conner, RN, began conducting blood pressure screenings in Wright's Barbershop, Dr. Conner's own hometown barbershop since age 17.

After four years of small-scale operations facilitated by the Conners, a 2012 partnership with the CBHC Health Access Committee, and later the Colorado Kaiser Permanente African American Center of Excellence in Culturally Competent Care (AACE), brought the Barbershop/Salon Health Outreach Program fully to life.<sup>22</sup> CBHC's Health Access Committee, chaired by Dr. Terri Richardson, provided an established community-based network of peers and institutions offering financial contributions and volunteers, while the AACE partnership facilitated publication of the Barbershop/Salon Outreach Toolkit, a step-by-step guide to implementing health-related interventions in the barbershop/salon environment. Though focused on interventions related to hypertension, diabetes, and HIV, the toolkit was applicable to a variety of health education and screening programs presented in a shop environment.

After partnering with CBHC, the program grew from a single barbershop, where the Conners' dedicated but intermittent efforts to screen and educate clients amounted to roughly 45 blood pressure screenings over three years, to a partnership of 12 barbershops and salons across Denver and Aurora that conducted 3,625 blood pressure screenings, 781 blood sugar readings, 50 referrals and logged 2,098 service hours from 2012–2016.<sup>23</sup>

### ***Project Origins and Structure***

Before partnering with the CBHC, the Conners relied on ad hoc research, a few blood pressure monitoring cuffs purchased with their own funds, their professional expertise as Black medical practitioners, and a good bit of trial and error to steer the project out of the gate.<sup>24</sup> Informed by what Dr. Conner called community "groundtruthing"—"assessing, researching, and mapping out a geographic region via personal relationships on the ground"—operations relied on the strength of face-to-face relationships and the identification of cultural perspectives.<sup>25</sup> Because both Byron and Alfredia were actively engaged as community volunteers through the CBHC and other community-based organizations, when the time came to expand operations, the Conners already knew which shops to approach. As Dr. Conner noted, the barbershop clientele was "already familiar with us."



After establishing the partnership with the CBHC, the Barbershop/Salon Health Outreach Program began holding traveling screenings in local shops every Saturday (the busiest day at shops) and “Power Saturday” events, which placed volunteers simultaneously at multiple shops. Program leaders’ primary focus was “to screen and educate to improve health outcomes.” They were adamant that they were “not substituting for primary care physicians; [but rather] advising people.”<sup>26</sup> Their ultimate goal was to empower clients through health education, providing individuals with enough information to understand specific risk factors, ask their doctors relevant questions, and become advocates for their own health.

The CBHC program attracted interest from out-of-state volunteers hoping to replicate the program within their own communities. CBHC prided itself on running a “low-budget” program, insisting that its basic functions needed only minimal funding. However, it was the additional funding from Kaiser Permanente and other institutional partners that allowed the program to maximize output and capture outcomes. CBHC has continued to operate and expand its service offerings throughout the metro-Denver area and beyond, and to provide ongoing consultations to those interested in following its example.<sup>27</sup>

### ***Design Elements***

Embedded Education is the practice of educating people through everyday interpersonal encounters within organizations and networks that exist primarily for non-educational purposes. Program designs vary depending upon the environment, the targeted individuals and outcome, and pedagogical processes.

By using an existing trust environment (barbershops) and minimal supplies, the CBHC’s embedded education program provided an effective and efficient means of reaching and empowering a medically underserved population. As a barbershop client waited for a haircut or made his way out of the shop, he became a learner in a personalized health-related educational encounter. Armed with new knowledge, peer support, and, when appropriate, a referral to a local low-cost medical practitioner, that client was primed to make a behavioral change. In this way, the intervention could begin to chip away at the health disparities afflicting the African American community.

#### EXISTING RELATIONSHIPS

African American men utilize neighborhood Black barbershops because of the unique requirements of their hair and because these barbershops are comfortable, congenial places. Even after moving away, some men return to this familiar location for continued services and community dialogue. In the shop’s relaxed and culturally specific atmosphere, men can freely discuss shared experiences, current events, and personal relationships. Individuals may spend a considerable amount of time in the shop—before, during and after services—talking to barbers, fellow clients, and the family members, friends, and passersby who stop in to say hello. As a frequently visited environment where dialogue, information-sharing, and community-building are the norm, the barbershop is ideally situated for this kind of embedded education encounter.<sup>28</sup>

Though the barbershop environment is spatially targeted to access African American men, its community placement also enables interaction with African American women, children and other ethnic minorities. For this reason, targeted health-interventions spill over into the larger family structure and greater community.

In the Denver area, CBHC volunteers capitalized on the communal atmosphere and peer relationships within the barbershop environment. Volunteers were encouraged to engage clients even if they did not take part in screening, and used giveaways and promotional items to incentivize participation when available. Patrons waiting for services, receiving services, and lingering after haircuts observed other clients engaging with volunteers, and often took part in the exchange themselves after seeing their peers doing so.<sup>29</sup> Similarly, barbers and owners played a role in encouraging participation, engaging medical volunteers and patrons in discussions of long-held medical assumptions or beliefs.<sup>30</sup> The role of barbers and owners was voluntary and often a by-product of the communal shop environment, the program’s consistent presence, and volunteer engagement.<sup>31</sup>

#### EMBEDDED EDUCATION PRACTICE

##### *Content, Learning Objectives, and Anticipated Change*

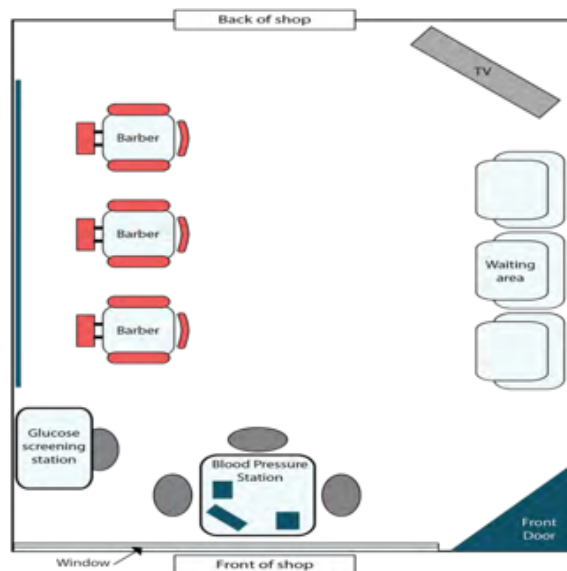
The objective of CBHC’s efforts was to “empower through education,” reducing hypertension rates and improving the long-term health of African American men and communities. By screening and educating patrons, program leaders aimed to arm them with

enough information to begin taking control over their health, making healthy lifestyle choices, and seeking preventative care. By creating positive associations between clients and the medical community, CBHC helped to dispel social stigmas that may have prevented individuals from actively seeking care and/or trusting medical providers.

*Pedagogy, Tools, and Activities*

For four hours every Saturday, a team of trained medical and non-medical volunteers, under the supervision of at least one medical professional, provided free screening and health counseling services at various barbershops and salons across the metro Denver area. Volunteers rotated through 12–15 partnering shops, completing cycles about every six weeks. The team set up portable stations in convenient locations, paying close attention to the size and layout of the shop to avoid interfering with normal business operations and ensuring that volunteers were visible and accessible. Program leaders also adjusted the number of volunteers and/or physical layout to support the flow of shop operations. In some instances, operations were moved to other shops due to particularly slow business.<sup>32</sup>

.....  
**FIGURE 1: EXAMPLE OF BARBERSHOP LAYOUT**



Source: CBHC “Toolkit,” Appendix C.

The physical placement of volunteers could affect the operation's overall effectiveness. Program leaders explained that the screening table would ideally be placed towards the front of the shop but without interfering with the usual flow of operations. "One shop set-up wanted us behind a wall, [but] no one could see us back there and we didn't want people to not know what we were doing," said Dr. Richardson. "We're usually up front so people can see that we are providing services and we can engage people that aren't getting their blood pressure checked; those people want to know what's going on so they can engage their family member."<sup>33</sup>

.....  
**FIGURE 2: STATION SET-UP, BLOOD PRESSURE SCREENING**



Source: Terri Richardson, "More Than a Haircut," presentation (no date provided).

Both clients and volunteers initiated interactions. Sometimes volunteers approached clients as they waited, and clients also approached volunteers on their own, prompted by barbers, other clients, or their own curiosity. When available, free merchandise like pedometers, stretch bands, healthy snacks, and cookbooks also helped to attract interest.

For blood pressure screenings, volunteers asked if clients would like to have their blood pressure checked, and sometimes inquired into their medical history, last

doctor's visit, and/or last screening.<sup>34</sup> Using a "patron card" given to the client to take home, volunteers recorded the blood pressure reading and explained the results (see appendix). Volunteers provided clients with printed literature on hypertension, diabetes, and/or healthy eating habits. Depending on the blood pressure reading, volunteers referred clients to the on-site medical professional for additional counseling or to a low-cost clinic. They also provided positive reinforcement of the behaviors that led to a positive screening. While all patrons were provided with information for follow-up care, those with abnormal readings were referred to local safety-net clinics and, in some instances, were urged to seek medical attention right away.

Volunteers distributed educational materials related to hypertension, stroke, and heart disease published by the American Heart Association, the American Diabetes Association, and other institutional partners. Clients also received information to help them understand their previously diagnosed conditions, prescribed medications, and treatment plans. Before sharing with patrons, however, program leaders reviewed and amended materials to ensure cultural relevance. This included adding or substituting culturally relevant images, such as images of Black men or families or food traditionally associated with African American culture. These changes made conversation about the associated health content easier. Materials were also sometimes edited for ease of comprehension, eliminating medical jargon or striking a more conversational tone. To Dr. Bill Releford, founder of BBHOP, these kinds of changes help undercut the narrative that "health care doesn't care about Black men."<sup>35</sup>

To promote a sense of self-efficacy and equip patrons with useful knowledge for their day-to-day lives, volunteers employed a discussion-based and participant-centered learning model which used personalized screening information to communicate general statistics or health information relevant to the African American community. At the start of screenings, volunteers reviewed basic questions like "what is blood pressure?" with the aid of hand-outs.<sup>36</sup> Following the screening, patrons were asked about their personal choices and habits: for example, "what did you have for dinner last night?"<sup>37</sup> If they mentioned bread, as they often did, volunteers took the opportunity to point out that bread was number one on the list of "The Salty Six" (see appendix). Volunteers also shared stories of how others had benefited from the program, or their own personal health journeys, to connect and engage with the target group.

Health counseling conversations sought to empower clients with new information on the theory that knowledge conveyed by trusted peers in a safe environment would encourage behavioral changes to support their health, allowing patrons to become better custodians of their bodies and advocates for their health.<sup>38</sup>

*Educators and Training of Trainers*

Both medical and non-medical volunteers were trained to conduct blood pressure and glucose screenings while sharing culturally appropriate handouts and giveaways (when available). Through the *Barbershop and Salon Health Outreach Toolkit*, CBHC provided both medical and non-medical volunteers with a curriculum on the cultural significance of the barbershop space, health characteristics of the African American community, and culturally-specific dietary and genetic predispositions that affected the target population.

Training sessions began with a historical overview of the role and importance of the barbershop in the African American community. Volunteers were also equipped with community-specific statistics, and trained to use blood pressure and glucose monitoring equipment. Training emphasized the need for volunteers to display confidence, since timid approaches could worsen already strained relations between clients and the medical community.<sup>39</sup>

Volunteers were trained in the “AIDET,” “LEARN,” and “Four Habits” communication models. These models employed different strategies but all focused on maintaining a conversational tone helpful for effective engagement (see appendix). The AIDET acronym stands for “Acknowledge, Introduce, Duration, Explanation, [and] Thank You,” and the model encouraged volunteers to greet clients with a welcoming tone, introduce themselves, explain how the screening services could provide assistance and options for seeking out services, and thank them for their time. The “LEARN” acronym stands for “Listen, Explain, Acknowledge, Recommend, [and] Negotiate,” and the model advocates using similar techniques while also recommending a plan of care and negotiating that plan in light of the patron’s particular circumstances and feedback. The “Four Habits” model recommended providing diagnostic and educational information at the end of the encounter, with an initial focus on eliciting the patron’s perspective and using empathy to build a positive rapport.

Both medical and non-medical volunteers were sourced through CBHC organizational partnerships and local universities. Although the volunteers that conducted the screenings did not always reflect the racial demographic of barbershop clientele, the medical professionals that conducted health counseling sessions *did*. According to Dr. Terri Richardson, the presence of Black medical professionals was powerful because they were rarely seen volunteering within their communities.<sup>40</sup>

The use of volunteers departs from another common model of the intervention, like that documented in the Texas-based Barber-1 study, in which barbers conduct the screenings and provide the education. In this study and another, the Barbershop Talk with Brothers program (BTWB), barbers were compensated for the interference with their regular business practices.<sup>41</sup>

The Connors made a strategic decision to minimize costs by using trained volunteers and volunteer medical professionals rather than pay barbers for their direct involvement.<sup>42</sup> Barbers were not trained to carry out the intervention but provided valuable indirect support. For example, barbers would hide their unhealthy food when medical providers/volunteers entered the barbershop, or would shout across the shop to clarify a long-standing health myth on the spot.<sup>43</sup> This allowed the barbers to continue “business-as-usual,” and CBHC to operate with a smaller budget.<sup>44</sup> Dr. Releford’s nationwide Black Barbershop Health Outreach Program (BBHOP) also used medical and non-medical volunteers rather than barbers to conduct screenings and education. Barbers in the BBHOP program displayed their support by wearing promotional t-shirts and using promotional capes on their clientele.<sup>45</sup>

**SUMMARY**

The design elements of CBHC’s embedded education program are listed and briefly described in the table below.

<b>Table 1: Design Elements</b>	
<b>Element</b>	<b>Description</b>
<b>Existing Relationships</b>	
Host	Barbershops
Encounter	Approach/approached by volunteers while waiting for services or immediately following services
Target individuals	African American men (barbers, owners, clients)
Community	Family and friends of target population, barbershop visitors and passersby
<b>Embedded Education Practice</b>	
Content	Cardio-metabolic disorder prevention knowledge, results of blood pressure/glucose screening, health-related statistics pertinent to the Black community, tips for healthy eating and living
Learning objectives	Screen and educate to improve health outcomes: ability to read and interpret blood pressure screening, awareness of diet/lifestyle-changes necessary for better health; decrease stigma of medical community, increase contact between African American men and medical community
Anticipated change	Personal empowerment around health and medical encounters; increased likelihood to seek medical care and adopt a healthy lifestyle
Pedagogy	Individual counseling, participatory/interactive dialogue concerning educational materials, peer role models, social group pressure
Tools	Individual screening/education: patron card, culturally-appropriate handouts addressing hypertension, diabetes, heart disease and stroke, healthy diet, exercise, weight control, stress, depression, smoking cessation (including Kaiser Permanente’s DASH Diet and the American Heart Association’s Salty Six hand-out), peer stories, promotional giveaways such as pedometers, healthy snacks, stretch bands, and cookbooks (when available)
Activities	1–10 minute screening sessions provided free of charge, one-on-one medical counseling with practitioner if necessary/desired
Educators	Educator Tier 1: Medical/non-medical volunteer formally trained by program staff Educator Tier 2: Medical professional, at least one on-site during full encounter Both sets of educators complete a mandatory training session (details available in the published toolkit)
Training of trainers	Historical context, cultural competency, race-specific health statistics, and models of communication shared during mandatory training period



**Impact**

Table 2 provides an overview of the short, medium, and long-term outcomes of the barbershop intervention within its overall logical framework:

<b>Table 2: Project Logical Framework</b>					
<b>Inputs</b>	<b>Activities</b>	<b>Outputs</b>	<b>Short-term outcomes (knowledge change)</b>	<b>Medium-term outcomes (behavioral change)</b>	<b>Long-term outcomes (changes in well-being)</b>
CBHC-developed curriculum for program operations	Blood pressure screenings	Number of individuals screened	Clients show increased knowledge of culturally salient information related to cardiometabolic health	Clients are more inclined to seek medical care, ask questions and are empowered over their own health	Reduced rates of hypertension
Human resources/volunteer Training	One-on-one dialogue	Number of individuals referred for follow-up treatment	Clients learn preventative tools to stabilize and/or decrease levels of hypertension		Decline in cardiometabolic health disparities amongst African American men
Acceptance and promotion by shop owners	Patron-specific health counseling sessions				Men become agents over their own health, with diffuse effects on the greater community

Between 2012 and 2014, the CBHC Barbershop/Salon Health Outreach Program screened approximately 1,523 African Americans for hypertension, 441 for diabetes, and logged over 1,483 hours of volunteer service.<sup>46</sup> The 2014 Power Saturday initiative alone conducted 232 screenings, with 60% of participants falling within the hypertensive range and consequently referred to a health provider for further evaluation and treatment.<sup>47</sup>

Due to budgetary limitations, CBHC did not track referrals to partnership clinics or follow-up visits to existing medical providers, or maintain trackable records of previous screening encounters. However, CBHC gathered anecdotal evidence of individual and community impact, and strove to ensure that the program followed established protocols for promoting behavioral change.<sup>48</sup> Following initial screening encounters, patrons have made further inquiries about dietary recommendations and medical services related to their current health status. Some patrons were recognized or identified themselves as repeat clients of the program. Even if patrons did not fully participate

in the screening themselves, they often collected materials to take home or brought in friends or family members to engage with service providers.<sup>49</sup>

The program's impact did not end with patrons. Volunteers and barbers also thought about their own health and reviewed literature for themselves between patron interactions.<sup>50</sup> Program benefits spilled over to owners as well. Owners had a new sense of authority and purpose in talking about health matters, and some partnering barbershops initiated their own health-related activities and solicited CBHC for support. For example, one shop owner in Colorado planned a diabetes walk and annual health fair.<sup>51</sup> The CBHC's publication of the *Toolkit* allowed the program to provide guidance to volunteers across six states who contacted CBHC for assistance in developing their own initiatives.<sup>52</sup>

A program much larger in scope, the Nationwide Black Barbershop Health Outreach Program (BBHOP) screened over 10,000 men across the nation in cities including Los Angeles, Chicago, Atlanta, and New Orleans.<sup>53</sup> BBHOP had not developed a mechanism to determine behavioral changes since operations were organized as single-day events in various cities. However, the program justified continued operations through community outreach efforts and growing scope. Aside from the diffusion of health education from patrons to their families/friends, BBHOP also reached the wider community by utilizing local businesses for promotional items and giveaways. In exchange, businesses received publicity and positive branding.<sup>54</sup>

Project leaders insisted that providing services for free supported patron participation. Having an influx of patrons who took advantage of free services mutually reinforced both the outreach program and the barbershop as a business. While barbershops gained free publicity and increased clientele through the program's press materials, health outreach programs benefited from increased numbers of patrons and passers-by who accessed their services.

## DISCUSSION

### *Stakeholder Analysis*

For the program to succeed, CBHC had to align the interests of various stakeholders both within and outside of the barbershop context, all while holding true to their theory of change.

Medical professionals had a vested interest in the program and a high degree of influence over its success. Their volunteer involvement provided accurate health-related information and established the necessary referral mechanisms for continued care. In addition, their physical presence (especially when the medical professional was an African American him/herself) worked to counter the notion that medical providers did not care for (or were not present in) Black communities.<sup>55</sup>

Partnerships with universities like the Metropolitan State University of Denver and Regis University were necessary to field both medical and non-medical volunteers. While medical volunteers had an interest in furthering their practical experience, non-medical volunteers desired to engage with the target community. Though academic calendars led to an ebb and flow of volunteers, there was a general upward trend in total number of volunteers over time.<sup>56</sup>

Barbershop owners, barbers, and clients were key stakeholders with a high level of influence over programmatic success. Program leaders noted that having shop owners who “bought-in[to]” the intervention, as well as barbers who (voluntarily) encouraged clients to take part in the intervention’s free services, had a positive impact on client engagement. Barbershops (including owners and barbers) had an interest in maintaining shop operations, retaining and increasing their clientele, as well as preserving the relaxed atmosphere of the barbershop environment. Clients had an interest in preserving their expected shop encounter, retaining their intended schedule, and preserving their own health and well-being. Ultimately, it was the clients’ ability to acquire and retain knowledge, then transform that knowledge into positive behavioral changes that allowed the program to achieve its long-term objectives.

CBHC sought to foster and maintain existing trust relationships by engaging with the target community before launching the initiative, responding to the imperatives of the operating environment, and using cultural competence to inform both the

educational methodology and patron-volunteer interactions. By using existing community ties, program leaders built a network of barbershops that welcomed the program. By negotiating with shop owners, making amendments to station set-up, and training volunteers, CBHC showed respect for the barbershop environment. By using volunteers rather than barbers to conduct blood pressure and glucose screenings, CBHC limited interference with usual business operations and kept down program costs.

Institutional safety-net partnerships, including Denver Inner-City Health Center, had an interest in reaching underserved clients in their surrounding community. By aligning with the CBHC Barbershop/Salon Health Outreach Program, Denver Inner-City Health Center helped to effectuate its mission to provide a “healthcare home for underserved individuals.”<sup>57</sup> For CBHC, a program without a referral mechanism would be incomplete since client encounters would end at the site of the barbershop without a clear direction for follow-up care. The health center provided discount vouchers for CBHC referrals, helping the barbershop program reduce barriers to follow-up care and extending the health center’s reach into the underserved community it hoped to serve.<sup>58</sup>

CBHC also received in-kind and monetary donations through institutional partners who provided educational materials and promotional giveaways integral to the screening encounter and health messaging conversations/counseling sessions. Kaiser Permanente (KP) provided financial support for CBHC’s Power Saturday initiatives as well as programmatic support to Drs. Conner and Richardson. For this reason, KP had a vested interest in both the success of its employees and the barbershop program’s impact on the community it served.<sup>59</sup> Public health organizations, including the American Heart Association, the American Diabetes Association, and Alzheimer’s Association, provided educational handouts and updates on health guidelines of relevance to the African American community. These organizations each had an interest in effectuating organizational missions and maintaining their international brands.<sup>60</sup>

### *Governance Challenges*

**Developing, testing and fine-tuning a theory of change.** Program designers strategically considered the impact of data collection on program operations. Specifically, they did not want to exacerbate existing mistrust of the medical community by simulating an experimental environment. Requiring patrons to provide personal data may

have made them less likely to engage with volunteers or seek follow-up care. Recognizing data collection as a necessary component of follow-up analysis, CBHC program leaders undertook research in the hope of developing a tracking mechanism would not threaten clients' trust. With limited funding, however, this hope went unfulfilled. Without a partner to facilitate this research, program evaluation remained limited to anecdotal evidence and individual observation.<sup>61</sup>

**Developing and communicating the value proposition to partner organizations.** There was little debate over the need for outreach efforts in medically underserved communities. In light of the health risks facing African American men, the need to increase awareness and access and empower individuals with knowledge was apparent. For some barbershop owners, the primary motivation was not community concern but rather the hope of increased clientele resulting from partnership in the program. Some shop owners who initially welcomed the program were unresponsive to follow-up communication. With many barbershops willing to take part, however, program leaders did not spend a great deal of energy trying to persuade or maintain partnerships with those who were reluctant or seemed burdened by the request.<sup>62</sup>

**Limitations on human resources.** Early on, the CBHC program struggled to secure staff with the necessary grant-writing skills to maintain consistent funding for program operations. Program staff was overextended with responsibilities and could not sacrifice the additional time necessary for fundraising. However, by utilizing community networks and publicizing their needs through local media sources, the organization was able to grow its volunteer base to assist with administrative operations.<sup>63</sup>

**Institutionalizing the practice and making it sustainable.** CBHC also struggled for some time to sustain fundraising goals without supplemental financial support from volunteers. Though operating with relatively low overhead costs, program leaders noted a decrease in financial support from both volunteers and sponsoring organizations over time, making coordinated initiatives like Power Saturday more difficult to sustain. Despite initial support from Kaiser Permanente's AACE, budget cuts and minimal staff at the center stalled operations. At the time of this case study (2016), no other Kaiser Permanente site had instituted similar operations, and funding for the AACE had ceased.<sup>64</sup>

At BBHOP, changes in leadership also threatened program sustainability. Though BBHOP successfully screened thousands of men across six states, the temporary loss of this program's innovative leader, Dr. Bill Releford, stalled operations and stunted program growth. While Dr. Releford intended to re-instate operations before 2017, the momentum that came from positive press coverage petered out. It seems the operational model of CBHC's outreach program, rooted in a network of volunteers, may have provided a higher degree of sustainability. However, CBHC's need for medical volunteers was at times difficult to satisfy without its founders' personal and professional networks facilitating their continued involvement.

### *Operational Challenges*

**Finding space and time.** Despite the presence of numerous barbershops within African American communities, not all shops had the square footage, layout or client flow necessary for successful program operations. CBHC terminated some barbershop partnerships due to low client volume. Through trial and error, program leaders eventually settled on Saturdays as the day for barbershop presence since it consistently yielded a high number of clients.

In addition, barbershop programs had to balance volunteer availability for program operations. In early operations, CBHC attempted to hold screenings twice a day; however, this proved too daunting for time-strapped volunteers. In response, CBHC changed their model to once-weekly four-hour sessions, with volunteers rotating through a list of partnering shops by the week.

**Finding the right mix of educational tools and strategies.** The Conners were unable to access any established guidelines or protocols to direct their initial efforts. Despite failed attempts to contact the leading program at the time (BBHOP), the Conners decided to start small and define their own design by reviewing published literature and incorporating their past experiences as Black medical professionals. While BBHOP's published shop layout helped to inform CBHC's spatial design, other CBHC program aspects were organically designed. With the assistance of Kaiser Permanente, CBHC ultimately created the toolkit described thus by Dr. Conner:

Everything we're doing, what's in that toolkit, [are] things we've come up with based on our own experience with the barbershop program and some prior community outreach experience. We've added more as the program has grown much bigger than I've ever dreamed, both in terms of the number of volunteers and [partnering] shops.<sup>65</sup>

To sustain their model, educational materials were continuously reviewed and updated to ensure cultural relevance and applicability. Though this process required additional effort, Dr. Richardson considered it a key factor in building trust between the volunteers and target community.

**Retaining volunteers to make the practice sustainable.** Despite a growing volunteer base, CBHC has had to decline potential barbershop partners for lack of volunteers. Balancing volunteers' availability with the already strenuous schedules of the program's three leaders, one of whom was required to be on duty at a partner shop every Saturday, proved challenging.

With the volunteer base primarily consisting of college and university students, CBHC also had to align efforts with school schedules and academic calendars. To accommodate its growing student base, CBHC amended volunteer policies to require volunteers to participate only once per semester (though many engaged more frequently). Additionally, when program funding allowed, program leaders offered volunteers tokens of appreciation or thank-you events that acknowledged their efforts.<sup>66</sup>

**Creating trust, sense of urgency, and incentives to participate.** To assist volunteers (especially non-Black volunteers and those unfamiliar with the barbershop environment) who felt apprehensive about the initial encounter, program leaders provided education on the history of the Black barbershop, as well as health factors unique to the Black community. By understanding their operating environment, volunteers respectfully engaged with it and maintained the trust relationships already in place. Volunteers also created and sustained trust by delivering confident messages, using the "patron card" as a "cheat-sheet" in case of any missteps, and using communication models as relayed during orientation. While giveaways were helpful tools used to incentivize participation, these materials were contingent upon in-kind donations and not always available.<sup>67</sup>

**Obtaining hard data to confirm the behavioral changes.** Neither the CBHC program nor nationwide BBHOP initiative quantitatively tracked data that would have linked screened clients to follow-up encounters and/or resulting behavioral changes. While both programs identified data mechanisms as a key goal for future efforts, their focus on initiating and sustaining trust relationships between clients and the medical community prevented them from collecting patron data. As noted, funding and human resource limitations also hindered efforts to push data-collecting initiatives forward.

**Negotiating with hosts.** Both CBHC and barbershop owners had to end program operations at particular shops for various reasons. When a barbershop owner unexpectedly instructed CBHC volunteers to move their station outside of the shop in oppressive summer heat, for example, CBHC decided to end their partnership with the host site.

Owners also ended partnerships on the basis of inconsistent programming and/or volunteer staffing. Sometimes, owners terminated the partnership without clarifying a reason. Dr. Conner, who primarily handled barbershop negotiations, was “old-school” in his response to such cases: rather than pester unresponsive or uninterested shop owners, he chose to focus on those shops who were interested in serving as hosts. “There are too many shops,” he said, and plenty of community members in need of this service.<sup>68</sup>

**Sustaining operations with limited funding.** CBHC was a small non-profit that operated efficiently to execute its projects. In 2014, contributions from Kaiser Permanente were supplemented by donations from volunteers and in-kind contributions from partnering organizations. When financial contributions from Kaiser Permanente were discontinued, Drs. Conner and Richardson insisted that base operations could be sustained at a low cost. Though obtaining the equipment and materials for glucose screenings was costly, conducting blood pressure screenings and the additional materials needed for that work—such as a small card table, a few chairs, donated health education materials, and “patron cards”—remained an inexpensive core activity that could keep the program operating in leaner times.



## APPENDIX

### *Method*

Our study uses a multiple-case replication design, within which we investigate our topic of interest through in-depth research and analysis of multiple cases. Robert Yin notes that the “distinctive need for case study research arises out of the desire to understand complex social phenomena.”<sup>69</sup> Embedded education is a complex phenomenon that includes multiple actors whose activities and frames of reference are shaped by both highly formal organizational systems and informal community norms. As such, we decided to use the case study method to ensure that we captured the rich complexity of the phenomenon. This is especially important because though there are many examples of embedded education from around the world, the research work we conducted was one of the first, if not the first, to explicitly focus on it as a phenomenon worthy of study in its own right.

We chose to study multiple cases to enable us to gather as much information about the phenomenon as possible. Using a literal replication strategy, we selected two cases in China, one in the U.S.A., and one in the Netherlands that we believed were exemplars of embedded education in that the programs were clearly embedded in an existing system and were explicitly focused on educating a group of learners.<sup>70</sup>

To explore how innovations happen in service delivery, our design encompasses multiple units of analysis, including service encounters, individual participants, communities, organizations, and inter-organizational relationships. For service *encounters*, we are concerned with the important variables to consider in designing a meaningful educational encounter as well as the challenges in doing so. For individual *participants*, we seek to identify evidence to show changes in knowledge, behavior, and overall wellbeing amongst the participants, with special attention paid to whether the design is concerned with the acquisition of critical thinking skills and personal empowerment. In a similar way, our focus on *communities* calls for attention to whether there is any demonstrated impact on the communities in which the participants live and work, and how effects are transmitted from individual to community. Our focus on *organizations* looks at their motivations for getting involved in the projects, and whether there is any evidence that embedded education has a positive impact on the operations of the host

organization(s). Finally, our focus on inter-organizational relationships begins with an understanding that embedded education demands the (disruptive) integration of the intervention/program into the existing operations of a host organization. With this in mind, our focus is on the challenges of making such integration work, especially given that there are normally multiple organizations involved. More generally, we expect the research to yield insights into cross-sector collaboration and identify whether embedded education creates the opportunity for the integration of other social interventions into the operations of existing delivery systems.

Our data collection relies heavily on information from individual interviewees at the organizations, but it also taps into a number of other data sources including public records, published reports, media materials, internal reports, and standardized curriculums for triangulation.

***Data Sources***

This paper draws from two sets of sources. The primary sources were interviews with key personnel at CBHC in Colorado. The secondary sources were reports and other publications and materials we collected in the field from research participants and online.

Handouts

**THE SALTY SIX**

# DID YOU KNOW?


**THESE SIX POPULAR FOODS CAN ADD HIGH LEVELS OF SODIUM TO YOUR DIET\***

The American Heart Association recommends that you aim to eat less than 1,500 mg of sodium per day.

When you see the Heart-Check mark on a product, you know the food has been certified to meet nutritional criteria for heart-healthy foods, including sodium.

- BREADS & ROLLS**  
Some foods that you eat several times a day, such as bread, add up to a lot of sodium even though each serving may not seem high in sodium. Check the labels to find lower-sodium varieties.
- COLD CUTS & CURED MEATS**  
One 2 oz. serving, or 6 thin slices, of deli meat can contain as much as half of your daily recommended dietary sodium. Look for lower-sodium varieties of your favorite lunch meats.
- PIZZA**  
A slice of pizza with several toppings can contain more than half of your daily recommended dietary sodium. Limit the cheese and add more veggies to your next slice.
- POULTRY**  
Sodium levels in poultry can vary based on preparation methods. You will find a wide range of sodium in poultry products, so it is important to choose wisely.
- SOUP**  
Sodium in one cup of canned soup can range from 100 to as much as 960 milligrams—more than half of your daily recommended intake. Check the labels to find lower sodium varieties.
- SANDWICHES**  
A sandwich or burger from a fast food restaurant can contain more than 100 percent of your daily suggested dietary sodium. Try half a sandwich with a side salad instead.

\*Source: The Sodium Content and Preparation, Marketing and Primary Health Report (NHW05), Risk Factors, Food Categories Contributing to High Sodium Consumption—United States, 2017–2024, February 16, 2011. © 2005, 2010



**HIGH BLOOD PRESSURE**

*You may have high blood pressure and not even know it. That's why getting regular checkups is important. They're quick, easy, - and painless. And they can save your life.*

**TAKE THE PRESSURE OFF**

High blood pressure is sneaky. It can damage the arteries and veins that carry blood through your body, and you may not even know it until something bad happens to you – like a heart attack or a stroke.

When you have your blood pressure checked, you will receive two numbers. Both measure different things. For example:

**120** The top number (systolic) is the pressure when your heart beats.

**80** The bottom number (diastolic) is the pressure when your heart is at rest.

**BLOOD PRESSURE GUIDELINES\***

Systolic		Diastolic	Indicates
Less than 120	AND	Less than 80	Normal
120–139	OR	80–89	Prehypertension
140–159	OR	90–99	High — Stage 1
160 or higher	OR	100 or higher	High — Stage 2
More than 180	OR	More than 110	Crisis — Get help now! Emergency care needed

\*Based on American Heart Association's 2010 Treatment Guidelines

**LEARN MORE**

### African Heritage Diet Pyramid



The African Heritage Diet Pyramid is a guide to the healthy traditional diets of African American ancestors. Base your meals mostly on a variety of foods nearest the base of the pyramid.

- Go For Greens. Greens like spinach, collards, mustards and leafy greens are a big part of African heritage cuisine. They help keep your blood, liver, and kidneys in top health. Cook them lightly to retain all of their extraordinary nutrients!
- Every day, enjoy vegetables, fruits, mostly whole grains and cereals, beans, herbs and spices, peanuts and nuts, and healthy tubers like sweet potatoes. These are the core African Heritage foods to shop for, prepare, and eat most often.
- Tuna, mackerel, and salmon are rich in heart-healthy omega-3 fatty acids. Sardines and other small, bony fish are rich sources of calcium and vitamin D. Enjoy them grilled, broiled, or lightly pan cooked in water and a tiny bit of oil.
- Use small amounts of healthy oils, like sesame or olive oil for dressings, and canola, red palm oil, or extra virgin coconut oil for cooking.
- Eat eggs, poultry and other meats moderately, in small portions, or use as garnishes for other dishes.
- Consume dairy in small portions, and if you are lactose intolerant, enjoy other calcium-rich foods like greens, beans, and almonds.
- Sweets, at the top of the pyramid, are foods to eat less often, limiting them to once a week or at special meals.
- Drink plenty of water throughout the day. If you drink alcohol, limit it to one glass per day for women, two for men.

### Health Through Heritage

The diseases we know today, like diabetes, heart disease, cancer, and obesity, were much less common with traditional diets in earlier times. Scientific studies show that conditions like these skyrocket as traditional diets are left behind.

The African Heritage Diet Pyramid is based on scientific research that shows eating like your ancestors can help:

- Lower your risk of heart disease, high blood pressure, and stroke
- Avoid or help treat diabetes
- Fight certain cancers and many chronic diseases
- Reduce cataracts, glaucoma, and kidney disease
- Nurture healthy babies
- Achieve a healthy weight and avoid obesity
- Reduce depression
- And more!

### Easy African Heritage Recipes

Use healthy African heritage foods to style any meal!

- Hearty Pumpkin or Squash Soup
- Delicious Rice and Bean Medleys
- Stewed Tomatoes and Okra
- Healthy Potato Salad and Corn Bread
- Plus dozens more!

To find recipes and details on the latest scientific studies for enjoying health through heritage, visit the African Heritage section of the Oldways website at:

[www.oldwayspt.org](http://www.oldwayspt.org)



HEALTH THROUGH HERITAGE  
266 Beacon Street  
Boston, MA 02116 USA  
617-421-5900

© 2010 Oldways Preservation and Heritage Trust

## Welcome to the African Heritage Diet

Claiming Your Health by Claiming Your History



Diabetes is not part of your heritage. Neither is heart disease.

What is in your heritage is a healthy heart, a strong body, extraordinary energy, vibrant and delicious foods, and a long, healthy life.

You have the power to claim all of this, using heritage as your guide.

Brought to you by




With national support from the Walmart Foundation







## DASH Diet: Dietary Approaches to Stop Hypertension

The DASH (Dietary Approaches to Stop Hypertension) eating plan is rich in whole grains, vegetables, fruits, and dairy products which are low in fat and fat-free. These foods are also naturally low in sodium and contain nutrients that may help lower blood pressure. Even if you don't have high blood pressure, eating this way can help prevent increases in blood pressure that occur as you get older.

### Getting started

**Start small. Make gradual changes in your eating habits.**

- If you eat one or two vegetables a day, add a serving at lunch and another at dinner.
- If you don't eat fruit now or have only juice at breakfast, add a serving to your meals. Eat fruit as a snack.
- Use only half the butter, margarine, or salad dressing as you do now.
- Gradually increase dairy products to two or three a day. Choose low-fat or fat-free dairy products.

**Treat meat as one part of the whole meal, instead of the focus.**

- If you eat large portions of meat, cut back gradually—by a half or a third at each meal. Increase servings of vegetables, rice, pasta, and dry beans at meals.
- Include two or more vegetarian-style (meatless) meals each week.

**Eat fruits or low-fat foods as desserts and snacks.**

- Fruits and low-fat foods offer great taste and variety. Use fruits canned in their own juice. Fresh fruit needs little or no preparation. Dried fruit is easy to carry with you.

Food group	Servings	1 serving equals	Healthy examples and notes
whole grains and grain products	6 to 8 per day	1 slice bread 1/2 cup dry cereal 1/2 cup cooked rice, pasta, or cereal	whole wheat bread, English muffin, pita bread, whole grain cereals, grits, oatmeal, tortillas, pasta, brown rice
vegetables	4 to 5 per day	1 cup raw, leafy vegetables 1/2 cup cooked vegetable 6 oz. low sodium vegetable juice	tomatoes, potatoes, carrots, peas, broccoli, turnip greens, collard greens, kale, spinach, artichokes, green beans, sweet potatoes
fruits	4 to 5 per day	6 oz. fruit juice 1 medium fruit 1/4 cup dried fruit 1/2 cup fresh, frozen, or canned fruit	apricots, bananas, dates, grapes, oranges, orange juice, grapefruit, grapefruit juice, mangoes, melons, peaches, raisins, strawberries, tangerines
low-fat or fat-free dairy foods	2 to 3 per day	8 oz. milk 1 cup yogurt 1 1/2 oz. cheese	fat-free or 1% milk, fat-free or low-fat buttermilk, fat-free or low-fat yogurt, part skim mozzarella cheese, fat-free cheese
meats, poultry, or fish	2 or less per day	3 oz. cooked meat, poultry, or fish	lean meats, poultry, or fish. Trim away visible fat. Broil, roast, or boil instead of frying. Remove skin from poultry.
nuts, seeds, and legumes	4 to 5 per week	1 1/2 oz. (1/3 cup) nuts 2 Tbsp. seeds 1/2 cup legumes	kidney beans, garbanzo beans, lentils, almonds, filberts, peanuts, walnuts, sunflower seeds


### Reduce salt and sodium.

- Read food labels to select foods lower in sodium.
- To flavor foods when cooking, use herbs and spices (like oregano, thyme, paprika, nutmeg, turmeric, and coriander) instead of salt.
- Limit or avoid high-sodium foods (like smoked, cured, or processed foods; convenience foods or fast foods; high-sodium condiments; highly salted snacks; and sauces, mixes, and "instant" products).
- Use fruit juice or vinegar to marinate foods.

*Patron Card*

**A business sized card is used, front and back.**

**Front of Card**



*My blood pressure reading today is*  
\_\_\_\_\_

Glucose result \_\_\_\_\_

Date \_\_\_\_\_

Colorado Black Health Collaborative  
Phone Number: 720-777-777  
[ColoradoBHC@yahoo.com](mailto:ColoradoBHC@yahoo.com)

**Back of Card**

*Normal: Less than 120/80*

*Pre-Hypertension: 120-139/80-89*

*Stage I Hypertension: 140-159/90-99*

*Stage II Hypertension: 160/100*

*Client Communication Models*

.....

AIDET – ACKNOWLEDGE, INTRODUCE, DURATION, EXPLANATION, THANK YOU

***Acknowledge, Introduce, Duration, Explanation, Thank You (AIDET) Model – Adapted from Studer Group’s Five Fundamentals of Service***

**Acknowledge** — Greet people with a smile and use their names if you know them. Attitude is everything. Create a lasting impression.

**Introduce**— Introduce yourself to others politely. Tell them who you are and how you are going to help them. Escort people where they need to go rather than pointing or giving directions.

- “My name is Jennifer and I’m doing free blood pressure checks today. We also have other volunteers here who are doing glucose checks. Please feel free to stop by after your haircut.”

**Duration** — Keep in touch to ease waiting times. Let others know if there is a delay and how long it will be. Make it better and apply service recovery methods when necessary.

- “Would you like to get your blood pressure checked before or after your haircut?”

**Explanation** — Advise others what you are doing, how procedures work and whom to contact if they need assistance. Communicate any steps they may need to take. Make words work. Talk, listen and learn. Make time to help. Ask, “Is there anything else I can do for you?”

- “The blood glucose or sugar check takes about 5 minutes. We’ll clean your finger and take a small blood sample with a finger prick. The results are immediate. Would you like to read while you wait?”

**Thank You** — Thank the client. Foster an attitude of gratitude. Thank people for their patronage, help or assistance. Use reward and recognition tools.

- “Thank you for stopping by today. Is there anything else I can do today? It has been a privilege to care for you.”



LEARN

The following LEARN communication framework may be used to help health care providers overcome communication and cultural barriers to successful patient education.

**1. Listen**

Listen with empathy and understanding to your patient's perception of the problem. Encourage your patient to discuss his understanding of the causes and effects of his illness and to describe the treatment and resources he feels will contribute to recovery. "What do you feel may be causing your problem? What do you feel might help or hinder your recovery?" are examples of questions that elicit patient feedback.

**2. Explain**

Explain your patient's illness, the recommended plan of care and subsequent management of self-care. Even without a diagnosis, it is essential that you explain what you have in mind in terms the patient can understand. Take into account literacy level, cultural beliefs, and past experiences which may affect understanding and acceptance of any suggestions you give. Try to link your explanation to something the patient already knows. Do not ask for feedback by asking "Do you understand or have any questions?" but rather, discuss a particular point or pose a problem to which the new information can be applied.

**3. Acknowledge**

Acknowledge your patient's feedback and understanding of his illness and plan of care. Discussing the differences and similarities with your observations will help promote patient involvement. Areas you agree upon should be recognized and differences resolved. Whenever possible, integrate your patient's suggestions into any care approach. This will give him a sense of control and commitment. If his suggestions would have a negative effect, explain the consequences and try to make the appropriate plan of care more desirable.

**4. Recommend**

Recommend a plan of care that fits within the patient's parameters. This can be accomplished after completing the 3 previous steps. The more involved your patient is in the development of his plan of care, the more interested he will be in its outcome. It is important to listen to concerns your patient may have and agree on solutions that will enhance commitment.

**5. Negotiate**

Negotiate agreement with your patient on a course of action. This requires a keen understanding of your patient's perspective and the ability to integrate the information you gained in the previous four steps. Successful completion of this final and key step can lead to a variety of patient-specific approaches that will increase the change of a successful recovery and healthier life.

.....  
FOUR HABITS

*The following communication model was developed by Terri Stein, MD, Director of Clinician-Patient Communication, The Permanente Medical Group, Kaiser Permanente.*

Habit	Skills
Invert in the Beginning	Create rapport quickly; Elicit patient's concerns; Plan the visit with the patient
Elicit the Patient's Perspective	Ask for patient's ideas; Elicit specific requests; Explore the impact on the patient's life
Demonstrate Empathy	Be open to patient's emotions; Make at least one empathic statement; Convey empathy non-verbally; Be aware of your own reactions
Invest in the End	Deliver diagnostic information; Provide education; Involve patient in making decisions; Complete the visit

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46. Kaiser Permanente “Coloradans Receive Free Blood Pressure Checks at Denver-metro Barbershops,” press release, Kaiser Permanente, May 31, 2014, <http://share.kaiserpermanente.org/article/coloradans-receive-free-blood-pressure-checks-at-denver-metro-barbershops/#sthash.vbtOyxWB.dpuf>.
47. CBHC Internal Report, “Colorado Black Health Collaborative Power Saturday at the Shops 2015,” Colorado Black Health Collaborative.

48. A study of the program's 2012–2014 operations found that a majority of patrons screened were male and that those aged 31–45 also had the highest rates of pre-hypertension. (Study provided by Terri Richardson, MD).
49. Richardson, Conner, and Alfredia Conner, interview by Deloris Wilson March 16, 2016; Mulatu, interview.
50. CBHC volunteer interview, Monica Scott (April 7, 2016).
51. CBHC Barbershop/Salon program interview, (March 16, 2016).
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56. Richardson, Conner, and Conner, interview.
57. Inner City Health Center, "About Us," Inner City Health Center, <http://innercityhealth.org/about-us/>.
58. Mulatu, interview.
59. Kaiser Permanente, "About Kaiser Permanente," Kaiser Permanente, <https://share.kaiser-permanente.org/about-kaiser-permanente/>.
60. See Dr. Conner's discussion above concerning guidelines not taking into account the salt-sensitivity of African Americans.
61. Richardson, Conner, and Conner, interview; Richardson, interview (April); Bill J Releford, Stanley K Frencher, Jr, and Antronette K. Yancey, "Health Promotion in Barbershops: Balancing Outreach and Research in African American Communities," *Ethnicity & Disease*, 20 (2): 185–188, 2010.
62. Richardson, interview (April).
63. Ibid; Richardson, Conner, and Conner, interview.
64. Kaiser Permanente Representative, interviewed by Deloris Wilson, May 4, 2016.
65. Richardson, Conner, and Conner, interview.
66. Ibid.
67. Ibid.
68. Ibid.
69. Robert K. Yin, *Case Study Research: Designs and Methods*, 5th ed. (Thousand Oaks, CA: Sage, 2014).
70. A literal replication strategy is one that presumes the cases selected will yield similar results thus serving to confirm each other, according to Yin (p. 57).



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