

**Audience Research on Self-Management Education**

**Attachment 1 to the HMTS Expedited Review Form**

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# **Attachment 1a: Research Plan**

## **Audience Research on Self-Management Education**

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**May 16, 2013**

#### **Background**

The Centers for Disease Control and Prevention (CDC) is exploring the feasibility of developing a communication campaign to promote self-management education (SME) to people with a variety of chronic conditions, including arthritis, diabetes, heart disease, and others.

As an initial phase in the research process to explore the feasibility of a general SME campaign, a targeted literature review, an environmental scan, and interviews with key stakeholders were conducted to guide the research plan. The objectives of this situational analysis included:

- Determining the degree to which the findings from previously conducted arthritis research apply to other chronic conditions
- Exploring audience characteristics to better define the campaign's target audience
- Learning how other disease groups and/or organizations are promoting their SME programs
- Connecting with others working in this arena to gather their input on the promotion of SME
- Informing a logic model depicting how a promotional campaign may contribute to an individual's decision to seek out a SME program

The next phase of the feasibility study will focus on eliciting, developing, and refining concepts, messages, and possible channels to raise awareness among people with a chronic condition.

#### **Methodology and Research Design**

FHI 360 will conduct focus groups with the key audience to test concepts aimed at exploring different ways to impart information, demonstrate benefits, address barriers and increase receptiveness to SME programs. Focus groups are valuable in exploring consumer reactions to design and message concepts before additional resources are put into their development. The objectives of the research task are to:

1. Explore differences in target audiences' attitudes toward and awareness of SME
2. Test messages about SME to assess comprehension, relevance, benefits, and credibility
3. Explore differences in target audiences' reactions to the messages
4. Assess audiences' preferred channels

The research will be conducted in two phases:

- Phase I – Preliminary Concept and Channels Testing, and
- Phase II – Revised Concept and Channels Testing.

Phase I: The objective of the first phase of focus group testing is to distill from a number of message concepts the most resonating and appealing messages for further exploration. Potential channels for messages will be tested as well.

Phase II: The objective of the second phase of focus group testing is to test revised concepts and channels. Phase II research will be informed by the previous phase of focus group research as well as discussions with CDC.

For each phase of focus group research, FHI 360 research staff will develop instruments, recruit respondents, conduct the focus groups, analyze the data collected, and summarize key findings in two topline reports (one report per phase). FHI 360 will analyze all responses in aggregate form. Information transmitted to CDC will be de-identified. Summary reports will not identify any individuals.

### Site Selection

FHI 360 considered the following criteria when selecting the locations for Phase I and Phase II of focus group testing:

- Geographical distribution
- Diversity of population
- Diversity of medical options, including SME (rural participants will be recruited in at least one market)

### Phase I

For Phase I of testing, FHI 360 proposes conducting a total of 6 focus groups divided between three locations: Richmond, Virginia (East); Chicago, Illinois (Mid-West); and Phoenix, Arizona, (West). For each focus group, 10 participants will be recruited for 8-10 participants to show. The research design for the first phase is presented in table 1 below:

**Table 1: Phase I focus groups with persons with chronic conditions**

<b>Audience</b>	<b>Richmond, VA</b>	<b>Chicago, IL</b>	<b>Phoenix, AZ</b>	<b>TOTAL</b>
Women with 1 or more chronic condition	1	1	1	3
Men with 1 or more chronic condition	1	1	1	3
<b>TOTAL</b>	<b>2</b>	<b>2</b>	<b>2</b>	<b>6</b>

*Phase II*

For Phase II of testing, FHI 360 proposes conducting a total of 6 focus groups divided between three locations: Atlanta, GA (East); Houston, Texas (South-West); and Des Moines, Iowa (Mid-West). For each focus group, 10 participants will be recruited for 8 participants to show. The research design for the second phase is presented in table 2 below:

**Table 2: Phase II focus groups with persons with chronic conditions**

<b>Audience</b>	<b>Atlanta, GA</b>	<b>Houston, TX</b>	<b>Des Moines, IA</b>	<b>TOTAL</b>
Women with 1 or more chronic condition	1	1	1	3
Men with 1 or more chronic condition	1	1	1	3
<b>TOTAL</b>	<b>2</b>	<b>2</b>	<b>2</b>	<b>6</b>

# Attachment 1b : Burden Hours and Distribution of Respondents

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## Burden Hours

Type of Respondents	Form Name	Number of Respondents	Number of Responses per Respondent	Burden per Response (in hr)	Total Burden (in hr)
Individuals with 1 or more chronic conditions	Focus Group Eligibility Screener (Phase I and Phase II)	120	1	10/60	20
	Moderator's Guide for Phase I Focus Groups	60	1	90/60	90
	Moderator's Guide for Phase II Focus Groups	60	1	90/60	90
				Total	<b>200</b>

## Total Number of Respondents and Distribution by Region

Type of discussion group	Total # of groups <i>(across all 3 regions*)</i>	Total # of respondents that will be recruited for each group	Total # of respondents
Phase I Focus Groups with individuals with 1 or more chronic conditions	6 <i>(2 in each region)</i>	10	60 respondents
Phase II Focus Groups with individuals with 1 or more chronic conditions	6 <i>(2 in each region)</i>	10	60 respondents
*Phase I: (1) East; (2) Mid-West; and (3) West. Phase II: (1) East; (2) South-West; (3) Mid-West.			<b>120</b> respondents

# **Attachment 1c : Focus Group Justification of Incentive Use**

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All participants will receive a \$50 incentive. With respect to the level of incentive, Krueger and Casey, in the publication “Focus Group: A Practical Guide for Applied Research” (2009), indicate the following: “At the time of this writing, amounts of \$50 to \$75 usually work for public and nonprofit studies.”<sup>1</sup> The U.S. Food and Drug Administration (FDA) has previously received OMB approval to provide a \$75 incentive to participants (prescription drug users and their caregivers) in a series of 2011 focus groups.<sup>2</sup> Therefore, the proposed \$50 incentive represents the minimal level of incentive deemed suitable for focus group participants in the recent past. Additionally, the incentive is less than the amount approved by the OMB for focus group research with a similar audience.

The \$50 incentive will be a cash incentive rather than an alternate form of incentive (e.g., gift card to a store) because guidance on focus group research also suggests that “incentives should be selected that have universal value to participants; what may be valuable to one person may have little value to other. This is one reason money is employed most often.”<sup>3</sup> The focus group participants will receive the incentive in cash at the focus group facility immediately after the conclusion of the discussion groups.

Use of incentives may reduce the time to complete recruitment, reduce “no-shows”, increase level of participant engagement during the focus group, and result in long-term savings.<sup>4</sup> Appropriate incentives are key to the success of research efforts and to preventing over-burdening the public. “Incentives are needed because it takes effort to participate in a focus group... it [also] serves as a stimulus to attend the session. The primary function of the incentive is to get participants to show up for the focus group—and to show up on time.”<sup>5</sup> In other words, even when individuals agree to participate, insufficient incentive may result in a greater likelihood of participants not showing up to participate in the discussion (i.e., “no-shows”). This may not only negatively impact the ability to gather the necessary data but, additionally, the time that would have already been spent in the recruitment of these participants would therefore translate into unnecessary burden to the public. Additionally, because there are costs associated with recruiting each participant (even for no-shows), when participants are no-shows it involves expenditures that could otherwise be avoided.

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<sup>1</sup> Krueger, R.A. (2009). Focus Groups: A Practical Guide for Applied Research (4th ed.). Thousand Oaks, CA: Sage Publications.

<sup>2</sup> ICF Macro. (2012). Focus Group Report on Consumer Perceptions of Prescription Drug Companies. U.S. Food and Drug Administration.

<sup>3</sup> Stewart, D.W. & Shamdasani, P.N. (1990). Focus Groups: Theory and Practice. Newbury Park, CA: Sage Publications.

<sup>4</sup> Marriner, V. (2011) *Qualitative Research Incentives: 5 Reasons Why More is Better*. The Research Bunker. Retrieved on May 2, 2013, from <http://rmsbunkerblog.wordpress.com/2011/03/14/qualitative-research-incentives-5-reasons-why-more-is-better/>

<sup>5</sup> Krueger, R.A. (2009). Focus Groups: A Practical Guide for Applied Research (4th ed.). Thousand Oaks, CA: Sage Publications.