Using Focus Groups to Understand Health-Related Practices and Perceptions of African Americans: Nashville REACH 2010 Preliminary Findings

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To gain an understanding of health-related practices and perceptions, Nashville REACH 2010 conducted focus studies among 5 community groups. Attitudes about health, personal risk behaviors, quality of health care, and models of personal behavior change were assessed. All focus-group sessions were transcribed and analyzed using a consensus panel methodology.

A combined analysis of the focus groups revealed 3 categories of barriers to healthier living: 1) personal, 2) environmental, and 3) systemic. Personal barriers included lack of adequate finances, physical limitations, lack of knowledge, and stress. Environmental barriers were related to the unavailability of healthy food choices and adequate places to exercise in the community. The accessibility and quality of health care were the most pervasive systemic barriers identified. Though these findings are not novel to urban African-American communities, they will serve as the framework by which Nashville REACH 2010 will implement strategies to reduce and, ultimately, eliminate cardiovascular disease and diabetes disparities. (*Ethn Dis.* 2004;14[suppl 1]:S1-72–S1-78)

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Introduction

One of the emerging themes in health promotion is the mobilization and empowerment of communities through collaborative partnerships.[1] These collaborations represent the commitments made between individuals and organizations from various sectors to work toward achieving better health outcomes for community members.[2] An attractive feature of such partnerships is the potential to "create and sustain" conditions that are necessary for better health outcomes.[1]

To address various disparate health conditions among racial and ethnic minorities in communities across the United States, government health agencies have embraced the growing practice of engaging the community in health promotion. One such initiative, Racial and Ethnic Approaches to Community Health (REACH) 2010, is a Centers for Disease Control and Prevention (CDC)-supported demonstration project that focuses on ". . . empowering communities, building coalitions, and creating solutions that can be used throughout the nation to eliminate health disparities once and for all."[3] The Nashville REACH 2010* component of this national effort focuses on reducing, and, in time, eliminating diabetes and cardiovascular disease (CVD)-related disparities among African Americans in North Nashville, Tennessee. This community was targeted based on data indicating that African Americans living there have significantly higher age-adjusted death rates due to CVD and diabetes compared to Caucasians in the same county.[4] Further, the death rate was higher for local African Americans than for African Americans on a national level.[5]

With the perspective that community input should be the catalyst for future interventions, Nashville REACH 2010 conducted a series of focus groups designed to solicit community members' perceptions regarding health practices and behaviors affecting health. This paper presents a summary of the focus group results, and provides a number of recommendations for interventions among community, health provider, and political organizations, relative to the issues raised. Participant responses related specifically to access to care and quality of healthcare issues were published previously.[6]

* Nashville REACH 2010 is a major effort of the Nashville Disparities Coalition, which includes Matthew Walker Comprehensive Health Clinic, lead agency for the project, Meharry Medical College, Tennessee State University, Fisk University, Vanderbilt University, Metropolitan Health Department, Nashville NAACP, Interdenominational Ministerial Fellowship, and many others.

Methods

Focus Groups

A focus group is a carefully planned discussion designed to elicit topic-specific views from a target population. Participants generally share a common characteristic, such as race, gender, age, or socioeconomic status and have a mutual interest in the topic.[7] Participants respond to a series of open-ended ques-

tions under the direction of an objective moderator.[8] One of the benefits of utilizing focus group methodology is that it fosters the expression of thoughts and feelings that may not have been revealed using other methods of disclosure.[9]

Participants

Five focus groups were conducted, with all participants being recruited through Matthew Walker Comprehensive Health Center, the lead agency for the Nashville REACH 2010 project. The composition of the 5 groups was as follows: 1) patients diagnosed with CVD and/or diabetes; 2) residents of subsidized housing; 3) healthcare providers; 4) church leaders; and 5) youth between the ages of 14 years and 18 years. All participants lived, worked, or attended school or church in North Nashville. On average, there were 8 to 10 participants in each group. Focus group members received a meal and monetary compensation for their participation. The moderator and all participants were African-American.

Under the guidance of a moderator, participants responded to a series of open-ended questions that specifically addressed barriers and facilitators to eating nutritious foods, exercising, screening, and seeking out and receiving health care. The adult focus groups were conducted at Matthew Walker Comprehensive Health Center, and the youth focus group was conducted at a church in the target community. Each focus group met for approximately one hour. All sessions were audiotaped, videotaped, and transcribed verbatim.

Consensus Panel Analysis Procedure

Qualitative data analysis was based on the methodology of Anderson et al.[10] A multidisciplinary panel, including a behavioral scientist, a dietician, and 2 community outreach workers from the Nashville REACH 2010 staff, participated in analysis of the focus group transcripts. Prior to reviewing the transcripts, panel members received training that highlighted general concepts of focus group research and practical experience in identifying psychosocial issues. Psychosocial issues were defined as "those factors in an individual's life, community, family, and/or finances that significantly influenced health behaviors and/or outcomes."

From each transcript, panel members examined the participants' responses and used these responses to assign psychosocial issues (ie, the psychosocial issue "lack of social support for exercise" was ascribed to the statement "I don't care for walking alone" and "I like walking if it's walking with somebody"). The panel members' individual lists of psychosocial issues were pooled by eliminating overlapping issues and combining others. This process was repeated for each focus group, resulting in 6 to 8 psychosocial issues for each group.

The compiled lists of psychosocial issues were then ranked according to each individual panel member's interpretation of the importance of each issue, from the perspective of the focus group participants. The most important issue was assigned a priority ranking of 1, the next was ranked as 2, and so on. Each panel member followed this procedure for all the psychosocial issues related to each of the 5 focus groups.

The next step was to establish unanimous agreement among the panel's individual priority rankings. Any differences in priority rankings were discussed until consensual agreement was achieved. This process resulted in a list of prioritized psychosocial issues for each focus group.

RESULTS

Summary of Psychosocial Issues

A combined analysis of the psychosocial issues from all groups (See Figures 1–5) revealed three general types of barriers to achieving and maintaining a healthier lifestyle: 1) personal, 2) environmental, and 3) systemic.

Personal Barriers

Finances

In every focus group, the financial expense associated with healthier living was viewed as a significant obstacle. Participants felt that health insurance was too expensive, and behavioral changes, such as eating low fat foods, and getting regular exercise, had the potential to strain budgets.

Physical Limitations, Knowledge, and Stress

Members of the patient group reported that physical limitations prevented them from participating in regular exercise. Participants also expressed that their limited knowledge of nutrition hindered their ability to make appropriate dietary adjustments. Healthcare providers were of the opinion that people deny the symptoms associated with diabetes/CVD, and ignore the relationships between behavioral risk factors and development of these diseases. Members of the patient group, however, revealed that limited knowledge of how their behavior affects their health was a contributing factor to not making lifestyle changes. Stress was also identified as a barrier to making healthier living a reality.

Environmental Barriers

Available Food Choices

In all 5 focus groups, participants voiced that the unavailability of healthy foods in the North Nashville area made it difficult to adopt healthier eating habits. Youth participants articulated that the importance of healthy eating was not emphasized in their schools, specifically commenting on the accessibility of "junk food" in, or around, their schools. Church leaders noted that the church environment was, often times, not a model for healthy living because the food served at many church gath-

PRIORITIZED PATIENT PSYCHOSOCIAL ISSUES

1. The influence of personal challenges (shopping for and storing fresh foods, adhering to special diets), personal preference/habits (dislike for taste of fruit, giving in to sweet cravings), personal choices/attitudes (disregard for health care provider's nutritional advice, lack of motivation to eat healthier), and limited knowledge (unaware that too much fruit may be counter productive for a diabetic, unaware of benefits of fresh fruit) on one's willingness and ability to eat a healthy diet.
2. The impact of physical limitations (allergies, weakness), the environment (unsafe neighborhoods, limited access to pools and other exercise facilities), absence of social support (exercise classes are discontinued due to lack of participation, no one to exercise with) and personal feelings (exercise is boring, exercising in the heat is uncomfortable, lack of motivation) on one's willingness and ability to incorporate exercise into their lives.
3. The role of finances (fixed incomes) on eating healthy (healthy foods are too expensive) and securing and maintaining health insurance (high cost of monthly premiums).
4. The difficulties associated with receiving healthcare insurance and/or quality healthcare (insurance denials, physicians not providing adequate care, insurance discrimination, high cost of premiums).
5. The role of stress and/or competing priorities on indulging in unhealthy behaviors (smoking and making thoughtless food choices) and health outcomes (stress brings on many illnesses).
6. Lack of knowledge and/or confusion regarding nature (cause, signs and symptoms) and seriousness (will only seek medical attention when symptoms are extreme) of chronic illnesses (diabetes mellitus, high blood pressure).

Fig 1. Patient focus group results

erings/meetings was of low nutritional value.

Available Support for Promoting/ Increasing Exercise

Participants in all groups expressed that conditions in the community, such as crime, limited availability of exercise facilities, and pollen, were impediments to incorporating regular exercise regimens into their lifestyles. Youth participants stated that getting regular exercise was not emphasized in their schools, and the fact that active participation in physical exercise classes was not enforced by the school's administration (eg, merely "dressing out" for physical education classes was considered participation by physical education instructors). Church leaders added that many congregations do not actively promote or facilitate exercise programs.

Social Interactions

Participants viewed cultural traditions as a significant impediment for one striving to adopt a healthier lifestyle through diet modification and exercise. In this regard, lack of support from family/friends was viewed as a significant barrier to making lifestyle adjustments.

Systemic Barriers

Access to Care

Among the many factors that influence access to care, the issue participants mentioned most often was the financial commitment associated with paying insurance premiums and co-pays. This was perceived as a significant barrier to taking full advantage of available healthcare services. Church leaders asserted that the healthcare system discriminated against the uninsured.

The frequency of insurance claim denials was also mentioned as having a negative impact on access to care. Members of the patient group voiced that these denials were often due to an insurance company's awareness of patients' preexisting medical conditions. All the groups acknowledged that negotiating the healthcare system was a confusing and laborious process.

Quality of Care

There was a general consensus among the focus group participants that long waiting periods in their healthcare provider's office had a negative impact on perceived quality of care. Moreover, patient participants expressed that they did not experience adequate time with their healthcare providers, and that this adversely affected their perceptions of the quality of care received.

Many group participants expressed the view that quality of care varied, and was often influenced by the type of insurance coverage to which one subscribed. Participants also expressed the belief that a reduced standard of care occurred as a result of those insurance companies that limit treatment options in order to save money. Healthcare providers acknowledged that the current healthcare system is not designed to deliver high quality individualized care to a large patient population, and identified patient overload as a justification for reduced patient counseling, and, consequently, a diminished standard of care.

SUMMARY

The compiled lists of psychosocial issues presented here provide a brief summary of perceived health practices and behaviors in the 5 groups. Many of the psychosocial issues revealed here are consistent with findings from similar qualitative studies involving African Americans.[9,10]

PRIORITIZED RESIDENT PSYCHOSOCIAL ISSUES

1. Impact of limited nutrition education (without knowledge of what is healthy, individuals make haphazard food choices) and confusing health advice (certain foods are a health risk today and okay tomorrow) on the willingness and ability of an individual to make appropriate dietary changes.
2. The impact of the environment (bad air, unsafe neighborhoods, fast food companies make unhealthy foods enticing and affordable) on adopting and maintaining a healthy lifestyle.
3. The difficulty created by the perception that eating healthy and reducing stress are expensive (can't afford a vacation, low-fat foods are expensive).
4. The inability to deal with competing priorities (constant requests from family members, perception that there is not time to relax) and its effect on one's ability to adhere to healthy lifestyle (avoiding the convenience of fast food, incorporating exercise into lifestyle, not depending on unhealthy food or cigarettes to reduce stress).
5. The negative impact of culture (adding salt to fruit), perceived taste of healthy foods (fruit today are not as palatable as they used to be), and personal preferences (unhealthy food choices, taking cars rather than walking) on eating healthy and getting adequate exercise.
6. The problems associated with getting health care coverage (access to dental care, confusing insurance process), receiving a high standard of care (long wait time for exams, discomfort with exam), a lack of self-responsibility, and/or a lack of patient trust for the medical field.
7. The difficulty of adhering to a healthy lifestyle without a support system (refusal of family to eat healthier food when prepared, no exercise companions).
8. Difficulties associated with exercising (physical limitations, fatigue).

Fig 2. Residents of subsidized housing focus group results

RECOMMENDATIONS

The following recommendations may serve as a starting point for addressing common barriers to achieving and maintaining healthier lifestyles among African Americans. We also highlight progress made, pertinent to these recommendations. Evaluation is ongoing for specific activities listed.

Addressing Personal Barriers in Communities

Finances

Recommendation: Develop and implement budget management workshops that teach individuals how to create and live on budgets. Particular emphasis should be placed on providing cost-effective strategies for shopping for healthier food items.

Progress: Metropolitan Development and Housing Agency (MDHA), which oversees the management of the federal public housing units, conducts workshops to promote better management of income to encourage residents to move toward self-sufficiency and home ownership. Nashville REACH 2010 has established functional and supportive linkages with MDHA, and conducts nutrition programming with its residents. Metropolitan Development and Housing Agency (MDHA) has been invited to join the Disparities Coalition as a partner. It is anticipated that REACH will have greater access to residents for an increased number of workshops to assist them in managing their food budgets to include healthier choices.

Recommendation: Disseminate and support messages that highlight "cost-free" methods of incorporating exercise into daily routines (ie, housework, gardening, walking through the mall).

Progress: Nashville REACH 2010's goals and objectives are implemented primarily through the work of 4 strategy teams: 1) Access to Healthcare; 2) Tobacco; 3) Screening; and 4) Health and Wellness. The Health and Wellness team has initiated activities throughout North Nashville to encourage physical activity. Recommendations to groups, including those with physical limitations, encourage "cost-free" methods of achieving personal exercise goals, including walking, chair aerobics, and Tai Chi. Earth Matters, a local group that supports gardening as a form of physical activity, works with Nashville REACH to conduct learning situations that encourage physical activity, while promoting the consumption of more fruits and vegetables. To support walking as a cost-free method of exercise in one's own neighborhood, Nashville REACH participated in focus groups conducted by the mayor's office to identify areas in Nashville without sidewalks, or those with sidewalks in need of repair. As part of the focus-group session, Nashville REACH presented information identified through its community audits that resulted in a massive revitalization of the areas' sidewalks that is still underway.

Physical Limitations, Knowledge, and Stress

Recommendation: Incorporate practical exercise alternatives for persons with physical limitations into all activity-focused interventions (ie, water aerobics, chair aerobics).

Progress: Nashville REACH has formed partnerships with the local YMCA and the Arthritis Foundation, as additional resources available to residents with physical limitations. Nash-

PRIORITIZED HEALTHCARE PROVIDER PSYCHOSOCIAL ISSUES

1. The lack of convenience associated with eating a healthy diet and exercising (lack of local availability of quality healthy food choices, extra cost of healthy food, extra time associated with purchasing and preparing healthy food, finding a safe place to exercise, limited transportation).
2. The relationship between psychological issues (stress, anxiety, depression, hopelessness) and an individual's ability to adhere to a healthy lifestyle (exercise, healthy diet, medication adherence).
3. The financial expense associated with a healthy lifestyle (cost of healthy food, cost of insurance/medical expenses, cost of exercise equipment/facilities).
4. The impact of cultural traditions and attitudes on changing (and adhering) to a healthy lifestyle (high fat food preferences, larger body image, hairstyles that inhibit exercise, less family support for healthy behaviors).
5. The problems associated with getting health care coverage (insurance denials, cost of premiums), receiving a high standard of care (thorough patient counseling, continuity of care) and/or a lack of patient trust for the medical field.
6. Difficulty understanding nutrition (food nutrition labels, how food is used by the body) and how nutrition and exercise benefit health.
7. The difficulty associated with balancing life demands (work, family, finance) and adhering to a healthy lifestyle (exercise, healthy diet, medication adherence).
8. Denial of symptoms associated with diabetes/CVD and/or the association between behavioral risk factors (smoking, unhealthy diet, lack of exercise) and health status.

Fig 3. Healthcare provider focus group results

ville REACH is currently collaborating with the Arthritis Foundation to offer training programs for community members to facilitate some of the sessions in North Nashville.

Recommendation: Design and implement culturally appropriate patient education methods that specifically focus on the relationship between behavioral risk factors and development of chronic diseases.

Progress: All Nashville REACH strategy teams incorporate culturally appropriate methods into their education and awareness outreach that emphasize the integral relationship between behaviors and the development of chronic diseases. The importance of having a balanced diet and being more physically active is a major educational priority.

Recommendation: Offer workshops that focus on stress management, with a primary objective of providing individuals with healthier coping strategies when confronted with competing priorities.

Progress: Stress management workshops are held periodically at the Matthew Walker Comprehensive Health Center as a part of its Nashville REACH 2010 Patient Awareness and Nutrition Workshops.

Addressing Environmental Barriers in Communities

Available Food Choices

Recommendation: Promote healthy food options in order to raise awareness, and encourage individuals to adopt healthier lifestyles, thereby creating a demand for local stores and restaurants to provide healthier food options.

Progress: Interventions that are currently being evaluated are cooking demonstrations and sampling of healthy dishes. A protocol for "Healthy Options" is under review that would request local restaurants to place labels on their menus emphasizing healthy choices. In addition, Nashville REACH strategy teams and other community stakeholders present numerous sessions on nutrition each year throughout the area.

Recommendation: Activate parent units to address the readily available sources of "junk" food in and around schools.

Progress: The local school system has addressed the need to remove soda machines, but allowed the machines with unhealthy snacks to remain. However, some schools have placed some "healthy" items in the machines. Efforts to activate parent units have not been initiated.

Recommendation: Create and disseminate culturally appropriate cookbooks to provide healthier alternatives for community organizations and individuals in preparation of meals for gatherings.

Progress: "A Taste of Health," North Nashville's healthy cookbook, has been disseminated throughout the community. Nine hundred copies have been given to individuals who either have, or are at high risk for developing, cardiovascular diseases and type 2 diabetes. Periodic assessments are conducted to determine whether people have used these cookbooks, and, if so, whether they intend to use them again.

Available Support for Promoting/ Increasing Exercise

Recommendation: Implement Neighborhood Watch programs in order to decrease crime, and promote a sense of security among community members.

Progress: North Nashville is considered a high-crime area. Many of the existing neighborhood associations started out as anti-crime programs. Collabora-

PRIORITIZED CHURCH LEADER PSYCHOSOCIAL ISSUES

1. The impact of the church environment (positive-providing encouragement, modeling healthy behaviors, promoting exercise, preaching about healthy living, providing healthy food choices at gatherings, and negative- not modeling healthy behaviors, serving fried food or unhealthy food, not providing support and encouragement for healthy behaviors) on maintaining a healthy lifestyle.
2. The cultural traditions associated with eating (eating what you were raised eating, great family memories associated with eating certain foods, identifying with one's heritage when eating certain foods) and the difficulty in changing personal eating preferences.
3. The difficulty of maintaining a healthy lifestyle (healthy eating, recreation, exercise, stress reduction, emotional balance) without the support of family and community.
4. Negative associations with the healthcare system (long waiting period, perception that "good physicians" don't accept the uninsured, lack of insurance coverage, high cost, confusion/complication associated with health insurance system, communication problems between patient and physician, lack of comprehensive care, lack of trust in physician).
5. The inconvenience associated with the lack of local availability of healthy food choices.
6. The impact of not understanding nutrition and/or maintaining false health beliefs (must be in pain if you are not healthy, too young to get sick) on following a healthy lifestyle.

Fig 4. Church leader focus group results

tions with these groups have been initiated.

Recommendation: Continue to make churches, gyms, and other facilities available as safe havens for exercise. Emphasis should be placed on aggressively advertising these services.

Progress: Some of the churches in Nashville REACH's target area have developed health ministries, added exercise equipment, and started walking clubs. One church has built a new gym as an addition to the building to encourage its members, and the general community, to exercise.

Recommendation: Mobilize and empower parents to verbalize their concerns to proper school officials regarding the lack of enforcement of participation in physical activity curricula.

Progress: Children in after-school programs, especially the Boys and Girls Club, have participated in a number of Nashville REACH 2010 activities. This is our first step toward mobilizing and empowering parents.

Social Interactions

Recommendation: Seek innovative ways to establish formal and/or informal support groups and buddy systems within family units, churches, civic organizations, and other community organizations that represent individuals' social environments.

Progress: Nashville REACH has been influential in encouraging churches to form walking groups as a way of providing social support for exercise.

Recommendation: Communities should encourage individuals, such as community leaders, healthcare providers, and parents, to serve as positive role models and advocates for healthy behaviors.

Progress: Nashville REACH 2010 invites any individual or group to become a part of one of its 4 strategy groups. Many have accepted, and have proven to be important agents of change.

Addressing Systemic Barriers in Communities

Access to Care

Recommendation: Provide workshops that provide guidance and practical experience in navigation within the healthcare system.

Progress: Workshops have been successfully conducted throughout the North Nashville community on accessing resources. A community resource guide was developed to assure that residents with cardiovascular disease or diabetes had access to information on available resources.

Recommendation: Develop and make available to all community organizations health resources manuals, containing physician referral lists, applications for various insurance plans, transportation contact organizations, etc.

Progress: In addition to being provided to residents, the community resource guide is distributed among a diverse group of organizations in the community.

Quality of Care

Recommendation: Present to local governing bodies the issues related to the difficulty of providing comprehensive individualized care in the current system.

Progress: This activity is a priority, but will prove to be a great challenge, due to recent streamlining in the state's healthcare plan for the uninsured.

CONCLUSION

Three broad areas of barriers to healthy lifestyles emerged from the 5 community focus groups: personal, environmental, and systemic. Finding effective ways to deal with these barriers will involve multifaceted approaches from a variety of community, health

PRIORITIZED YOUTH PSYCHOSOCIAL ISSUES

1. The impact of the lack of school support for exercising and eating healthy (exercise programs not taken seriously, availability of junk food at or near school, limited choices of healthy foods at school).
2. The impact of the community on access to healthy versus unhealthy food (dining facilities that sell unhealthy food on every corner, food drives that sell high fat foods) and creating an environment conducive to exercise (unsafe neighborhoods, limited exercise facilities).
3. Time associated with leading a healthy lifestyle (longer preparation of healthy foods, no time to exercise, more convenient to eat unhealthy when you are busy).
4. The negative impact of cultural traditions and/or risk behaviors on engaging in healthy behaviors (limited fruit and vegetable consumption, influence of weather on food preferences, overeating, succumbing to unhealthy cravings, striving for the "model figure", preference for high fat foods, body size misperceptions).
5. Difficulties associated with receiving high quality healthcare (lack of trust, high cost and limitations of insurance coverage, high patient to physician ratio).
6. Difficulty understanding how to eat healthy (food portions, nutrition) and overcoming hygienic consequences of exercising (sweating and smelling bad) and eating healthy (must be on a "diet").
7. The impact of financial considerations on a healthy lifestyle (teens working at fast food restaurants tend to eat at them, fruit too expensive, exercise facilities too expensive, insurance too expensive).
8. Lack of family support and education (not supporting each other in choosing healthier foods, misperception that body size is indicative of health status, non-healthy food purchases for younger family members largely influence nutrition of all members).

Fig 5. Youth focus group results

provider, and political organizations. The community-driven recommendations provided here offer a general framework for conceptualizing and engaging in practical health solutions in an African-American community where disparate health conditions persist. Prior to being adopted by other African-American communities, these recommendations should be appropriately tailored to meet the needs of the community members.

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REFERENCES

1. Roussos ST, Fawcett SB. A review of collaborative partnerships as a strategy for improving community health. *Annu Rev Public Health.* 2000;21:369–402.
2. Himmelman AT. Inside/out: change agents and community partnerships. *Health Forum J.* 1998;41(4):40–42.
3. Troutman A. *Racial and Ethnic Approaches to Community Health (REACH 2010): Addressing Disparities in Health.* Atlanta, Ga: Centers for Disease Control; 2001.
4. Huang J. Age adjusted and premature death rates for North Nashville and Davidson County using 1998 death records. Unpublished data. 1998.
5. *Health, United States, and Aging Chartbook.* Hyattsville, Md: National Center for Health Statistics; 1999.
6. Miller ST, Seib HM, Dennie SP. African-American perspectives on health care: the voice of the community. *J Ambulatory Care Manage.* 2001;24(3):37–44.
7. Krueger R. *Focus Groups: A Practical Guide for Applied Research.* Newbury Park, Calif: Sage Publications; 1988.
8. Folch-Lyon E, Trost J. Conducting focus group sessions. *Stud Fam Plann.* 1981;12(1): 443–449.
9. Blanchard MA, Rose LE, Taylor J, McEntee MA, Latchlaw LL. Using a focus group to design a diabetes education program for an African-American population. *Diabetes Educ.* 1999;25(6):917–924.
10. Anderson RM, Barr PA, Edwards GJ, Funnell MM, Fitzgerald JT, Wisdom K. Using focus groups to identify psychosocial issues of urban Black individuals with diabetes. *Diabetes Educ.* 1996;22(1):28–33.