

“Have a Heart”

Community Assessment Report: Prevention and Management of Cardiovascular Related Chronic Disease among Refugee and Asylee Newcomers in San Francisco



***A Project of the
Newcomers Health Program
of the
San Francisco Department of Public Health
in collaboration with Family Health Center's
Refugee Medical Clinic,
International Institute of the Bay Area, and Bay Area
Community Resources***

Fall 2007

“Have a Heart”

Community Assessment Report: Prevention and Management Cardiovascular Related Chronic Disease among Refugee and Asylee Newcomers in San Francisco

Author: Patricia Erwin, MPH

Contributing Authors:

Kaitlin Alsofrom

Samira Causevic

Linette Escobar, MA

Megan Orr, MPH, MD, Candidate

Neil Sachs, MPH, MD, Candidate

A Project of the
Newcomers Health Program
of the

San Francisco Department of Public Health

in collaboration with Family Health Center’s Refugee Medical Clinic,
International Institute of the Bay Area, and Bay Area Community Resources

Fall 2007

Newcomers Health Program
1490 Mason Street, Suite 107
San Francisco, CA 94133-4222

Phone: (415) 364-7647

Fax: (415) 364-7660

Email: newcomershealth@yahoo.com

<http://www.sfdph.org/dph/comupg/oprograms/CHPP/Newcomers/default.asp>

TABLE OF CONTENTS

Acknowledgements

Executive Summary.....1

Introduction.....4

Overview of Newcomers Health Program.....4

Purpose of this Assessment.....4

Limitations.....5

Definitions.....5

Methodology/Findings.....6

General Overview of Methodology.....6

Background Data/RHEIS.....6

Stakeholders.....8

 A. New Arrivals.....8

 A.1. RHEIS Lifestyle Assessment.....8

 A.2. New Arrival Survey.....9

 A.3. New Arrival In-depth Interviews.....14

 B. Community-Based Organization/Volags.....16

 B.1. Community Based Organization (CBO) Interviews.....16

 C. Clinical Staff and Providers.....19

 C.1. Focus Group.....19

 C.2. Key Informant Interviews.....22

Recommendations.....25

Conclusion.....28

Appendices

 A: New Arrival Survey (English Language).....30

 B: New Arrival Survey (Simplified Chinese).....31

 C: New Arrival Survey (Traditional Chinese).....32

 D: New Arrival Survey (Russian Language).....33

 E: New Arrival Interview Tool.....34

 F: Key Informant Interview Tool: Volags and CBOs.....35

 G: Focus Group Agenda: Providers.....38

ACKNOWLEDGEMENTS

We would like to especially thank all the health providers and staff at Family Health Center, for taking time out of their busy schedules to offer invaluable input to this assessment and for their tireless commitment to refugee, asylee and immigrant health: Frances Baxley, Annette Burns, Adelia Carandang, Shotsy Faust, Jim Francovich, Aurene Johnson, Zina Kuperman, Leon Kwong, Mina Matin, Rebecca McEntee and Linda Truong. A special thank you to Hali Hammer and Lisa Ward, Medical Director and Assistant Medical Director respectively for their leadership at Family Health Center's Refugee Medical Center and support of this research.

Many community based agencies provide wonderful support services to people adjusting to a new country. Staff at the following agencies took the time to give their valuable perspectives and recommendations: African Immigrant and Refugee Resource Center, Arab Cultural and Community Center, Bay Area Community Resources, Burmese American Democratic Alliance, Catholic Charities CYO of San Francisco, Chinatown Public Health Center, Donaldina Cameron House, Free Burma Association, International Institute of the Bay Area, International Rescue Committee, Jewish Family and Children's Services, Refugee Transitions, and Survivors International.

The staff of Newcomers Health Program and interns who have worked with us have provided invaluable support and helped make this report possible. These individuals not only provided direct patient support through bilingual/bicultural services at Refugee Medical Clinic, but also contributed to the implementation of this assessment and writing of this report. They include: Samira Causevic, Tania Dubrovsky, Michelle Huang, Patrick Ledesma, Carly Leung, Freda Luu, Mary Murphy, and Guillermo Padilla. Interns include Kaitlin Alsofrom, Megan Orr, Neil Sachs and Angela Tran.

We apologize for inadvertently omitting any others who supported this project and are not included here.

Most importantly, a special thank you to the patients at Family Health Center and Refugee Medical Clinic for sharing their personal experiences, challenges and insights to help guide our process. Finally, we would like to acknowledge the California Department of Public Health, Refugee Health Section and San Francisco Department of Public Health for funding to conduct this assessment.

This assessment and report were made possible in part by funds received from California Department of Public Health, Refugee Health Section, Grant #06-90-9461-1 and 07-90-90841-1, and City and County of San Francisco, General Funds.

“Have a Heart”

A Community Assessment Report on Cardiovascular Related Chronic Disease among Refugee and Asylee Newcomers in San Francisco

EXECUTIVE SUMMARY

Refugees and asylees face a host of issues when they first arrive in San Francisco. They are generally challenged by the language, are dealing with the trauma of the refugee experience, and are finding that even the simplest tasks can take an extraordinary amount of effort. Moving to one of the most expensive cities in the world, they are understandably stressed by the high cost of housing. Additionally, new arrivals need to learn English, figure out how to access public education, healthcare and other social services; buy food they may have never seen before with foreign currency; secure employment; navigate new social mores; and the list goes on. Even if preventing cardio-vascular-related chronic disease (CVD), such as heart disease, was on their list of concerns before resettlement, it certainly is not on the radar when dealing with the more urgent matters that accompany adjusting to life in a new country. However, heart disease and other CVDs are one of the highest, yet most preventable causes of death worldwide. Assisting new arrivals with behavior changes around cardiovascular health can help them lead healthier, more productive lives, which can ultimately reduce the trauma of resettlement and adjust more successfully to a new life in the United States.

Recognizing the opportunity to address this preventable cause of death, the California Department of Public Health, Refugee Health Section (CRHS) asked county refugee health programs to assess the state of refugee and immigrant health around CVD in their local area, propose appropriate interventions and use the research to create a program that adequately serves local refugee and asylee population needs. In response, the San Francisco Department of Public Health, through the Newcomers Health Program, conducted an assessment to identify and understand CVD among new arrivals and determine culturally appropriate solutions, and summarized the information in this report. We will use this research to help prevent and better respond to the heart health needs of new arrivals accessing services through the Family Health Center’s Refugee Medical Clinic at San Francisco General Hospital. We encourage other providers and community-based agencies to use this research for planning their own culturally appropriate services for refugees and other recent arrival communities.

Refugee populations in San Francisco change based on political, social, economic and disaster-related events occurring around the world. In recent years, Chinese-speakers are the largest group of new arrivals receiving health assessments through San Francisco’s Refugee Medical Clinic. The second largest group is from the former Soviet Union with nearly half of all patients coming from various countries throughout the world.

The data collection process entailed several steps, involved multiple sources for information and used various methods of data collection, including:

- statistical information through Refugee Health Electronic Information System (RHEIS) data analysis;
- input from new arrivals through both surveys and interviews;

- information directly from the clinical providers and staff working with new arrivals at Family Health Center's Refugee Medical Clinic through a focus group and individual interviews;
- interviews with 13 community-based organizations (CBOs) including Volags and other agencies identified as important key players in newcomer integration during resettlement.

Key Findings on CVD Health Issues Facing New Arrivals in San Francisco

- Refugees in San Francisco are affected by preventable CVD health conditions, particularly hypertension and abnormal blood pressure readings.
- Health behaviors of all new arrivals regardless of country of origin include: 11% of patients using tobacco; 41% exercising; 29% adding salt to their foods, 19% eating fried foods, and 24% eating sweets daily.
- There are high rates of tobacco use among certain cultures.
- The top age group affected by CVD is 45 to 54, and males have higher rates (56%) than females.
- New arrivals from Ukraine and Russia are those most affected with CVD diagnoses.
- Chinese-speakers with CVD have a high incidence of hypertension.

Barriers to Addressing CVD Conditions

- Language barriers are a major challenge in promoting new arrival health.
- San Francisco's high cost of living makes relocation particularly stressful which results in the new arrival feeling their time is limited and health is a low priority.
- Newcomers do not know where to get health information or how to access the health care system.
- Religious and cultural restrictions, particularly among women, restrict exposure to opportunities for health education and exercise.
- Some cultures prefer non-western medical practices or are limited by religious and cultural mores in how to use western medication. Some providers are not aware of or are not asking about these issues.
- If the new arrival was not diagnosed in their home country, they may not feel they are at risk or do not consider prevention in their health needs. Some cultures believe it is bad luck to look for a problem that has not surfaced.

Community Recommendations to Addressing CVD among New Arrivals

- Utilize culturally- and linguistically-appropriate materials and interventions for all ethnic groups, and in particular for women who may believe obesity is natural with aging.
- Develop peer leaders to provide health education, healthy living groups and medical navigation in a linguistically and culturally appropriate manner
- Communicate information through health care providers as they are usually highly respected.
- Include family members in behavior change and educational interventions and model healthy behaviors (such as healthy snacks and activity breaks during sessions).
- Foster socially supportive group environments.
- Build on assets of new arrival communities, including strong foundations, desire to improve lives, healthy ethnic diets and not having the common American attitude of "more is better".

- Conduct outreach in creative ways and interventions in comfortable settings.
- Increase outreach and communication between health clinic staff, CBOs and refugee communities.

Proposed Interventions to Addressing CVD among New Arrivals

Through our processes of assessing our findings, identifying cultural barriers and assets to creating effective programs, reflecting on our experiences with other communities and related health issues, and reviewing recommended intervention from the CRHS, we developed a comprehensive program with multiple interventions to address CVD and promote healthy living among new arrivals. Our interventions will include:

- Systematic changes to assist us in tracking and following up with new arrivals diagnosed with CVDs;
- Prevention-focused interventions including basic education on healthy eating and active living in the US, healthy eating sessions, activity groups and education on shopping for healthy foods;
- Development of peer leaders who can assist us in reaching community members and leading activities to promote healthy living;
- Support for new arrivals diagnosed with CVD through health education, provider support and behavior change strategies to support patients in managing their conditions.

In terms of support for new arrivals with CVD diagnosis, we analyzed the appropriateness of four clinic-based interventions: telephone support, education sessions (one-on-one and small-group), “teamlet” model/peer-coaches, and group medical visits. The process of analyzing this data revealed further insights into the cultural competency issues of meeting the needs of each group. The following is summary of clinic interventions we are planning, in addition to basic education and linguistically/culturally-appropriate health materials.

Arrival Group by Language/Region of the World	Telephone Support	Education Sessions	“Teamlet” model/peer coaches	Group Medical Visits
Chinese-speakers	X	X	X	X
Russian-speakers		X	X	X
Spanish-speakers	X			X
Burmese-speakers	X	X	X	

In conclusion, we based our interventions on the information gathered in this assessment from all the key stakeholders. We believe that jointly, the new arrivals, community based agencies and clinic staff have provided us with a blueprint for improving the health of refugees and immigrants in San Francisco by addressing issues related to CVD and building on their cultural assets.

For more information or a copy of the complete assessment, please contact:

Newcomers Health Program

1490 Mason Street, Suite 107 ~ San Francisco, CA 94133-4222

Phone: (415) 364-7647 ~ Fax: (415) 364-7660

Email: newcomershealth@yahoo.com

<http://www.sfdph.org/dph/comupg/oprograms/CHPP/Newcomers/default.asp>

This assessment and report were made possible in part by funds received from California Department of Public Health, Refugee Health Section, Grant #06-90-9461-1 and 07-90-90841-1, and City and County of San Francisco, General Funds.

INTRODUCTION

Overview of the Newcomers Health Program

Newcomers Health Program, a collaborative program of the San Francisco Department of Public Health, is a clinic and community-based refugee and immigrant health program that has promoted the health of refugees and immigrants in San Francisco since the late 1970's. We work closely with two San Francisco Department of Public Health clinics (Family Health Center's Refugee Medical Clinic and Ocean Park Health Center) and two community-based collaborators, the International Institute of the Bay Area, and Bay Area Community Resources, to provide culturally and linguistically appropriate health assessments and ongoing primary health care to virtually all new arrival refugees and asylees in San Francisco. Clinic-based programs coordinated and implemented by the Newcomers Health Program include: coordination and support of comprehensive health assessments of newly arriving refugees, medical interpretation, health education, referrals, and patient support services. Community-based health projects conducted by Newcomers Health Program are designed to improve community well-being and enhance community capacity in a variety of diverse immigrant communities. Current projects include chronic disease prevention and management programs for Russian-speakers: the SUNSET Russian Tobacco Education Project and the Let's Be Healthy! Project. Our community based-health projects respond to emerging health issues and shifting populations such as our past projects focusing on SARS Education and the influx of Bosnian refugees after the Balkan conflict.

Purpose of this Assessment

The California Department of Public Health, Refugee Health Section (CRHS) provided funding to county refugee programs throughout the state, such as Newcomers Health Program, to implement the Refugee Preventive Health Program (RPHP), focusing on cardiovascular related chronic disease (CVD) management and prevention, for a 5 year period (2006-2011).

The first year of this project involved developing and carrying out an assessment to identify the state of refugee and asylee health in relation to cardiovascular related health conditions, including diabetes, hypertension, obesity, etc., and related risk factors, such as lack of physical activity and unhealthy eating. Subsequently, using the information presented in the assessment, the grantees, we expected to create a project with appropriate interventions to adequately serve local refugee and asylee population needs. In response, the San Francisco Department of Health, through the Newcomers Health Program's Refugee Preventive Health Program (RPHP), conducted this assessment from the fall 2006 through spring 2007, and summarized the process and findings in this assessment report.

The primary goals of this assessment were to:

1. Identify target groups among refugees and asylees for areas of focus and chronic health conditions to address;
2. Identify barriers refugees and asylees face in following up with identified chronic conditions;
3. Identify culturally and linguistically – appropriate strategies to improve follow-up and management support for identified chronic health conditions and, ultimately, improve health outcomes;

4. Share our findings with other providers of resettlement services to increase cultural competency and collaboration in improving the health of new arrivals.

Through strategic planning processes, education, promotion of physical activity and healthy eating, and support for patient self-management of chronic health conditions, Newcomers Health Program's RPHP aims to assist new arrivals with prevention, early detection treatment, and management of CVDs, ultimately allowing them to achieve self sufficiency in becoming and staying healthy.

Limitations

Please take note that the findings of this assessment are limited by the resources available for conducting the planning process and the methods utilized to carry out the study. Consequently, the findings are reflective only of the individuals and data sources used. However, the information presented is useful beyond the scope of this assessment, both for its general findings and as a starting point for more comprehensive assessments. Despite the limitations noted above, the variety of stakeholders and the scope of data gathering methods allowed for the compilation of important information of newcomers' health in the San Francisco area that may surpass the limitations of this assessment.

Definitions

Refugee: The United States Refugee Act (1980) defines refugees as "persons outside their own countries of nationality who are unable or unwilling to return because of persecution or well-founded fear of persecution." The persecution or fear thereof as referred to in this Act must be based on race, religion, nationality, membership in a particular social group, or political opinion and persons lacking nationality must be outside the country in which they last habitually resided to gain refugee status. Refugees are eligible to adjust to lawful permanent resident status after one year of continuous presence in the United States. Additionally, the Refugee Act authorizes financial assistance by the federal government in cooperation with state and local government and voluntary agencies; federal funding provides refugees with benefits including eight months of Medi-Cal Insurance and Temporary Aid to Needy Families payments (General Accounting Office, 1990).

Asylee: An alien in the United States or at a port of entry who is found to be unable or unwilling to return to his or her country of nationality due to persecution or a well-founded fear of persecution, as defined above. Once granted asylum in the United States, asylees are eligible for the same benefits and services granted to refugees. (see above)

Throughout this document, the terms refugee, new arrival, and newcomer are used interchangeably and encompass both refugee and asylee populations, as well as other eligible populations, such as victims of trafficking.

METHODOLOGY/FINDINGS

General Overview of Methodology

Newcomers Health Program's first step was to identify which new arrival populations to focus on based on RHEIS data. Initially, to help give a clear picture of the populations and CVD related chronic health conditions, the team gathered statistical information through RHEIS data analysis. The RHEIS data analysis focused on chronic disease diagnosis among new arrivals, grouped by language spoken, from 2000-2006 and helped focus efforts towards specific populations, develop additional assessment processes for this report, and plan interventions.

To ensure the comprehensiveness of this assessment, the assessment process also included qualitative methods and involved multiple sources for information, as well as various types of data collection. Most importantly, diverse key stakeholders—refugee communities, community-based organizations, and healthcare providers—were included as vital components in the planning and execution of this report.

The project team was led by Patricia Erwin, manager of Newcomers Health Program. It included two University of California, Berkeley MPH candidates, The NHP Clinic Site Coordinator and other NHP staff and interns, with consultation from the Director of Refugee Medical Clinic (RMC).

To gain valuable information for the identified key stakeholders, the team gathered input from new arrivals through the lifestyle portion of RHEIS data, surveys, and interviews; from community based organization through a focus group, and from providers through a similar focus group as well as key informant interviews. The findings from the team's research is presented in this community health assessment. Please refer to the appendices for the assessment tools.

Background Data/RHEIS

Methodology: The California Refugee Health Section (CRHS) provides funding for the Newcomers Health Program to conduct comprehensive health assessments for newly arriving refugees and recently documented asylees. An online case management database system, the Refugee Health Electronic Information system (RHEIS), was developed by CRHS to allow all funded counties to enter, report, and track newcomer data collected during the health assessments, such as demographics, health history, and diagnoses. RHEIS data is the electronic version of the information the Refugee Medical Clinic collects about health issues of new arrivals during the comprehensive health assessment process (physical exams, labs, diagnoses, etc).

As a starting point, data from RHEIS helped identify top health conditions and affected populations and gave the assessment team a clear starting point. The assessment team reviewed and analyzed RHEIS data related to reported chronic health conditions diagnoses from October 2000 through September 2006. However, due to technical issues at the CRHS, comprehensive data with detailed information in terms of age, gender, and country of origin was only available from 2000-2005, and not for the 2005-2006 time period. For the 2005-2006 time period, information came from the RHEIS standard reports of top ten reported diagnoses. These various sources of RHEIS data provided similar information and

contributed to a more complete picture of reported CVD-related health conditions for a longer period of time.

In addition to the RHEIS data for new arrivals, the assessment team examined primary care diagnoses from medical records of the Refugee Medical Clinic of San Francisco General Hospital's Family Health Centers to compare repeat visit diagnosis trends with data from the health assessment RHEIS data is extracted from. The longer-term primary care trend confirmed the RHEIS diagnosis data.

Findings: From RHEIS data reviews, the top reported CVD health conditions facing newcomers based on their health assessment in San Francisco from 2000-2006 are:

- Essential (primary) hypertension and abnormal blood pressure reading
- Mental and behavioral disorders due to tobacco use
- Disorders of lipoprotein metabolism and other lipidemias
- Chronic ischemic heart disease and complications and ill-defined descriptions of heart disease
- Obesity
- Cardiac arrhythmias, atrial fibrillation and flutter
- Unspecified diabetes mellitus an noninsulin-dependent mellitus
- Angina pectoris
- Other chronic obstructive pulmonary disease and cardiomyopathy.

The most recent data, from October 2005 through September 2006, shows that there were 235 new arrivals in San Francisco who received a refugee health assessment, with 60% of those having one or more health conditions diagnosed. The top reported CVD related health conditions among the newest arrivals (October 2005 through September 2006) were essential (primary) hypertension (13%), abnormal blood pressure reading without diagnosis (6%) and mental and behavioral disorders due to tobacco use (5%).

In examining RHEIS data for the past three years, out of the top ten diagnoses (including those not related to CVD), four were identified as CVD chronic health conditions:

- Essential (primary) hypertension;
- Disorder of lipoprotein metabolism and other lipidemias;
- Mental and behavioral disorders due to use of tobacco;
- Abnormal blood-pressure reading without diagnosis.

Because of limited information related to this and the inability to stratify this information by country of arrival or other factors, the time frame for the dataset was extended for the period of 2000-2005 and major health conditions were examined by country of origin, age, and gender.

After eliminating all health conditions unrelated to CVDs, CVD diagnoses from the RHEIS data of 2000-2005 confirmed findings of the top CVD health conditions from the past three years as noted above. In addition, the top three age groups affected by major health conditions were found to be (in descending order): 45 to 54, 55 to 64, and 35 to 44. While a majority of the reported diagnoses were among men, reported incidence of CVDs was still high among women, at 44 percent of diagnoses. Refugees from Ukraine and Russia were most affected by CVDs. The incidence of CVDs among Ukrainians was 111 and among Russians was 105. Seventy-one percent of Ukrainian cases were attributed to males and

forty-four percent of Russian cases were male. In San Francisco's current largest new arrival group, Chinese asylees, it was found that 10 percent of all diagnoses affecting them are CVD-related and almost 60 percent of these diagnoses were directly related to hypertension.

Stakeholders

In order to comprehensively assess refugee chronic health issues in the San Francisco Bay Area beyond health diagnoses, the project team conducted qualitative analyses by working with a diverse group of key stakeholders: the new arrival community, healthcare providers and community based organizations (CBO) including Volags (voluntary agencies that provide resettlement services for refugees). These stakeholders were chosen because they reflect the diversity of people interested in and knowledgeable about this population.

A. Stakeholder: New Arrivals

New arrivals represent a crucial stakeholder group. Therefore, the project team carrying out this assessment was deliberate in prioritizing input from new arrivals, and gathered information from this group through three channels: data from the RHEIS lifestyle assessment section (177 new arrivals from 24 countries), an anonymous survey (42 new arrivals: 20 Chinese-speakers, 18 Russian-speakers, and 4 English-speakers), and 5 one-on-one in-depth interviews.

A.1. RHEIS Lifestyle Assessment

The RHEIS lifestyle assessment data was collected during health assessments from the 13-month period from January 1, 2006 through January 31, 2007. During this time, a total of 177 patients from 24 countries completed new arrival health assessments; the dataset includes 37% (65) of patients from China, 9% (16) from Burma, 8% (14) from Ukraine, 6% (11) from Mongolia, with the remaining 40% (71) coming from a range of countries (Armenia, Azerbaijan, Belarus, Brazil, Ethiopia, Eritrea, Cameroon, Colombia, Georgia, Guatemala, India, Iran, Korea, Nepal, Mexico, Mongolia, Pakistan, Sudan, Syria, Tunisia and Uzbekistan).

The information collected by the RHEIS lifestyle assessments represents three areas related to CVD-related issues stated by patients in their first interview during health assessments:

1. Tobacco use- 11% of patients used tobacco
2. Exercise- 41% stated that they exercised and
3. Nutrition- 29% reported that they added salt to their foods, 19% ate fried foods, 24% ate sweets daily

The data was broken down by patient country of origin, and compared to the average, providing interesting and useful results. Patients from China were healthier than the average: only 3% reported using tobacco, 52% of patients exercised, 6% ate fried food, and 9% ate sweets daily. Conversely, across all measures, Ukrainian patients had less healthy behaviors than the average: 21% used tobacco, merely 21% reported exercising, 64% added salt to their food, 57% ate fried foods, and 57% consumed sweets daily. Mongolian patients showed a higher tobacco use (27%) than the average. These results are illustrative of the differences among different refugee populations and point to the need for cultural sensitivity and knowledge when addressing CVDs in new arrivals.

Additionally, the RHEIS lifestyle health assessment examined which sources are preferable to new arrivals for receiving health information. The clear majority (68%) preferred receiving health information from healthcare providers; 19% of patients, the second highest percentage, preferred that health information come from family members. Less popular media sources for receiving health information included: pamphlets (14%), television (7%), and community leaders (3%). Unlike the CVD-related information, these preferences did not illustrate disparities when broken down by country of origin—they existed regardless.

A.2. New Arrival Survey

The purpose of an anonymous survey was to gather information from newcomer patients receiving healthcare services at the Family Health Center's Refugee Medical Clinic. The survey focused on patient knowledge related to chronic disease prevention, healthy eating and physical activity behaviors, as well as the preferred methods of receiving health information.

Several members of the interdisciplinary project team conducting the research for this assessment originally developed the survey tool collaboratively. It was reviewed by the survey design center at the University of California, Berkeley, and the Director of the Refugee Medical Clinic. Once the survey had received final approval and before being distributed, it was translated from English into Chinese (traditional and simplified), and Russian (see Appendices A-D). The latter two languages reflect the languages most widely spoken in San Francisco's refugee population in recent years.

Patients were recruited by convenience sample from the waiting room to voluntarily take the written survey. The survey was completed by 42 new arrival patients at the Refugee Medical Clinic: 4 took the survey in English, 20 in Chinese, and 18 in Russian. Given these numbers, information from the Chinese and Russian speakers were considered with more weight, whereas the information garnered from surveys of English-speaking newcomers was not considered to have as much validity.

Question 1: Country of Birth of Respondents:

Seventeen of those surveyed (40%) were born in China, 8 (19%) were born in the Ukraine, and 5 (12%) were born in Russia. The remaining 12 (21%) patients came from a range of countries, including: Hong Kong, India, Vietnam, Belarus, Uzbekistan, Latvia, and Mexico.

Because the survey was only available in 3 languages, it excluded patients who did not write or read in English, Chinese or Russian. Nonetheless, the country of origin results in this survey roughly reflect the makeup and diversity of new arrivals in San Francisco.

The answers given to this question help illustrate the importance of considering country of origin when implementing interventions and workshops as part of the RPHP. It is important to take into account a plurality of countries represented in the San Francisco Bay Area and to acknowledge the inherent challenge of meeting the needs of every patient's language and culture.

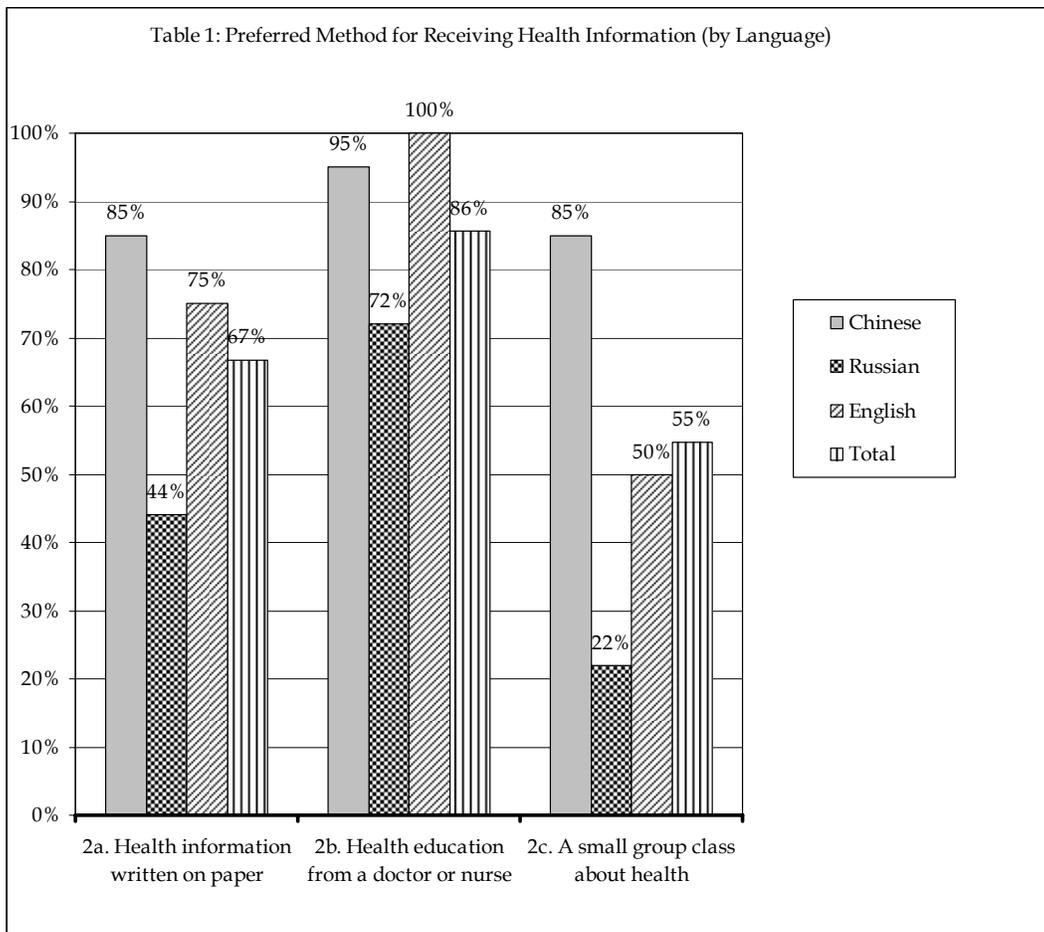
Question 2: Preferred Method for receiving information to help change health habit:

The purpose of this question was to assess the most effective format for RPHP in serving new arrival patients. The survey provided three options, and asked the participant to circle 'yes' or 'no' in response to each: (1) Health information written on paper, (2) Health

education from a doctor or nurse, and (3) A small group class about health (see Table 1). Overwhelmingly, (36 participants, 86% of those surveyed) patients responded that they would most likely want to change their health habits if provided education from a doctor or nurse. Comparatively, 28 participants (67 %) indicated the same feelings about information written on paper, and 23 patients (55%) felt that small group classes would support them in their health habits.

When broken down by language, the results illustrated a mixed preference about small groups and written information among English speakers; relatively equal preference for written information, education from a provider, and small group classes among Chinese speakers; and a high preference for health education from a provider over information in a small group setting among Russian speakers.

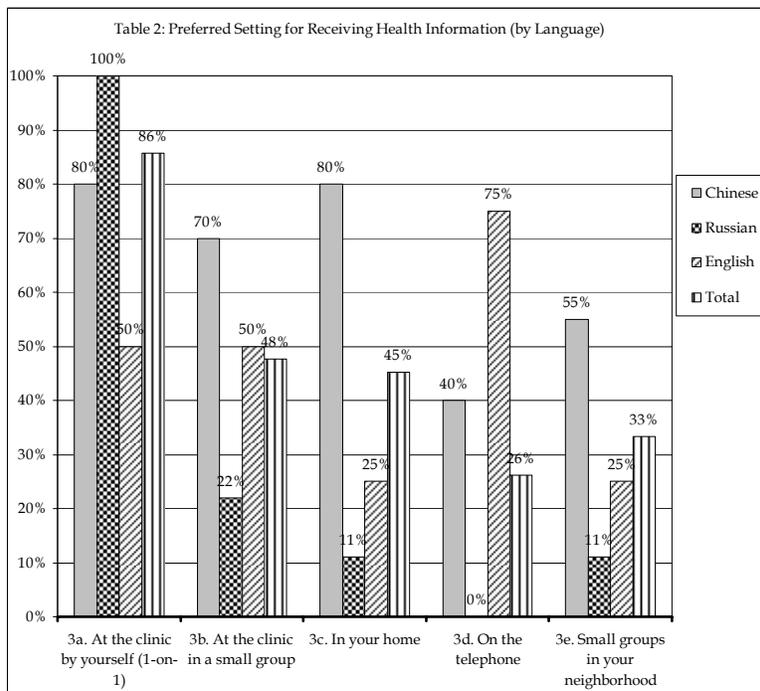
Health information in written format is feasible in terms of resource allocation. However, when designing methods for RPHP to support patients in changing their health habits, the resources of the Refugee Medical Clinic and Newcomers Health Program staff (i.e. the number of available providers and staff members) with the preferences of patients (i.e. the high likelihood of a change in health habits when education comes from a provider) need to be taken into consideration.



Question 3: Preferred Setting for Receiving Health Information:

This question aimed to gain insight into what setting patients preferred receiving health information. The survey listed five options and asked the participant to circle ‘yes’ or ‘no’ : (1) At the clinic by yourself (one-on-one), (2) At the clinic in a small group, (3) In your home, (4) On the telephone, and (5) Small groups in your neighborhood (see Table 2). In general, the survey illustrated that a high majority of patients (36 participants, 86%) preferred receiving health information in a one-on-one setting. The least popular setting for receiving health information was in a small group, neighborhood setting—only 14 participants (33%) indicated a preference for this option. The other options listed showed mixed popularity: 20 participants (48%) indicated preference for receiving information at the clinic in small groups; 19 participants (45%) said ‘yes’ to receiving information at home; while 11 participants (26%) preferred receiving information on the telephone.

Broken down by language of respondent, the data shows that Chinese speakers equally preferred receiving health information in small groups either at the clinic or in their neighborhoods, and in their homes. Russian speakers all preferred to receive information in a one-on-one setting in the clinic; many fewer Russian speakers liked receiving information in small groups either at the clinic or in their neighborhoods, in their homes, or on the telephone. Looking at the survey responses from Question 2 and Question 3, it is clear that different language groups have different preferences for the setting in which they receive health information; these results should be considered when developing CVD interventions.

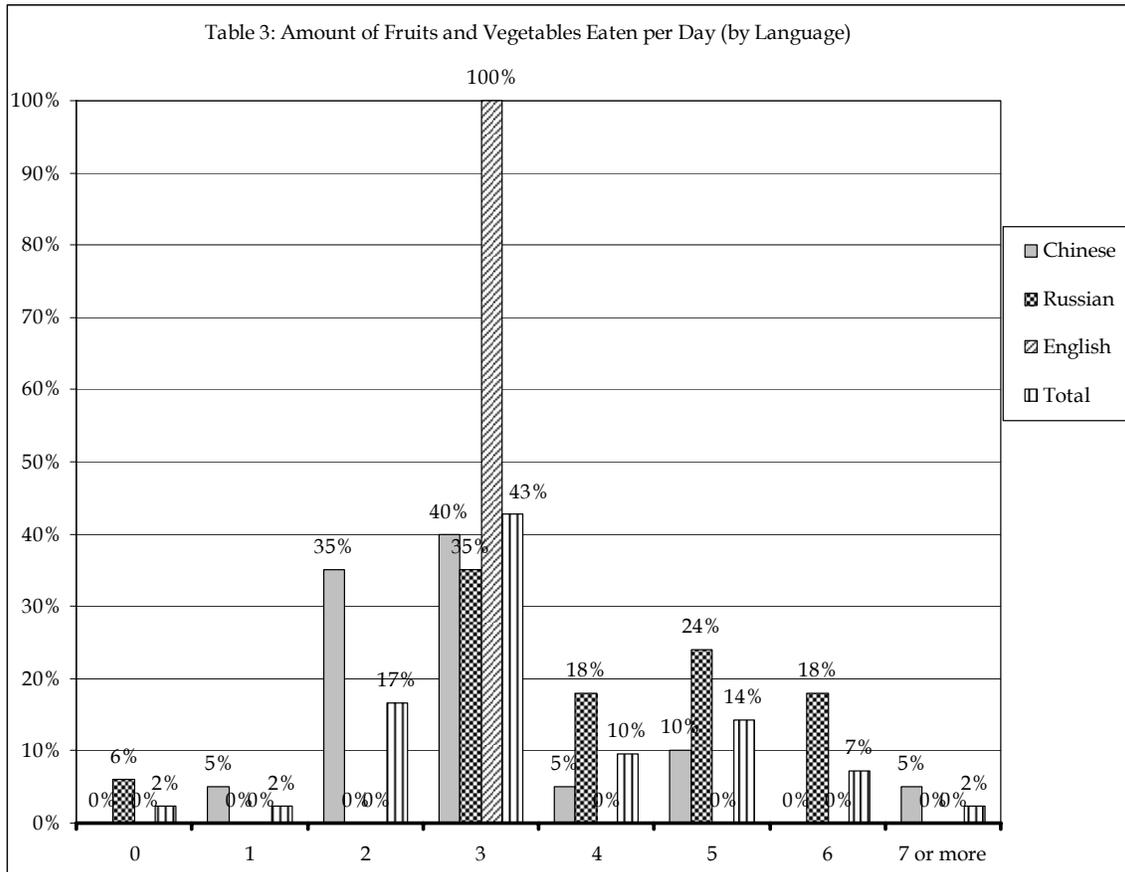


Question 4: Smoking Status in the Home:

The purpose of this question was to assess the extent to which those surveyed were exposed to tobacco smoke either through smoking or regular exposure to secondhand smoke—a serious risk factor for CVDs. A total of 16 patients (38%) answered ‘yes’ to this question: eight Chinese speakers (44 % of Chinese-speakers surveyed), six Russian speakers (33% of Russian-speakers surveyed), and two English speakers (50% of English-speakers surveyed). These data illustrate the somewhat high number of refugees exposed to tobacco smoke on a regular basis, and the subsequent need to initiate RPHP interventions, which will, hopefully, decrease the percentage of new arrivals exposed to the risk of CVDs via tobacco smoke.

Question 5: Number of Fruits and Vegetables eaten per day:

The aim of this question was to assess fruit and vegetable consumption, an important component of healthy eating habits for CVD prevention and maintenance. The data from this question formed a bell-shaped distribution among all language groups, with the majority eating 3 servings of fruits and vegetables the day before the survey was administered. This is just over half of the minimum recommended of 5 servings per day, and therefore demonstrates an area for RPHP to focus on. (See Table 3)

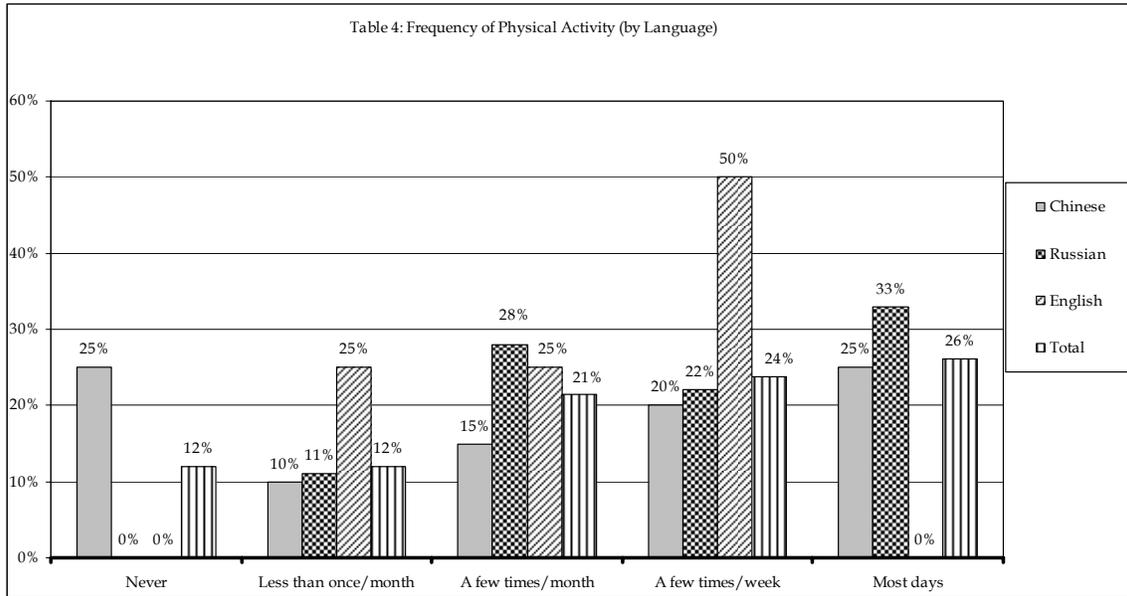


Question 6: Frequency of Physical Activity?

In addition to tobacco use and healthy eating, physical activity is another factor affecting CVD prevention and maintenance. This question was meant to uncover the amount of physical activity those surveyed participated in. This question gave 5 options, and asked the patient to choose one option from the following: never; less than once/month; a few times/month; a few times/week; most days (see Table 4). The answers illustrated that 12% of those surveyed (five participants) never participated in physical activity, an additional five participants (12%) did so less than once per month, nine patients (21 %) participated in physical activity a few times per month, while ten patients of those surveyed (24%) did physical activity a few times per week and eleven patients (26 %) did physical activity on most days.

The data gathered from this question show that about half the patients surveyed (19 patients out of 42) participate in physical activity a few times per month or less. This indicates a need

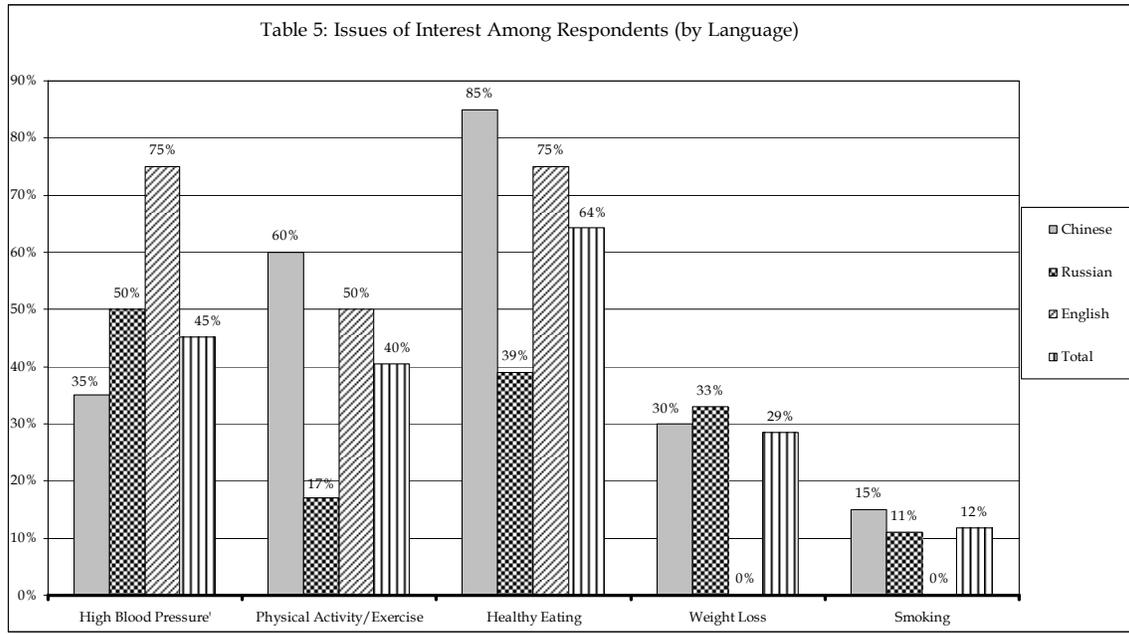
for physical activity to be promoted as a crucial element in preventing chronic diseases and maintain health.



Question 7: CVD Issues Respondents would like to learn more about:

The final question on the survey was meant to gather information about health topics of particular interest to the patients surveyed at the Refugee Medical Clinic. The survey presented 5 options—high blood pressure, physical activity/exercise, healthy eating weight loss, smoking—and asked the patient to circle all that applied (see Table 5). A majority of patients (64%) showed interest in learning more about healthy eating, and about half of those surveyed (45%) expressed interest in learning about high blood pressure. Additionally, 17 participants (40%) wanted to learn more about exercise and 12 participants (29%) were interested in weight loss. Very few patients (5 participants, 12%) expressed an interest in learning more about tobacco issues.

Interestingly, Russian speakers showed a lack of interest in learning more about physical activity (only 3 participants or 17%). Also, no English speakers expressed interest in learning more about weight loss or smoking. The information gained from the responses to question 7 indicates that smoking cessation is less of a priority for new arrivals than learning about healthy eating.



A.3. New Arrival In-depth Interviews

The in-depth interview tool for refugees was developed and used in order to target specific refugee opinions and provide a more open-ended forum for information gathering from new arrival populations. Recognizing the need for a more open-ended forum, the project team identified five key informants in hopes that the data gained would capture qualitative information about the needs of new arrivals around the prevention and management of chronic diseases. (See Appendix E for tool)

Newcomers Health Program staff carried out five one-on-one, in-depth interviews; interviews in Burmese, Vietnamese, Russian, and Cantonese (a total of 2), with patients from Burma, Vietnam, Ukraine, and China respectively.

A range of responses came from the interviewees. While certainly, with 5 respondents, the views cannot be widely representative of any large population, the information gained is a useful supplement in developing interventions.

Question 1: Motivations to take care of self or family members:

The patients interviewed were generally motivated to take care of their own or their family members' health when they or their family member were sick. One patient explained, "My wife and I do not have any relatives or family members in the United States, so I'm afraid to get sick."

Another participant discussed the importance of regular physical checkups as an important way to take care of health. She spoke of her experience with breast cancer, and her subsequent realization of the necessity of regular care.

Question 2: Interest in learning about ways to eat healthier and do more physical activity.

About half of the patients were interested in learning about healthier eating and exercise. One respondent explained, "I would like to try to lose some weight and I want to do it the right way. So I would like to have information about how to do it." Another interviewee

stated they were interested in learning to eat healthier and do physical activity because of their “intention to live longer.” Patients who were not interested in learning more explained that they already knew how to eat healthy, or that they already felt in control of their diet.

Question 3: Challenges faced when trying to eat healthy foods, do more exercise or take medications:

Two of the interviewees felt they did not face any challenges with regards to healthier eating. Alternatively, one respondent answered that healthy foods were “not as tasty [as] eating pastries or sweets.” Furthermore, healthy foods, such as organic produce, were generally thought to be more expensive. One interviewee explained “My wife cannot cook and I do not know how to cook. We eat what we have or what we buy.”

When asked about challenges to physical activity, one participant stated that they had “no time for more exercise.” Another respondent answered that, while “doing physical activities and exercising might be time consuming, you need to find a dedicated time for it and do it on a regular basis.” A third person explained, “I do not have a chance to do exercise because my house is very small and I do not have money to go to the gym. I just do housework for exercise.”

The two individuals who discussed taking medications expressed that adherence was not a problem for them. One of the respondents elaborated, “I don’t have a problem taking my medications. Since I was diagnosed with breast cancer, I’m taking it everyday and I don’t want to miss a single one.” The other stated “I take coughing medicine everyday because sometimes I cough in the morning.”

Question 4: Motivations to come to a class or a special one-on-one session about heart health and healthy living, and preferences about grouping, location, time etc:

One of the respondents stated that she would attend either a class or a one-on-one session if it were conveniently located in her neighborhood. Another patient seemed self-motivated to attend a class: “I want to come to class about healthy living because I want to take care of my health.” This patient states that they would prefer group classes to one-on-one, because group classes would allow for communication and interaction with others, whereas a one-on-one session “seems boring and ineffective.” Additionally, this respondent noted that classes during the day would be most convenient. Another interviewee stated that they would attend a class offered on the weekend.

Question 5: Interest in receiving phone calls from the clinic staff in your language or through and interpreter to talk about ways you can take care of your health?

All participants, with the exception of one respondent who would prefer email correspondence, and were amenable to receiving phone calls from clinic staff, preferably in their native language.

Question 6: Issues would like to discuss with your doctor or nurse:

Two participants expressed no desire to speak further about any topic with their doctor or nurse. Another respondent would like to speak more with his doctor about medication—specifically, about American medications versus those in the home country. The remaining two respondents respectively expressed interest in speaking with their doctor about diabetes and women’s health, and taking care of someone with a mental illness.

B. Stakeholder: Community Based Organizations (CBOs)/Volags

Community based organizations (CBOs) that serve refugees and immigrants, including Volags (refugee resettlement agencies), represent a second crucial stakeholder group in this assessment. The project team identified 13 specific organizations as key players during resettlement and integration in San Francisco. The organizations interviewed for this report include: African Immigrant and Refugee Resource Center, Arab Cultural and Community Center, Bay Area Community Resources (Russian Community Health Projects), Burmese American Democratic Alliance, Catholic Charities CYO of San Francisco, Chinatown Public Health Center, Donaldina Cameron House, Free Burma Association, International Institute of San Francisco, International Rescue Committee, Jewish Family and Children's Services, Refugee Transitions, and Survivors International.

B.1. Community Based Organization (CBO) Interviews

Staff from the CBOs listed above were interviewed either in person or via telephone using a standardized, open-ended interview tool designed by the project team (see Appendix F). Issues addressed during the interviews focused on identifying barriers and main concerns for newcomers in CVD care, identifying population strengths and assets, identifying areas for collaboration among CBOs, gathering information on perceived methods useful for overcoming barriers to newcomers through collaboration between the Family Health Center Clinic staff and CBOs, and appropriate interventions that encourage newcomer participation.

Identifying Barriers

The CBO interviews focused first on perceived barriers to education about and effective prevention of chronic diseases. While a diverse range of responses was elicited, several themes were present in the responses of a majority of the organizations. Universal responses among the contact members of these organizations included language barriers and inadequate funding for increasing and promoting language services. Other commonly noted barriers included the newcomer's perceived lack of time to participate in health education and promotion programs due to large amounts of time spent finding housing, employment, learning English, and/or going to school. Several organizations mentioned that while San Francisco is a popular relocation site for refugees due to diverse community and wide range of culturally appropriate services, the high cost of living often makes the transition more difficult and stressful. Many of the CBOs discussed a lack of community education and information as a common barrier to CVD prevention education. Several stated that new arrivals do not know where they can receive CVD-related information, while several others mentioned that newcomers are often unsure of how to effectively access the healthcare system or take advantages of services offered to them. In accessing healthcare, literacy and educational levels may also act as barriers, as some refugees may not be able to read handouts provided.

In addition, religious and cultural restrictions were frequently cited as barriers. For example, in traditional Arabic cultural settings, women spend the majority of their time indoors cooking, cleaning and doing other housework; and other than going to work or to their mosque, they do not spend much time outside their homes. Therefore, women in this context are not usually exposed to educational opportunities, or opportunities to do physical activity. Another cultural barrier discussed was western medicine versus the alternative and traditional practices of many new arrivals. Some cultures are resistant to adopting western

medical practices, instead continuing with herbal remedies and more traditional medical practices. When it comes to chronic cardiovascular-related conditions, many newcomers simply do not think they are at risk if they have not been diagnosed prior to their arrival in the United States. This attitude is a challenge because many newcomers come from countries or refugee camp experiences with limited health care. Many newcomers do not think to access healthcare for preventative measures. Furthermore, in some populations, several CBOs mentioned seeking out healthcare when one does not feel sick may be seen as bringing on bad luck.

Many CBOs interviewed also mentioned provider misunderstanding as a barrier to CVD care—specifically, a frequent lack of cultural sensitivity to new arrivals. For example, many interviewees stated that healthcare providers do not generally ask about culturally sensitive issues regarding home remedies or other religious views surrounding health. Several CBOs expressed the need for providers to be more aware of specific religious and cultural practices or beliefs that may affect healthcare. One example provided was that when working with Muslim patients, providers should be aware that during the month of Ramadan, no medication may be taken between sunrise and sunset. Providers should also be aware of cultural norms; we were told that certain populations, such as Russian-speakers, typically do not discuss health issues in any type of public setting. Therefore, they may have different needs in terms of methods for receiving health education.

Primary Concerns

During the interview process, CBOs were asked to help identify some of the primary concerns that newcomers may have in relation to their health, specifically their cardiovascular health. The issues identified mainly focused on figuring out how to navigate the healthcare system, dealing with resettlement stress, establishing appropriate physical activity and nutritional practices patterns, and curbing the amount of smoking (including tobacco smoking with hookahs in Arabic culture).

While these health concerns were identified, the majority of CBOs interviewed felt that specific health concerns (like CVD prevention and maintenance) fell well behind general concerns that newcomers have about resettlement and adaptation. The level of importance given to specific health concerns is generally influenced by a newcomer's age, ethnicity, and level of education.

Strengths and Assets of Newcomer Populations

CBOs were asked to identify some of the assets within refugee populations associated with CVD prevention and management. The strengths identified varied widely. Several organizations stated that simply being atypical from American culture is often an asset for newcomer populations, because these populations have not necessarily been raised with the “more is better” attitude so common in the United States. Along these lines, various ethnic eating habits were viewed as strengths in combating CVDs. Additionally, some refugee communities were identified as having strong central foundations, with the majority of newcomers eager to learn a variety of ways to better their lives.

Several of the CBOs interviewed also identified strengths within specific newcomer populations. One organization identified the high level of education common among Russian-speaking refugees as a community asset. African communities were cited as being exceptionally receptive to health education and learning in general, as well as being capable of mixing socially, despite political differences.

Overcoming Barriers

An important part of the CBO stakeholder interviews was to elicit ideas about strategies to overcome some of the identified barriers to education and prevention. This concept, like the others, focused on in these interviews, generated a wide range of responses, including more access to interesting and language appropriate materials, such as DVDs, wall-posters, and flyers with contact information. Several agencies suggested that passing out information at the immigration office may be a good way of reaching a wide variety of newcomers; other agencies mentioned that targeting materials to specific places, such as senior centers, may be an effective way to distribute information. Another important strategy suggested by several CBOs to overcome barriers to preventing chronic disease and promoting health living was to spend less time talking about healthy eating and physical activity and more time encouraging and leading communities in practice.

One effective way of doing this, CBOs suggested, was by using role models from within various new arrival communities. The use of role models would allow community members to witness people of their own ethnic background who have adopted healthy life practices that prevent and manage cardiovascular disease. It was suggested that the role models be age and gender specific to the target population in order to increase the target population's ability to understand and relate to the role model. Another suggestion included the use of testimonials from people in various newcomer communities that have been through the process of changing their lifestyle and gaining control over the cardiovascular health. Finally, CBOs suggested that community members or staff members at the Refugee Medical Clinic should provide educational sessions on the basics of navigating the healthcare system. Essentially, if more new arrivals better understood how to receive services and did not feel so intimidated by the complicated process and associated paperwork, there would be a greater utilization of available health services.

Another common response among CBOs was the importance of healthcare providers; several organizations stated that if healthcare providers stressed the importance of healthy living and good cardiovascular health, more newcomers would pay attention. More specifically, offering group or individual classes with a healthcare provider would help to illustrate that experts are concerned about and focusing on CVDs. Some other suggestions included targeting family members to help advise and encourage healthy lifestyle choices during the refugee health assessment education process, and providing incentives, such as health-related prizes, during community meetings and health education sessions. Finally, several organizations emphasized the importance of starting the education process early. For example, one organization specified the importance of targeting women, since it is commonly believed that obesity and high blood pressure are just natural signs of aging. Early education allows for targeting younger generations, who are still able to prevent CVDs before they occur, and for emphasizing longevity, healthy living and quality of life.

Encouraging Participation

CBOs were asked to identify ways to potentially encourage participation in health education or activity sessions. While many of the responses overlapped with the responses listed above regarding overcoming barriers to education and prevention, there were some suggestions for improving participation for health education sessions. In the *Overcoming Barriers* findings, one suggestion mentioned was to provide incentives. Along those lines, it was recommended that healthy snacks and foods be provided during education sessions. This not only provides incentive, but also models elements of healthy eating.

Additionally, many CBOs felt that education sessions that are made into a series, rather than a single class, foster a social and supportive environment and may therefore be more appealing to participants. Another element that may increase participation is offering workshops on topics identified as important by newcomers. For example, a health education series which offers one workshop on navigating the healthcare system and several sessions on CVD health was suggested.

Outreach in the form of television advertisements, material distribution at cultural festivals, and in mosques and other religious structures received mention from several of the interviewed CBOs. To increase participation, several CBOs noted the importance of timing: scheduling around refugee family structures and routines to help a larger number of individuals attend sessions. Some examples given were doing sessions in client's homes while children were at school, or offering drop-in sessions at the clinic. Almost all of the interviewed organizations mentioned the need for language appropriate materials, and the efficacy of targeting different populations with specific advertisements and incentives.

Collaboration

Most of the CBOs expressed interest and/or willingness to collaborate with health clinic staff on health education and community outreach projects. Some ways to collaborate included holding workshops specifically for CBO clients, especially in community spaces, as well as having CBO staff involved in translation efforts. Additionally, collaboration with existing groups, such as women's groups, was suggested.

Despite a willingness to collaborate, many of the CBOs interviewed indicated that a shortage of staffing and lack of time could make collaboration difficult. One important suggestion for collaboration was getting a group of organizations together to examine what has already been attempted, in order to avoid wasting energy and resources on something that was previously unsuccessful. Despite the shortage of staff, CBOs almost universally identified a need for more outreach and a greater volume of communications between health clinic staff, community volunteers and refugee communities.

C: Stakeholder: Providers

Providers represent the third and final stakeholder group in this assessment; providers are a crucial stakeholder group due to their position on the front lines dealing directly with refugees and addressing their health issues. To gain a more complete picture of the best ways to prevent and address CVDs among new arrivals through clinics, the project team gathered information from providers at San Francisco General Hospital's Refugee Medical Clinic, part of the Family Health Center. Information was gathered from providers through a focus group with diverse Family Health Center Staff (see Appendix F for tool), and two key informant interviews with the Director of the Refugee Medical Clinic and a Family Nurse Practitioner, both of whom were interested in the research being carried out and in further providing feedback.

C.1. Provider Focus Group (with Refugee Medical Clinic Staff and Providers)

On February 2, 2007, the assessment team held a strategic planning focus group with a multi-disciplinary group of Refugee Medical Clinic providers and staff to discuss appropriate interventions for addressing CVDs among newcomers. Attendees of the focus group

included: five NHP health workers (representing Russian, Cantonese, Vietnamese, and Burmese-speakers), the senior unit clerk, a Medical Evaluation Assistant, three Registered Nurses (RNs), two Family Nurse Practitioners (FNPs), the Newcomers Health Program Clinic Services Coordinator, and five medical doctors including the Family Health Center's Medical Director. These diverse participants have a combined wealth of experience and cultural sensitivity in working with new arrivals. Given this group's expertise and collaboration on actual interventions that will be implemented, the focus was on giving feedback on four potential interventions as described below.

Telephone System

The first intervention the focus group discussed was the phone system. Through phone calls by NHP staff or an automated phone system, patients would be called on a regular basis to follow-up on issues identified in clinic visits and for reminders about recommended behavior changes, appointments, etc. Health workers would be trained not only to educate patients but also to remind them of their health goals and behavior change plans.

The focus group found the phone system intervention to be an inappropriate intervention for new arrivals. The biggest concern among the group was cultural appropriateness and language access. The group seemed to agree that refugees, still dealing with the complexities of the resettlement process would find it difficult to use the phone system, making it an added burden in learning to navigate an already foreign medical system. Another concern was that the phone system is too impersonal. The lack of personal connection may create a situation where patients would not feel the need to be truthful or may have only one choice to a question that may have a variety of factors in the answer. Speaking to someone in person would allow patients to explain their situations more fully.

Russian and Burmese-speaking staff in particular found the idea of using an automated phone system culturally offensive, because they expressed that their communities place a high value on personal attention. Other concerns with the system were cost, capacity of different language options, difficulty in reaching patients, and whether newcomers would even have access to telephones.

Any phone system, especially an automated one, would be more effective for patients who are already knowledgeable about managing their disease. For example, a diabetic who already uses a glucometer may find the phone system a helpful reminder. However, the phone system may not reach those who are less disease or tech savvy. Although the phone system was generally found by the focus group to be a less appropriate intervention, positive aspects identified were that it would be one more contact with the patients, an efficient way to monitor medications without patients having to make time for an office visit, and that it might be an effective way for education and showing interest in patients.

If this system were not automated, but rather calls to patients were made by health workers, it may be more effective and eliminate some of the problems around cultural sensitivity and personal connections.

Patient Education Sessions

The next intervention discussed was patient education sessions. Led by NHP staff or other interested providers, education would be offered in a variety of topics, identified and discussed during sessions held at the clinic, primarily focusing on educating and empowering patients to participate in activities that would decrease the impact of chronic cardiovascular

disease. The sessions would also help teach patients ways to incorporate the information into everyday practice. This intervention was seen more favorably among focus group members than the phone system intervention. In contrast to the phone being an additional barrier to health care, patient education sessions could help orient patients to health care in this country. Sessions could include information on the particular clinic that the session was being held at, and could also include explanations of the necessity of preventative care, which may be new to certain cultural groups.

The health workers who would be responsible for helping lead education sessions if they were offered felt that they would have time for the sessions, and that patients would appreciate receiving free professional services from someone who is bicultural and bilingual. Patient education sessions would place focus on the patient and on different communities, and would include an opportunity for family members to be involved.

The drawbacks to this intervention are that they are non-reimbursable but require an investment. Physical space would be taken away from patient care. The sessions may be time consuming if family members of the patients attended. It may be difficult to limit sessions to just one topic. There is also a limited availability of health workers. From the patient's end, it might be difficult to motivate patients to participate in education sessions. There is no feedback to patients on their personal health goals, and individual needs may still need to be addressed in individual health visits. Additionally, there may not be educational materials available in all necessary languages. However, some of these may be challenges in any intervention implemented.

Group Medical Visits

Group medical visits, which would consist of 10-15 patients who speak the same language and have similar health conditions, was the third intervention the focus group examined. Group medical visits are designed to increase ability, peer support and motivation for self-management of CVDs. Groups would meet monthly for 6 months and would be co-led by NHP staff along with a multi-disciplinary team of healthcare providers including a medical director, staff physicians, nurse educators, nutritionists, and pharmacists. During group visits, patients would receive the benefits of group support along with comprehensive tools and information for managing their condition. Despite the fact that it is a group visit, patients also receive one-on-one time with a medical provider during the visit, and all group members develop an individualized self-management plan.

Group medical visits were seen as beneficial, and as having many positive outcomes even though they were seen as requiring significant support for coordination. Unlike the patient education sessions, the group visits are billable as medical visits. Patients are able to measure and are held accountable for their self-management goals. Another benefit is that patients are able to network with each other, share resources and experiences, and meet others who are living with and managing the same illnesses. These factors may help patients build trust in peers and providers. However, it was determined that some patients may not respond well to the group medical visit model.

Group medical visits were seen as being an effective use of provider time, a good use of non-provider resources, a productive incorporation of interdisciplinary teams, an opportunity to provide additional training opportunities to staff, and a creation of standardized care. Barriers identified to this model's success include: challenges of finding appropriate health workers/interpreters for all necessary languages, finding time for the

group visits, logistical scheduling and administrative issues, a lack of expertise among providers, some limits to attention on individual needs and an inability to secure patient confidentiality. The focus group questioned how long it may take to form groups, specifically in finding enough patients who speak the same language and have similar diagnoses.

The Teamlet Model

The teamlet model features a clinician and a health coach who would provide pre- and post-visit support, as well as between visit care. During the pre-visit, the patient and health coach negotiate an agenda. Patients are asked questions relating to relevant cardiovascular diseases. While the health coach carries out necessary documentation, the clinician expands on the previously asked questions with the patient, and together, they create a plan. During the post-visit, the health coach gives the patient an after-visit summary, answers any questions the patient may have, and has the patient repeat their understanding of the plan. Between medical visits, the health coach follows up with the patient.

Like the patient education sessions, the teamlet model was seen as highly beneficial, but as a strain on staff resources. The focus group supported the one-on-one attention provided in this model. Benefits of this final intervention are that it is individualized, offers more time for patient education, and provides patients attention in between visits. The focus group liked that patients would be matched with health workers who shared their language and/or culture. Focus group participants saw this as beneficial because the patient/health worker relationship would help close the loop with patients, expands health worker's skills, foster collaboration, gives the provider more information about the patient, and allows medical visits with providers to be problem focused.

The main drawback to this intervention is a result of the one-on-one approach taken—the model is labor and time intensive. Because the model is dependent on staffing, less common languages may not have equal access to these services. This intervention would require extra training for providers, health workers and MEA's, and require finding time in a variety of different schedules. These labor and time issues prompted questions among the focus group about the ability to effectively implement the teamlet model.

In summary, the Refugee Medical Clinic staff and provider focus group preferred interventions involving some type of personal contact, such as group medical visits and the teamlet model versus impersonal approaches, like a phone system. The staff offered valuable insights into cultural issues surrounding proposed interventions, and around the reality of administering these approaches in a busy clinic setting.

C.2. Key Informant Interviews

In order to supplement the focus groups, more in-depth interviews were conducted with Dr. Lisa Ward, Director of the Refugee Medical Clinic and James Franicevich, Family Nurse Practitioner at Refugee Medical Center.

Interview with Dr. Lisa Ward

Dr. Lisa Ward, Assistant Medical Director of Family Health Center and Director of the Refugee Medical Center participated in the focus group, but wanted to provide further input on the teamlet model. Dr. Ward provided valuable insights into the nuts and bolts of

implementing an effective teamlet model. Further, Dr. Ward shared anecdotal data on the pilot testing of the teamlet model at Family Health Center.

Dr. Ward highlighted significant challenges to the teamlet model and offered some specific solutions. Because the teamlet model is labor intensive, patients are not currently benefiting from the full potential of this model. As it now stands, there are too few health workers at Refugee Medical Clinic, and their time is already strained. To implement the teamlet model in its ideal form, more health workers would need to be trained. The health workers trained to carry out the teamlet model intervention would have to pay attention to detail. They would need to preview the patient list daily, know why each patient is coming in, and then triage and work with each patient accordingly. Also, resources would need to go into training new and existing health workers on topics relevant to specific to refugees.

In addition to the challenges and solutions listed above, Dr. Ward discussed the positive feedback the model has received so far, both from patients and providers. Based on the positive response, the teamlet model is expanding, and will soon incorporate more providers. Additionally, Family Health Center is hiring and training more volunteers (something Dr. Ward expressed will help the model reach its full potential). The Family Center is also strategically considering having set days each week as “teamlet days.”

In the near future, outcome data will be available to measure the initial success of this model. The evaluation will examine patient and provider satisfaction with the model, as well as clinical measurements of the patients participating in the teamlet model.

Interview with James Franicevich, FNP

James Franicevich, FNP, a Family Nurse Practitioner at Family Health Center, was unable to attend the focus group, but wished to give input on the issues discussed.

Mr. Franicevich spoke in detail about the need for cultural competency in dealing with new arrivals, and emphasized the need for this to be considered while undertaking any intervention. He echoed concerns the focus group had of newcomers being overwhelmed in their first year. Taking this a step further, Mr. Franicevich felt that new arrivals may not be able to deal with cardiovascular prevention and management until their resettlement process is well underway. He felt that one year after resettlement marked a more appropriate time for an intervention. During the first year, concerns like rent and employment—basic survival needs—are more pressing. Offering interventions for specific health issues rather than for immediate survival needs may be confusing to new arrivals.

Barriers and responses to interventions all depend greatly on patient age, language, education/literacy level, culture, religion, and geographic background. Even within cultures and cultural subgroups, there is a wide range of diversity and resource availability that stratifies communities. Additionally, factors which may not have been important prior to resettlement may become more prominent in the US. For example, individuals may not consider religion a powerful or important force in their lives prior to traumatic resettlement or other incidences, but after these experiences, may be drawn to religious affiliations. As another issue of cultural competency, Mr. Franicevich pointed out that disease prevention may actually be considered back luck or “tempting fate” to focus on a disease that has not yet been diagnosed. Mr. Franicevich expressed the importance of looking at the variety of cultural factors simultaneously, rather than looking at each factor on

an individual basis. He pointed out that working with newcomer families rather than individuals, and working with newcomers who have had relatives previously resettle in the US was helpful.

After restating his belief for the necessity of health workers/peer educators in any intervention, he suggested the use of culturally appropriate materials, such as comic books or graphic novels with minimal text incorporating health messages—he felt these materials may be more effective than simple brochures. He also noted that, in his experience, phone calls have been effective with certain communities.

RECOMMENDATIONS

The following general recommendations are based on the information gathered throughout the assessment process. The recommendations focus on developing effective, sustainable, and appropriate interventions related to CVD prevention and management. They are specifically based on the data showing that different ethnic groups may prefer receiving information in different ways. Additionally, the recommendations take the strength of family structures and the supportive role family members often have in supporting long-lasting lifestyle change into consideration.

- Utilize culturally- and linguistically appropriate materials and interventions for all ethnic groups. Additionally, materials specific to older women may be helpful in addressing the common belief that obesity is natural with aging.
- Develop peer leaders, who provide health education, lead healthy living groups, and assist with medical navigation.
- Include family members in behavior change and educational interventions
- Build on assets of new arrival communities, including strong foundations, social support, healthy ethnic diets, and attitudes differing from the typical American outlook of “more is better.”
- Develop opportunities for health workers and providers to collaborate on providing CVD education and management
- Offer incentives and model healthy behavior (such as healthy snacks and exercise breaks during sessions)
- Strengthen collaboration and referral services among CBOs and providers

Proposed Interventions to Addressing CVD among New Arrivals in San Francisco:

Through our processes of assessing our findings, reviewing recommendations, identifying cultural barriers and assets to creating effective programs, reflecting on our experiences with other communities and related health issues, and reviewing recommended interventions from the CRHS, we developed a comprehensive program with multiple interventions to address CVD and promote healthy living among new arrivals in San Francisco. Our planned interventions will include:

- *Systematic changes to assist us in tracking and following up with new arrivals* diagnosed with or at high risk for CVDs. In order to measure progress and success of interventions, we plan to follow-up and track any diagnosed or at-risk patients. Although NHP plans to follow the tracking and follow-up systems model developed in the previous round of RPHP funding focused on tuberculosis (TB) screening and treatment, we have come to recognize the increased complexity of tracking CVDs compared to TB. Complications of tracking CVDs are due to the wide range of possible conditions, and the resulting range of options in follow-up and treatment, and the long term nature of CVD follow-up.
- *Prevention-focused interventions* for all new arrivals including basic education, activity groups and education on shopping for healthy foods. We will focus on issues such as: healthy eating and accessing healthy food in the US, benefits of physical activity and integrating it into daily life, and information on accessing healthcare and working with providers in the US. Information will be provided in either one-on-one or small group sessions and in written format for the top 3-5 languages of new arrival groups.
- *Development of peer leaders* who can assist us in reaching community members and leading activities to promote healthy living.

- *Support for new arrivals diagnosed with CVD* through tracking and follow-up, health education, provider support and behavior change strategies to support patients in managing their conditions.

In terms of support for new arrivals with CVD diagnosis, we assessed the appropriateness of four clinic-based interventions as previously discussed. The process of analyzing this data revealed further insights into the cultural competency issues of meeting the needs of each group. The following is summary of clinic interventions we are planning for different groups, in addition to basic education and linguistically/culturally-appropriate health materials.

Chinese-speaking:

We plan to employ all of the four of the interventions discussed both because Chinese-speaking people constitute our largest group of new arrivals, and because all three stakeholders,—new arrivals, CBOs and providers—and data collected, indicate that all four interventions would be acceptable and appropriate with this population.

Russian-speaking:

All community assessment data supported the use of the teamlet model for Russian-speaking new arrivals. Although not as popular as the teamlet approach, data in this assessment also indicated that community education sessions and group medical visits would also be favorable. Since we provide extensive activities ranging from smoking cessation to community activity groups to group medical visits through other projects for the Russian-speaking community, we will primarily focus on strengthening our tracking and referrals to these community activities.

Spanish-speaking:

Despite the fact that we were not directly targeting the relatively small number of Spanish speaking new arrivals in this community health assessment, based on the limited information that was collected phone interventions and group medical visits may be viable interventions for this population. The implementation of both of these interventions may be feasible in collaboration with Family Health Center.

Burmese-speaking:

Although limited information exists for this population, providers supported the use of the teamlet model, which may be feasible due to small numbers of Burmese newcomers.

In addition to these specific interventions for those identified with CVD, NHP staff also will focus on contacting patients by telephone, letter, in person at the clinic or, resources permitting, by home visit. Home visits would be considered for patients who NHP staff are unable to contact by telephone or letter, and would take place 2-3 weeks after CVD diagnoses to ensure patients were aware of their diagnosis and appropriate follow-up measures, as determined by the provider. All patients will receive health education by NHP staff after they are initially diagnosed. Continuous follow-up will be provided by NHP for up to two years post diagnosis, or until the provider determines the patient is managing and/or controlling their condition. Information on patients after the health assessment will be kept in the patients' medical records and NHP will keep documents on any specific CVD tracking and follow-up completed.

As recommended, information will be provided in culturally and linguistically appropriate manners and tailored to specific groups to increase relevance to varied backgrounds and cultural health practices. We plan to use the expertise and linguistic/cultural backgrounds of our staff and patient health information provided by RHEIS data and healthcare providers to implement tailored interventions. As needed, we will request interpretation services for languages not spoken by our staff members. Additionally, we will strengthen the referral process linking new arrivals to CBOs that provide appropriate language services. This will not only be beneficial to new arrivals, but also help increase communication between health clinic staff and providers and CBOs—ultimately leading to strengthening ties between these two stakeholder groups.

CONCLUSION

Lessons Learned from this Assessment by the Newcomers Health Program

Although most colleagues in public health agree that assessment and asset mapping is the first key to creating appropriate programming, there is often not dedicated funding and staff resources to conduct the crucial first step. Although the issue of CVD was prescribed for the community, having the dedicated resources to take time to assess and plan before we implemented services made it much more manageable. It also engaged the health center staff in our process and invested them in the outcomes. We encourage service providers to work with their funders stressing the money saved in the long run by creating a program that is culturally responsive. Even with dedicated funding, it is a significant drain on staff time to conduct such labor intensive research. Working with graduate student interns has been an effective way for us to maximize our resources while supporting the future of our field.

Based on the findings and recommendations of this health assessment report, Newcomers Health program is in the process of developing infrastructure changes. For all new arrivals we will focus on general healthy living and chronic disease prevention issues that include: healthy eating and accessing healthy food in the US, benefits of physical activity and integrating it into daily life, issues of tobacco use, and information on accessing healthcare and working with providers in the US. Information will be provided in either one-on-one or small group sessions and in written health education materials in the top 3-5 languages of new arrival groups.

For all new arrivals with identified CVD conditions or with identified high risk behaviors, we will focus our educational and behavioral modification interventions specifically on the conditions of that individual. Additionally, the individual's socio-cultural background and the health practices and beliefs of the individual will help to shape any intervention.

Summary of Recommendations

1. Provide culturally- and linguistically-appropriate materials and interventions for all ethnic groups, and in particular for women who may believe obesity is natural with aging.
 - Invite other social service agencies to display information at your site.
 - Be aware of religious and cultural practices that may limit a woman's access to health education and exercise
 - Be aware of cultural events such as Ramadan that may affect a person's diet and medicine intake
2. Develop peer leaders to provide health education, healthy living groups and medical navigation in a linguistically and culturally appropriate manner
 - Invite groups that have done this to speak to your staff about the experience
 - Look for dedicated funding to support these leaders and groups
3. New arrivals respond favorably to advice on CVD health from providers.
 - Include CVD Risk Factors in initial client screening including asking about exercise, eating and stress.
4. Include family members in behavior change and educational interventions and offer incentives and model healthy behaviors
 - Provide healthy snacks and exercise breaks during sessions.
5. Build on assets of new arrival communities, including strong foundations, social support, healthy ethnic diets and not having the common American attitude of "more is better".

6. Conduct outreach in creative ways and interventions in comfortable settings.
7. Newcomer populations are generally eager to learn ways to better their lives.
 - CVD may be a low-priority but don't assume clients are not interested
8. CBOs almost universally identified a need for more outreach and greater volume of communication between health clinic staff, CBOs and refugee communities
 - Start or join a regular meeting of providers, such as a refugee health coalition
 - Present your work at conferences or other venues

Appendix: A

Refugee Medical Clinic ~ Newcomers Health Program
Health Education Patient Survey

Please take a few minutes to complete this short survey. Individual responses and information that you share will be kept anonymous. Your name will not appear on this form. Thank you.

1. What is your country of birth? _____

2. Which of these would make you want to change your health habits? (Circle "Yes" or "No" for each item.)

- a. Health information written on paper. Yes No
b. Health education from a doctor or nurse. Yes No
c. A small group class about health Yes No

3. Please let us know if you like to receive health information in these ways? (Circle "Yes" or "No" for each item.)

- a. At the clinic by yourself (one-on-one). Yes No
b. At the clinic in a small group. Yes No
c. In your home. Yes No
d. On the telephone. Yes No
e. Small groups in your neighborhood. Yes No

4. Do you or anyone you live with smoke cigarettes? Yes No

5. How many different fruits and vegetables did you eat yesterday?

- 0 1 2 3 4 5 6 7 or more

6. How often do you do physical activity?

- Never Less than once/month A few times/month A few times/week Most days

7. Would you like to learn more about any of the following (circle all that apply):

- High Blood Pressure Physical Activity/Exercise Healthy Eating Weight Loss Smoking

Thank you!

Appendix: B

難民診所 与 新僑健康計劃 簡体字

病人健康教育問卷

請用几幾分鐘的 ▫ 間填好 ▫ 份簡短的問題。你的个人答案和資料会以不記名方式保存。你的名字亦无須写在 ▫ 份問卷上。謝謝。

- 1) 你出生在那个国家? _____
- 2) 以下的情況是否会令你想改變自己的健康習慣?

{請在 ▫ 項 (是) 或 (否) 上打圓圈}

 - a. 当 ▫ 讀到一些好的健康常識.....(是) (否)
 - b. 医生或護士教導你的健康常識.....(是) (否)
 - c. 在小組課程里学到的健康常識.....(是) (否)
- 3) 請讓我們知道你是否想从以下的方式 ▫ 得健康資料:

{請在 ▫ 項 (是) 或 (否) 上打圓圈}

 - a. 在診所里个 ▫ 約見.....(是) (否)
 - b. 在診所內的小組課程里.....(是) (否)
 - c. 在你家中.....(是) (否)
 - d. 在電話里.....(是) (否)
 - e. 在你家鄰近的小組課程里.....(是) (否)
- 4) 你本人或与你同住的人吸烟嗎?(是) (否)
- 5) 昨天你吃了多少不同 ▫ ▫ 的水果和蔬菜?

0 1 2 3 4 5 6 7 ▫ 或更多
- 6) 你經常做身体活 ▫ 嗎?

从未 ▫ 月一次 ▫ 月数次 ▫ 星期数次 大多数日子
- 7) 你想學習多一些以下的健康項目嗎? (請圈起所有你感興趣的項目)

高血 ▫ 身体活 ▫ /運 ▫ 健康飲食 減肥 戒烟

☺ 謝謝! ☺

Appendix: C

難民診所 與 新僑健康計劃 繁體字
病人健康教育問卷

請用幾分鐘的時間填好這份簡短的問卷。你的個人答案和資料會以不記名方式保存。你的名字亦無須寫在這份問卷上。多謝。

- 1) 你出生在那個國家? _____
- 2) 以下的情況是否會令你想改變自己的健康習慣?
{請在 ▫ 項 (是) 或 (否) 上打圓圈}
 - a. 當 ▫ 讀到一些好的健康常識.....(是) (否)
 - b. 醫生或護士教導你的健康常識.....(是) (否)
 - c. 在小組課程裡學到的健康常識.....(是) (否)
- 3) 請讓我們知道你是否想從以下的方式獲得健康資料:
{請在 ▫ 項 (是) 或 (否) 上打圓圈}
 - a. 在診所裡個 ▫ 約見.....(是) (否)
 - b. 在診所內的小組課程裡.....(是) (否)
 - c. 在你家中.....(是) (否)
 - d. 在電話裡.....(是) (否)
 - e. 在你家鄰近的小組課程裡.....(是) (否)
- 4) 你本人或與你同住的人吸煙嗎?.....(是) (否)
- 5) 昨天你吃了多少不同種類的水果和蔬菜?
0 1 2 3 4 5 6 7種或更多
- 6) 你經常做身體活動嗎?
從未 ▫ 月一次 ▫ 月數次 ▫ 星期數次 大多數日子
- 7) 你想學習多一些以下的健康項目嗎? (請圈起所有你感興趣的項目)
高血壓 身體活動/運動 健康飲食 減肥 戒煙
☺ 多謝! ☺

Appendix: D

**Медицинская Клиника для Беженцев – Программа для Вновь Прибывших
Медицинский Опросник**

Пожалуйста, уделите несколько минут для заполнения опросника. Ваши ответы и информация останутся анонимными. Ваше имя не будет указано на этой форме. Спасибо.

1. Укажите страну в которой Вы родились _____

2. Что из нижеперечисленного могло бы повлиять на Ваше желание изменить привычки, касающиеся Вашего здоровья? (обведите в кружок ответ «Да» или «Нет» в каждой строчке)

- | | | |
|--|----|-----|
| A). Информация о здоровье написанная на листе бумаги. | Да | Нет |
| B). Информация полученная от доктора или медсестры. | Да | Нет |
| B). Информация полученная в небольшой группе здоровья. | Да | Нет |

3. Пожалуйста, укажите какими из нижеперечисленных способов Вы бы хотели получать информацию о здоровье (обведите в кружок ответ «Да» или «Нет» в каждой строчке)

- | | | |
|---|----|-----|
| A). В клинике, один на один с доктором. | Да | Нет |
| B). В клинике, в небольшой группе здоровья. | Да | Нет |
| B). В своем доме. | Да | Нет |
| Г). По телефону. | Да | Нет |
| Д). В небольших группах здоровья по месту проживания. | Да | Нет |

4. Вы или кто-либо проживающий с Вами курит? Да Нет

5. Количество фруктов и овощей, которые Вы съели вчера?

0 2 3 4 5 6 7 больше

6. Как часто Вы занимаетесь физической активностью?

Никогда	Меньше чем раз в месяц	Пару раз в месяц
Пару раз в неделю	Почти каждый день	

7. Хотели бы Вы получить более подробную информацию о следующем (обведите в кружок, если Вы заинтересовались):

Высокое давление	Физическая активность/Упражнения
Здоровое питание	Потеря веса Курение

СПАСИБО!

**Refugee Preventive Health Program Assessment
New Arrival Interview Tool**

Name of Interviewer (Staff/Volunteer): _____

1. Country of origin

2. Native language

3a. Year of Birth

3b. Gender (male, female, other)

4. What motivates you to take care of your individual or your family members' health?

5. Are you interested in learning about ways to eat healthier and do more physical activity?
Why or why not?

6. What are challenges or difficulties you face when you try to eat healthy foods? What about
challenges with doing more exercise? What about taking medications? Why?

7. What would encourage you to come to a class or a special one on one session about heart
health and healthy living? Would you prefer groups or one-on-one? Where would you like
that to be held? What day and time is best for you?

8. Would you like to receive phone calls from the clinic staff in your language or through an
interpreter to talk about ways you can take care of your health? Why or Why not?

9. If you had more time with your doctor or nurse, what might you like to talk about?

Appendix: F

**Refugee Preventive Health Program Assessment Process
Newcomers Health Program
Key Informant Interview Tool - Volags and CBOs**

Purpose of the Assessment Process for the Refugee Preventive Health Program:

We are in the process of strategically planning an intervention for primary and secondary prevention of cardiovascular chronic diseases. The target population is newcomers to San Francisco (SF), defined as documented refugees, asylees and/or victims of trafficking who receive health services at Family Health Center's Refugee Medical Clinic at San Francisco General Hospital. The sponsoring organization is the Newcomers Health Program at the SF Department of Public Health (SFDPH).

To be plan the intervention, we are conducting a community assessment. This involves: 1) Interviews with CBOs and Volags, 2) Focus group with clinical staff, 3) Survey of newcomers and 4) Data on the diseases and the population.

Thank you for taking the time talk with us about these, your input is important.

Questions:

1. Barriers and Challenges

-What are the main barriers to educating newcomers about cardiovascular (CV) health care that newcomers face? What are the main barriers to educating newcomers about cardiovascular health/chronic conditions, and having them learn about how to prevent and manage these conditions?

-What strategies would you recommend to overcoming those barriers?

-With regards to cardiovascular health/chronic conditions, what are newcomer's main concerns? What are your main concerns?

-How important is CV health to newcomers? What would increase the importance of cardiovascular health for newcomers?

- If we were to offer educational sessions with a doctor or other health professional for newcomers with chronic conditions, what might be some ways we could make them more useful, and how would you suggest we encourage them to attend these sessions?

2. Assets and Strategies

-What are some strategies that you believe would work in to improve the prevention and management of chronic CV disease for newcomers? What are some strategies that you believe would work in to improve the management of chronic CV disease for newcomers? How would these strategies vary across gender and different ages?

-What are some strengths of the newcomer community that you could envision improving preventive and management of chronic CV disease?

-What kinds of incentives (e.g., material, social, educational) would help newcomers to care more about their CV health?

-With regards to CV health, what needs are not being met (i.e., what services are not being offered)?

3. Collaboration

-What would make a collaborative program related to chronic conditions with Newcomers Health Program and your agency or other Volags work well? What are some challenges you anticipate?

-Would you be interested in sitting on a Community Advisory Board for the RPHP? Do you know a newcomer or other staff member who would be?

-Who else would be a good person to talk with about prevention and management of CV disease?

Appendix: G

Refugee Preventive Health Program: Focus Group Guide

February 2, 2007

11:45-1:00

Megan Orr: megancorr@yahoo.com

Neil Sachs: neil.sachs@ucsf.edu

- I. Introduction of facilitators: Megan Orr and Neil Sachs (2 min)
- II. Introduction of who is there- would that be helpful to Neil and Megan??

II. Background (5 min)

Purpose of the 1st year of the RPHP: We are in the process of strategically planning an intervention for primary and secondary prevention of cardiovascular chronic diseases. The target population is newcomers to San Francisco (SF), defined as documented refugees, asylees and/or victims of trafficking who receive health assessment services at Family Health Center's Refugee Medical Clinic at San Francisco General Hospital. The sponsoring organization is the Newcomers Health Program at the SF Department of Public Health (SFDPH).

To be plan the intervention, we are conducting a community assessment. This involves: 1) Interviews with CBOs, 2) Focus group with clinical staff, 3) Survey of newcomers and 4) Data on the diseases and the population (Here is where we could share the data on new arrivals and also primary health conditions of new arrivals)

III. Purpose of the focus group (2 min)

We would to gather input based on your expertise and opinion to find out from you:

- the interventions we can implement to help new arrivals learn about an dmanage chronic health conditions
- the pros and cons, and barriers you anticipate in implementing these interventions and how
- your interest in being involved

Your input will shape the intervention.

IV. Activity: Open discussion (10 min)

Assets and challenges of the Refugee Medical Clinic – What are you hoping to get here, not sure how this relates – maybe time could be used to identify barriers/challenges in the interventions(10 min)

V. Description of four potential interventions (5 min)

1) Counseling by General Practitioners (how feasible is this for providers with limited time?? – for this reason teamlet was identified)

During one of the initial primary care visits, identified patients at risk are counseled on the importance of physical activity in the prevention and management of identified cardiovascular disease. Counseling may be focused on specific aspects of physical exercise such as increasing the breathing rate or resting heart rate. Advantages of physical activity are stressed, and patients would be counseled on how to incorporate exercise into their daily lives within the context of living in an urban setting in the United States.

2) Group Education Sessions

Specific topics would be identified and discussed during sessions held at the clinic, led by NHP Health Educaotrs or other interested providers. Topics would focus on educating and empowering patients to participate in activities decreasing the impact of chronic cardiovascular disease. Additional information on how to incorporate the information into practice would also be included.

3) Teamlet

The teamlet features a clinician and health coach, who provide pre-visit, visit and post-visit support, including between visit care. During the pre-visit, the patient and health coach negotiates an agenda with the patient. Prepared questions are asked the patient with regards to relevant cardiovascular diseases. The visit involves the patient, health coach and clinician. While the health coach performs the necessary documentation, the clinician expands on the previously asked questions and creates a plan with the patient. During the post-visit, the health coach gives the patient an after-visit summary, answers any questions of the patient still has and has the patient repeat her understanding of the plan. Between visits, the health coach follows up with the patient. This intervention is currently underway under direction of Tom Bodenheimer at SFGH.

4) Group Medical Visits

Group medical visits for patients who speak same language and have similar health conditions and designed to increase their ability and motivation to better self-manage their conditions. Group have 10-15 patients/group and meet monthly for 6 months and led by NHP staff and a multi-disciplinary team of health care providers (Medical Director, staff physicians, nurse educators, nutritionists and pharmacists). During these group visits, patients will receive the benefits of group support along with comprehensive tools and information for managing their condition and one-on-one attention from medical providers, all leading to the development of individualized self-management plans;

5) Phone System

Through phone calls by NHP staff (I do not think that automated is possible with all the languages and even logistically), patients are called on a regular basis. They then complete a survey on a number of items with regards to cardiovascular self-care, and

depending on response the health educator provides information, counseling, resources. Questions would also include reminders about appointments, if missed appointments, why, etc. . Health educators are trained not only to educate but remind patient's of their health goals. This intervention is currently underway by Dean Schillinger at SFGH.

VI. Activity: Staff input on pros and cons and how to overcome barriers of each intervention (15 min)

V. Activity: Staff input on their interest in being involved in implementing any of these interventions. (7 min)

VII. Conversation (5 min)

IX. Closing comments and followup interviews (2 min)