Strengthening Cardiovascular Disease Prevention and Management in Community-Based Primary Health Care

Final Report

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1 This project was funded through the New York State Department of Health’s (NYS DOH) Healthy Heart program.
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INTRODUCTION

Founded 36 years ago, the Community Health Care Association of New York State (CHCANYS) has long provided clinical education, training and other support to its member Community Health Centers (CHC) to address a wide variety of community health needs. In addition to its work with Health Resources and Services Administration (HRSA) in helping to coordinate the Health Disparities Collaboratives (HDC) in the Northeast Region, CHCANYS also addresses relevant clinical education needs in an annual Clinical Conference, which has routinely been certified to offer Continuing Medical Education (CME) credits to its attendees.

CHCANYS, as the HRSA-designated Primary Care Association (PCA) for New York State, is in the process of developing and implementing a new Pilot Cardiovascular Disease (CVD) Risk Management Clinical Education and Training Program. In essence, the pilot program will help facilitate integration and dissemination of a new CVD care model for CHCs whose current condition of focus is primarily diabetes. The intended outcomes will include the expansion to CVD by these organizations, not solely for patients with diabetes, but for all patients identified as hypertensive and/or dyslipidemic.

The first step in achieving the goals of this project was to conduct two focus group sessions that would inform the development of a model, one-day clinical education and training curriculum. The following report is a summary of the two focus group sessions with a discussion of how the focus group findings helped to inform the development of the one-day curriculum for the May 2007 Clinical Leadership Forum.

BACKGROUND

Recent HRSA and Bureau of Primary Health Care (BPHC) efforts have utilized Health Disparities Collaboratives to promote more effective health care models for populations at disproportionate risk for cancer, diabetes, depression, asthma and other chronic health problems. As a result, many CHCs in New York State are in the process of establishing and/or expanding more comprehensive, team-based and patient-centered approaches to a wide range of health conditions. To date, however, only two CHCs in New York have established comprehensive programs for CVD prevention and intervention.

Like other conditions associated with broad public health disparities in New York, CVD prevalence and incidence is excessively high among low-income as well as many racial/ethnic minority populations. Causes are multiform and include lifelong poor nutrition, tobacco use and other so-called lifestyle factors. But other health disparities also play a critical role. For example, diabetes, currently believed to affect >6% of all
New Yorkers (including 1 in 8 New York City residents), has been associated with very exceptional CVD incidence as well as markedly poorer health outcomes.\(^2\)

In general, the HDC experience has taught that one of the best ways to disseminate new care models for inadequately addressed health conditions is to start with existing, successful disease management efforts.\(^3\) It follows that one especially promising strategy for expanding the dissemination of more effective CVD programs throughout New York is to begin with the much larger number of CHCs that have developed or are developing more effective models of diabetes care. By no means is this to suggest that CVD program dissemination should end with these CHCs, or even be restricted to benefit their patients with diabetes alone. But by targeting new CVD care model dissemination efforts to CHCs with diabetes management programs, it will be possible to:

- Leverage existing care models and accompanying processes of organizational change to “jump start” effective CVD programs in these CHCs; and
- Achieve a relatively larger short-term impact on the public’s health, given the association between diabetes and exceptionally poor CVD outcomes.

### METHODOLOGY

#### Purpose

The purpose of the focus groups was to investigate, identify, assess and characterize specific barriers and challenges to implementing effective CVD risk management programs among participants who have attempted, are in the process or are considering implementing a CVD program and participants who have implemented a CVD program. In addition, the focus group will attempt to garner possible solutions for identified barriers and challenges from the experiences of participants with a CVD program.

#### Potential Participants

The full spectrum of community health primary care team members (physicians, physician assistants, nurse practitioners, nurses, social workers, patient representatives, health educators and outreach workers) from 18 CHC throughout the state of New York were invited to participated in one of two focus groups held in Rye Brook and Manhattan, New York. Of the CHCs that were invited to participate, 3 (17%) were located in upstate New York, 4 (22%) were located in the Mid-Hudson Region and 11 (61%) were located in New York City (see Table 1).

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\(^2\) According to the National Institutes of Health (NIH), nearly two thirds of people with diabetes die from heart disease or stroke — making it the leading cause of premature death among them.

\(^3\) This is because the general models for providing more collaborative, patient-focused and preventive care and management are typically very comparable, irrespective of the specific disease conditions they are intended to address.
The selection of the above CHCs was purposeful. Each center was selected to participate in the focus groups because of their experience with the health disparities collaboratives and their work with vulnerable populations. More importantly, these health centers were selected to participate because of their rich experiences in dissemination and implementation of the Care Model as a “system change” in their organization.

**Focus Group Facilitation**
Focus groups were conducted in Rye Brook and Manhattan, New York on January 26, 2007 and March 9, 2007, respectively. Table 2 shows that staff members from seven CHCs were scheduled to participate in the Rye Brook focus group and five attended and participated. In Manhattan, staff members from 9 CHCs were scheduled to participate and 9 attended and participated.

<table>
<thead>
<tr>
<th>Location</th>
<th>Scheduled</th>
<th>Participated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rye Brook</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Manhattan</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16</strong></td>
<td><strong>14</strong></td>
</tr>
</tbody>
</table>

A total of 14 individuals participated in both focus groups and each session lasted approximately two hours. Each session was facilitated by Ms. Wanda Montalvo, New York State Health Disparities Coordinator, who was assisted by Dr. Hugh Wesley Carrington. Dr. Carrington is Director of Evaluation and Special Projects at CHCANYS and served as Principle Investigator on this project.

**Day of the Focus Group**
As participants arrived in the room they were greeted and asked to complete the respondent’s profile questionnaire while they waited for the focus group to begin. The facilitator explained the purpose of the questionnaire and assured the participants of the confidentiality and anonymity of the reported information. The informed consent and agreement to participate form was also distributed to participants for them to review.

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4 The complete Facilitator’s Guide is included in the Appendix.
After the facilitator introduced herself, participants were asked to introduce themselves. They were then reminded of the purpose of the focus group and were informed about their confidentiality and anonymity related to all data collected during the session. Participants were queried to see if they had any questions and were asked to sign the informed consent and agreement to participate form acknowledging participation and giving the facilitator permission to tape record the session and use of anonymous quotations in subsequent reports.

The facilitator reviewed the ground rules for the session with the participants and began the discussion. At the end of the discussion, the facilitator thanked the participants for the willingness to share their thoughts and experiences. They were reminded of how the collected information will be used and were asked to make themselves available to review the transcripts of their comments to ensure accuracy.

**Research Questions**

1. Do CHCs encounter barriers and challenges when attempting to implement a CVD risk management program?

2. If barriers and challenges were encountered, are they different for CHCs who have implemented, have attempted, are in the process or are considering implementing a CVD program?

3. If barriers and challenges were encountered, are there identified solutions to help CHCs overcome them?

**Analysis**

The completed respondent’s profile questionnaires were entered into a database and used to describe the sample and their experience with CVD programs. Notes from the focus groups were analyzed and major concepts and themes, patterns and trends were identified and coded.

**RESULTS**

**Description of the Participants**

A total of 14 individuals participated in the focus group sessions held in Rye Brook and Manhattan, New York. Of those 14 participants:

- 12 (85.7%) were females and 2 (14.3%) were male
- 2 (14.3%) were 21 - 30 years old, 3 (21.4%) were 31 – 40, 4 (28.6%) were 41 – 50 and 5 (35.7%) were 51 - 60 years old
• 1 (7.1%) responded that he/she was Hispanic (Latin-American, Mexican), 2 (14.3%) responded Other and Asian or Pacific Islander, respectively, 4 (28.6%) responded non-Hispanic White (Caucasian) and 5 (35.7%) responded that they were Black (African American, Caribbean)

• 3 (21.4%) responded that they were college graduates (undergrad), 1 (7.1%) responded some post-graduate work and 10 (71.4) held post-graduate degrees

• 13 (92.9%) were employed full-time and 1 (7.1%) were employed part-time

• 8 noted their job titles as:
  o Chief Medical Officer (2)
  o Medical Director
  o Director of Performance Improvement
  o Director of IACH
  o PA/Medical Affairs Administrator
  o Social Worker
  o Quality Improvement Coordinator
  o Six participants did not respond

When the 14 participants were asked:

• How long have you worked with/for Community Health Centers?  3 (21.4%) responded less than 1 year , 5 (35.7%) said 1 - 5 years and 2 responded 6 – 10, 11 - 15 and 16 - 20 years, respectively

• Are health disparities a major concern in the community where you work? All 14 (100%) responded “yes”

• Are community health centers the right health care agency to address health disparities? 12 (85.7%) responded “yes” and 1 (7.1%) responded “no” and “don’t know”, respectively

• In your opinion, are community health centers doing enough to combat health disparities in their surrounding communities? 6 (42.9%) responded “yes” and 4 (28.6%) responded “no” and “don’t know”, respectively

• How many years experience do you have working with Cardiovascular Disease risk management programs? 8 (57.1%) responded less than 1 year, 3 (21.4%) said 1 - 5 years and 1 (7.1%) said 6 - 10 years – 2 (14.3%) participant did not respond
• What is your health center’s Cardiovascular Disease risk management program status? 3 (21.4%) responded that their health center had implemented a CVD program, 2 (14.3%) said “in the process”, 4 (28.6%) said “considering”, and 5 (35.7%) responded “Other” – specifying that they haven’t implemented a CVD program, it is part of their Core Model and that the program was implemented and terminated, respectively. Two participants were not specific in their response.

Barriers and Challenges
The focus groups revealed that CHCs did encounter barriers and challenges when attempting to implement a CVD risk management program. However, the barriers and challenges encountered were not necessarily different for CHCs who had implemented, had attempted, were in the process or were considering implementing a CVD program.

The following is a summary of barriers and challenges encountered by CHCs:

- Duplication of work (lack of coordination internal & external)
- Data (maintenance, accurate information); HEDIS, QUARR, HMO -- asking for more and more data; HMO has data we don’t have (i.e. hospitalizations, ER visits) but require us to give them data
- Prioritizing work, having a road map; Competing priorities
- Establishing priorities to support consistency of work where leadership sets the tone/message
- Obtaining agreement/some level of consensus this is not only clinical, must change roles and create capacity (staff, providers, health educators, medical assistants, patient assistant technicians)
- Formal trainings can be expensive, important to “own” the process of new skill set
- Identifying the correct partner to support training on ongoing basis
- Dizziness of reporting requirements across multiple agencies
- Staffing challenges; Staff turnover (commitment to FQHC mission); Nursing shortage (finding linguistically competent staff)
- No celebrating of successes
- Barrier to disease management is disease program instead of primary care focus
- Financial barriers; Not being reimbursed for this work; Incentive/Reimbursement for enabling services (i.e. case management); Cost of living in NYC (COLA does not match particularly in NYC and it's particularly challenging for front line staff/support staff)

- Space

- Patient visit re-design and quality of care

- Waiting times

- A lack of information technology, not being able to obtain population-based data because most information comes out of our billing system

- Time

- Linguistic needs

- Regulations

- Access to specialty care (linguistically appropriate, willing to see undocumented patients)

- Restricted to quantitative research versus qualitative research. Most money given to larger organizations and we're not able to capture NIH dollars

- Care model advocates for enabling services (i.e. care manager, not case management) these types of services are not reimbursed

- EMR = we’re actually doing more because higher standard of care but paid same amount of money for services

- Geographic challenge, not enough people in community to support front line employee pool

- Patients are mobile, hard to get a hold of them

- HMOs re-groups patients and shift the medical home; HMOs have higher revenue as part of their bottom line instead of being at the health center level where the work is actually being done

- Uninsured = can they come in for services? Afford their medications?

- Working with belief systems between/among our patients/staff

- Obesity in CVD = more difficult to care for patient
➤ Project view instead of organizational transformation

➤ Culture of the organization can be a challenge

➤ Educational materials: No respect for educational materials, the quality of the material; Not well produced and do not want to spend the money; Reading levels are not appropriate as well as language; Leadership support is essential “real support” not lukewarm

➤ Self-Management: Agreeing on definition on self management; Confusion among staff between the difference of patient education and self management; Front line staff and non-clinical staff members think self management is important; Clinicians believing self management is important and taking it on instead of “referral out” to staff to support self management; Time for clinicians to address self management goal; Patients may want someone who “understands my world” vs. a clinical person providing the instructions on self management; Goal tracking on self management; Self-Management is a concept that is a challenge for providers, staff and patients. How do you track progress towards Self-Management goal?

➤ Leadership: Nurturing future physician leaders; Developing the appropriate skill set in mentoring skills; Torn between staying alive and keeping doors open and quality care (is it planned care); Need to acknowledge quality is important not just finances; Hands in too many pots and higher commitment stretched staff resources; Leadership has to find ways to stay true to mission efficiency, effectiveness and consumer satisfaction; Leadership is not about looking good on paper but actually affecting care. The clinicians in the room want to see improved patient outcomes not just patient satisfaction; Leadership conflicts/disconnects – Finance, Clinical, Human Resources

**Top Barriers and Challenges**

While the focus group participants could not and did not provide solutions for all the barriers and challenges encountered by CHCs, the following is a summary of the participant-identified top barriers and challenges from each session, respectively.

January 25th Session:

➤ Duplication of work (lack of coordination internal & external)

➤ Data (maintenance, accurate information) and the dizziness of reporting requirements across multiple agencies

➤ Formal trainings can be expensive, important to “own” the process of new skill set
Self-Management is a concept that is a challenge for providers, staff and patients. How do you track progress towards Self-Management goal?

- Staffing challenges
- Barrier to disease management is disease program instead of primary care focus
- Financial: Not being reimbursed for this work

March 9th Session:

- Information technology (not able to obtain population-based data because most information comes out of our billing system) and care model advocates for enabling services (i.e. care manager, not case management) these types of services are not reimbursed.
- HMO has data we don’t have (i.e. hospitalizations, ER visits) but require us to give them data.
- Human capital; staff turnover (commitment to FQHC mission); nursing shortage; finding linguistically competent staff.
- Time and competing priorities
- Leadership
- Money, financial barriers and incentive/reimbursement for enabling services (i.e. case management)
- Regulations
- Self-Management

**Broad Themes**
The following are broad themes that emerged from the focus groups related to the implementation of disease management programs:

- Leadership must engage in capacity building that will aid in institutionalizing the Care Model Process.
- CHCs’ clinical leadership is spread too thin and unable to provide consistent decision support on guidelines necessary to address clinical concerns like disease management programs.
- The barrier to disease management is disease management programs.
• Implementation of disease management programs must be conducted in a generic way, where the focus is on the process and not the disease.

• Put a process in place and you’ll be able to fit any disease management program into the process.

• The center must select the right individual “a champion” to ensure the success of the process.

• The selected individual must be a champion of the process and not of a project or a disease management program.

• Constant staff turnover that results in a lack of continuity and wasted resources.

• A lack of financial support – reimbursement for providing disease management services.

• Improve centers’ understanding of the self-management concept and have patients fully involved in the planning process.

• Specific training is necessary that will enable staff to serve as patient self-management advocates.

• Organize a Care Model or Collaborative university/academy – a learning space where centers can learn from each other by sharing resources and best practices.

**DISCUSSION AND RECOMMENDATIONS**

**A Learning Place**

As noted above, the focus groups contributed several themes that could be utilized to inform specific segments of the May 2007 Clinical Leadership Forum to address cardiovascular disease. However, to actually achieve spread to a second chronic condition, the participants recommended using a collaborative approach as the gold standard.

Furthermore, it was suggested that CHCANYS establish a “Care Model or Collaborative Academy” under its auspices. The purpose of this Academy would be to “provide training and support for health centers as well as leverage and build expertise” in the use of the model. Many participants agreed with the concept, but cautioned that it is important to focus on the “model” for reducing disparities in a holistic manner including HIV, diabetes, CVD, etc...
CHCANYS as an organization, in collaboration with the NYS DOH, is in a prime position to create this type of learning space for NYS Health Disparities Collaborative teams. As suggested in the focus groups, there is a need to move away from a disease management program focus and towards thinking of this work as a system change. CHCANYS is grateful to have had the opportunity to partner with NYS Healthy Heart Program. As we move forward, we are excited about the broader public health benefits that our work together can achieve. Namely, bring about disease management program system change through use of the Care Model.

**Education and Training Curriculum**

While the facilitator began the focus group discussions by asking about barriers and challenges related to implementing CVD programs, it became obvious, very quickly, that participants were responding about barriers and challenges related to the implementation of any disease management program at their center and not just CVD programs.

The primary goal of this project, development of a model, one-day clinical education and training curriculum to achieve spread to cardiovascular, was deemed impossible by participants. The consensus among participants was that in order to generate enough momentum to move a process forward, additional resources and training are needed — “We’re not talking about CVD programs; we’re talking about disease management program re-design and education.”

While several themes emerged from the focus group sessions, it was impossible to address them all in one day. Nevertheless, the most salient of these themes were selected and several training tracks and breakout sessions were designed to address them at the forum. As such, the following training curriculum is being recommended:

**Salient Themes and Offerings**

**Theme:**
Leadership must engage in capacity building that will aid in institutionalizing the Care Model Process.

**How it will be addressed:**
- Plenary session by Paloma Hernandez, CEO of Urban Health Plan to address “Managing Change in our Organization” who will address key concepts on how to lead change in order to achieve organizational transformation and population-based patient management.

- Plenary session by Sharon Morrison, Healthcare for the Homeless to address “A Framework for Dissemination: What Works and What Doesn’t” to address best practice changes while working with the vulnerable populations: homeless and migrant. Proactive use of technology as well as gaining access to online tools/resources health centers can use as part of daily practice.
• Breakout Session by Debbie Lester from Urban Health Plan and Kathy Brieger from Hudson River Healthcare to address “Strategies to Help Manage Change within the Organization” to discuss how different approaches within the organization have worked towards addressing the challenges of population-based care and training staff. This session provides an opportunity for attendees to hear from peers assigned the task of organization transformation by leadership.

Theme:
CHCs’ clinical leadership is spread too thin and unable to provide consistent decision support on guidelines necessary to address clinical concerns like disease management programs.

How it will be addressed:
• Breakout Session by Dr. Wissam Hoyek, Cardiologist, Lutheran Medical Center and Dr. Akinola Fisher, Morris Heights Health Center to address “Cardiovascular Track -Decision Support: DM/CVD (Part I)”. A review of the evidenced-based guidelines linked to daily practice to help achieve planned care.

• Breakout Session by Jose Mejia, Behavior Health Specialist, Sunset Terrace and Trish Harren, Team Leader, Westside Health to address both the aspects of behavioral health issues in chronic disease management as well as the process of implementing key changes in a busy community health center from a team focusing on cardiovascular disease. This session is entitled: “Cardiovascular Track – Population-Based Care: Spreading the Care Model to DM/CVD.”

Theme:
Improve centers’ understanding of the self-management concept and have patients fully involved in the planning process.

Specific training is necessary that will enable staff to serve as patient self-management advocates.

How it will be addressed:
• Two different breakout sessions will focus on self-management and will address the following key concepts: The role of the health educator in engaging patients in self-management, strategies to increase physical activity while remaining culturally sensitive, using the support group process to engage patients in self-management, and techniques for brief interventions providers can use during the visit.

The presenters in these breakout sessions will be:
- Sylvia Johnson, Asthma Health Educator, Urban Health Plan
- Dr. Purnima Naik, Director of Health Education, Morris Heights
- Sheila Gittens, CDE, Diabetes Research Coordinator, CHCANYS
Scott Thomas, Ph.D. and Ashley Mevi, MPH, Manhattan Tobacco Cessation Program, Columbia University Mailman School of Public Health

Theme:
The center must select the right individual “a champion” to ensure the success of the process.

The selected individual must be a champion of the process and not of a project or a disease management program.

How it will be addressed:
- **Care Model Process Leader** track by Wanda Montalvo, RN, MSN, ANP who will conduct a four part series designed for health centers who want to develop Change Agents, Opinion Leaders who can be developed as the internal expert. The Care Model Process Leader is a person that will assist leadership in the organization’s effort in disseminating the Care Model to other sites, conditions, and moving towards population-based care. The Care Model & Model for Improvement will be used as a conceptual framework to improve primary care services.
Appendix
Focus Group Facilitator’s Guide

Strengthening Cardiovascular Disease Prevention and Management in Community-Based Primary Health Care

January & March 2007

Prepared by
Hugh Wesley Carrington, Ph.D.
Community Health Care Association of New York State

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New York State Health Disparities Collaborative

5 This project is funded through the New York State Department of Health’s Healthy Heart program.
FACILITATOR’S GUIDE

Focus Group of primary care team members to identify barriers and challenges to implementing effective Cardiovascular Disease (CVD) risk management programs

Purpose
To investigate, identify, assess and characterize specific barriers and challenges to implementing effective CVD risk management programs among participants who have attempted, are in the process or are considering implementing a CVD program and participants who have implemented a CVD program. In addition, the focus group will attempt to garner possible solutions for identified barriers and challenges from the experiences of participants with a CVD program.

Participants
The full spectrum of community health primary care team members – physicians, physician assistants, nurse practitioners, nurses, social workers, patient representatives, health educators and outreach workers

Day of Focus Group
As participants arrive in the room:
Greet participants as they arrive. Ask them to take a seat and make themselves comfortable. (If there are refreshments, encourage them to help themselves). Distribute the respondent’s profile questionnaire and ask participants to complete it while they wait for the focus group to begin. Explain that the questionnaire will provide us information about their background; and that this information will be used for descriptive purposes only. In other words, their names will not be in the survey, and we will never use any identifying information such as their name or the name of their health center in any report that comes from this focus group session. Also, distribute the informed consent and agreement to participate form for participants to review.
**RESPONDENT’S PROFILE QUESTIONNAIRE**

Note: All the information collected here will be kept strictly confidential. If you feel uncomfortable answering any question, you can leave it blank.

**Gender:**
- [ ] Female
- [ ] Male

**Age:**
- [ ] 21 to 30 years
- [ ] 31 to 40 years
- [ ] 41 to 50 years
- [ ] 51 to 60 years
- [ ] Over 60 years

**Are you:**
- [ ] American Indian or Alaska Native
- [ ] Asian (Chinese, Japanese) or Pacific Islander
- [ ] Black (African American, Caribbean)
- [ ] Hispanic (Latin-American, Mexican)
- [ ] Non-Hispanic White (Caucasian)
- [ ] Other (Please Specify) ______________________

**Highest level of education completed:**
- [ ] Some high school or less
- [ ] High school graduate/GED
- [ ] Some college
- [ ] College graduate
- [ ] Some post-graduate work
- [ ] Post-graduate degree
Current employment status:
- Full-time
- Part-time
- Retired
- Volunteer work
- Other (Please Specify) ____________________________

Please specific your job title:
_________________________________________________

How long have you worked with/for Community Health Centers?
- less than 1 year
- 1 to 5 years
- 6 to 10 years
- 11 to 15 years
- 16 to 20 years
- Over 20 years

Are health disparities a major concern in the community where you work?
- Yes
- No
- Don’t Know

Are community health centers the right health care agency to address health disparities?
- Yes
- No
- Don’t Know

In your opinion, are community health centers doing enough to combat health disparities in their surrounding communities?
- Yes
- No
- Don’t Know
How many years experience do you have working with Cardiovascular Disease risk management programs?
- less than 1 year
- 1 to 5 years
- 6 to 10 years
- 11 to 15 years
- 16 to 20 years
- Over 20 years

What is your health center’s Cardiovascular Disease risk management program status?
- We’ve implemented a Cardiovascular Disease risk management program.
- We’ve attempted to implement a Cardiovascular Disease risk management program.
- We’re in the process of implementing a Cardiovascular Disease risk management program.
- We’re considering implementing a Cardiovascular Disease risk management program.
- Other (Please Specify) _____________________________________________________

THANK YOU!
INFORMED CONSENT AND AGREEMENT TO PARTICIPATE

You are being asked to participate in this focus group about strengthening cardiovascular disease prevention and management in community-based primary health care because of your experience as a member of a community health primary care team. Read this informed consent and agreement to participate form carefully and ask as many questions as you like before you decide whether you want to participate in this focus group session. You are free to ask questions at any time before, during, or after your participation in this session.

**Project Title:** Strengthening Cardiovascular Disease (CVD) Prevention and Management in Community-Based Primary Health Care

**Facilitator:** Wanda Montalvo, RN, MSN, ANP (New York State Health Disparities Collaborative)

**Investigator:** Hugh Wesley Carrington, Ph.D. (Community Health Care Association of New York State)

**Purpose of the Focus Group:** To investigate, identify, assess and characterize specific barriers and challenges to implementing effective CVD risk management programs among participants who have attempted, are in the process or are considering implementing a CVD program and participants who have implemented a CVD program. In addition, the focus group will attempt to garner possible solutions for identified barriers and challenges from the experiences of participants with a CVD program.

**Procedures:** You will be asked to share your experiences and honest opinions about implementing effective CVD risk management programs at community health centers during a two hour session. In addition, you may be contacted at a later date to clarify your comments or to share any additional thoughts as a report is being prepared.

**Confidentiality and Anonymity:** Confidentiality and anonymity means that we will not share or use your name, health center, address, or any other identifying information in reports or other materials related to this study. All of the information we collect is confidential and all data will be pooled and published in aggregate form only.

**Participant Consent and Agreement:** I have read the information presented above about the focus group being facilitated by Wanda Montalvo of the New York State Health Disparities Collaborative. I have had the opportunity to ask any questions related to this study, to receive satisfactory answers to my questions and any additional details I wanted. I am aware that I have the option of allowing my interview to be tape recorded to ensure an accurate recording of my responses.

I am also aware that excerpts from the interview may be included in a report, with the understanding that the quotations will be anonymous.

With full knowledge of all foregoing, I agree, of my own free will, to participate in this focus group session and to keep in confidence information that could identify specific participants and/or the information they provided.

☐ YES  ☐ NO

I agree to have my interview tape recorded.

☐ YES  ☐ NO

I agree to the use of anonymous quotations in any reports that comes from this focus group session.

☐ YES  ☐ NO
Participant Name: ____________________________ (Please print)

Participant Signature: ________________________  Date: ____________

Witness Name: ________________________________ (Please print)

Witness Signature: __________________________  Date: ____________
Introduction

Introduction of Facilitator, Note Taker(s) and Others:
Welcome and thank you for coming today. My name is _________ and this is __________ and __________, etc... I will be leading today’s discussion. My role, for the most part, is to make sure that we get through our agenda, keep to the time frame and make sure that you all have a chance to talk. __________ and __________ will help me do these things, and they will also be taking notes. In addition we will be audio taping the session, which will ensure that we record the discussion accurately. The discussion session today will take about 1½ hours.

Participant Introduction:
Now, let’s go around the room and have each of you introduce yourselves; give your first name and any other information about yourself you want to share with the group.

Purpose of the Focus Group Session:
Our goal for this session is to investigate, identify, assess and characterize specific barriers and challenges that you may have had implementing effective CVD risk management programs. In addition, the focus group will attempt to garner possible solutions for identified barriers and challenges based on your experiences with CVD programs.

Confidentiality and Anonymity:
Confidentiality and anonymity means that we will not share or use your name, health center, address, or any other identifying information in reports or other materials related to this study. We will not identify any of the participants. All of the information we collect here today is confidential. All data will be pooled and published in aggregate form only.

Participant Consent and Agreement:
The informed consent and agreement to participate form will be our record that you have agreed to participate in the focus group and that you agreed to be tape recorded. Do you have any additional questions about the focus group or about the consent and participation form? If not, please sign and date the form.

We would like to collect the form and the questionnaire we asked you to complete when you arrived. Please pass the signed form and completed questionnaire forward.
**Instructions:**
Let me begin our discussion by reviewing a few ground rules about how we will conduct the session.

During this discussion, we would like you to focus on topics that are of particular interest to us. We are interested in what everyone has to say about our discussion topic. If someone throws out an idea that you want to expand on, or if you have a different point of view, please feel free to speak up. Occasionally, I may have to interrupt the discussion in order to bring us back to a particular topic to make sure that we cover everything on our agenda.

There are several common-sense guidelines that we will follow during this session:

1. In this type of group setting, it is important for everyone to get involved and express their opinions openly. We want all of you to express your honest opinions about the discussion topic – we are interested in multiple points of view on the topic. There may be differences of opinion, there are no right or wrong answers, and we are not here to resolve any issues you may bring up.

2. Please do not hold “side conversations” – don’t talk individually to other participants during the session. We want to be able to hear from everyone, and we want you to hear what everyone else has to say. Because we are also recording the session, it would really help us if you could speak up so that everyone can hear you.

If there no other questions, let’s begin the discussion.
Focus Group Guide – Questions:

1. Let’s begin by defining barriers and challenges in the context of a community health care setting.
   a. What is a barrier?
   b. What is a challenge?
   c. Is there a difference, if so what is that difference?

2. What barriers and/or challenges have you faced in implementing or attempting to implement your CVD program using the Care Model?
   a. Probe by asking about barriers and/or challenges related to...
      i. Center Leadership?
      ii. Financial Resources?
      iii. Human Resources?
      iv. Developing partnerships with other CHCs, local agencies & organizations?
      v. Availability of educational materials?
      vi. Availability of appropriate training?
      vii. Reporting of clinical outcomes?
      viii. Staff’s understanding of the self-management concept?
      ix. Patients:
         1. Disease education?
         2. Understanding of the self-management concept?
      x. Others?

3. You’ve identified a number of barriers and challenges – let’s quickly select the top seven. What are the top seven barriers and challenges?

4. Now that you’ve selected the top seven, I want to get your feedback on how you’ve responded to these barriers and/or challenges. For those of you who have made some progress in implementing a CVD program, can you please share how you’ve respond to the barrier and/or challenge?
   a. Identify the top seven barriers and challenges, one-by-one, and ask participants to respond about possible solutions...

5. What are the ideal steps that a community health center should follow to develop and implement a CVD program using the Care Model? First they should..., Second, Third, etc...
6. If you were going to develop a one-day clinical education and training curriculum to help community health centers develop and implement a CVD program, what would be included in that curriculum?

   a. Probe for in-depth topics that could be covered at each of the steps identified in question 5...

Ending the Focus Group:
Thank you very much for your willingness to share your thoughts and experiences and for participating in this focus group. The information you have provided has been very helpful. This information will be used to help us gain a better understanding of the barriers and challenges community health care centers face in implementing CVD programs using the Care Model. It will also be used to develop a model one-day clinical education and training curriculum to facilitate dissemination of best practice changes for CVD, suggest solutions to potential barriers and challenges, and make informed decisions about service priorities and appropriate use of resources.

As we draft a report of our session today, it is very likely that we will request your assistance, collectively and/or individually, to review your comments to ensure that we've captured your opinions accurately. At that time you will also have the opportunity to add any additional thoughts that you may have neglected to share today.

If you should have future questions, please contact me, Wanda Montalvo, at (718) 556-1007 or wmontalvo1@aol.com

Again, thank you.