ATTACHMENT 5A

MYRX PARTICIPANT ELIGIBILITY SCREENING FORM

Form Approved
OMB No. 0990-
Exp. Date XX/XX/20XX

ELIGIBILITY SCREENING FORM: HYPERTENSION AND DIABETES

(Completed by Program Staff at Time of Recruitment)

Patient Centered Care Collaboration to Improve Minority Health Initiative
[Houston Hub]

Conducted by Texas Southern University College of Pharmacy and Health Sciences

Step I. Recruitment Location *(please indicate by checking below)*

☐ Telephone Date:_____
☐ Lyerly
☐ Bellerive
☐ Historic Oaks of APV

Step II. Eligibility Section *(please ask the participant the following questions to determine eligibility)*

1. Do you have:

	Yes	No
High blood pressure?.....	☐	☐
Diabetes?.....	☐	☐

2. Are you taking at least one medication for:

	Yes	No
High blood pressure?.....	☐	☐
Diabetes?.....	☐	☐

3. Are you age 55 or older?

☐ Yes
☐ No

information collection is 0990- . The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 336-E, Washington D.C. 20201, Attention: PRA Reports Clearance Officer

4. What is your race/ethnicity?

- ☐ African-American
- ☐ Asian-American
- ☐ Hispanic/Latino

5. Are you a resident of (mention facility name checked in Step I)?

- ☐ Yes
- ☐ No

5a. If no, please indicate facility name:

_____

6. Do you have regular access to a telephone?

	Yes	No
For telephone follow-up.....	☐	☐

Step III. Determine participant eligibility *(Participant eligible, only if Yes to all questions above)*

- If answered "No" to any of the questions above, the participant is not eligible:
  - Use the following text to end the encounter with the participant: *"Thank you for your time. You are not eligible to participate in the study at this time."*
- If answered "Yes" to all questions above, please continue to Step IV below.

Step IV. Participant Demographics

Sex: ☐ Male
☐ Female

Participant Name (Last, First):_____

Phone Number 1:_____ Phone Number 2:_____

Address:_____

Date of Birth: |___|___|-|___|___|-|___|___|___|___|
MONTH DAY YEAR

Race/Ethnicity: _____

Please mark preferred spoken language:

☐ English
☐ Spanish
☐ Vietnamese
☐ Cantonese
☐ Mandarin

Please mark preferred written language:

☐ English
☐ Spanish
☐ Vietnamese
☐ Cantonese
☐ Mandarin

What is the highest level of education that you have completed?

☐ Middle school or lower
☐ High School
☐ Associate Degree
☐ Technical School Certification
☐ Four-year College Degree
☐ Graduate School

For telephone follow-up

When is a good time to come for a home visit? (Check all that apply)

	AM	PM
Monday.....	☐	☐
Tuesday.....	☐	☐
Wednesday.....	☐	☐
Thursday.....	☐	☐
Friday.....	☐	☐
Saturday.....	☐	☐
Sunday.....	☐	☐

Date:_____
Client ID #:_____

Step V. PCCC Items

We would like to know how you heard about this health program. Please check all answers that apply.

1. How did you learn about this health program?

   a. Through personal contact with a:

   - ☐ Friend, neighbor, or relative
   - ☐ Health care professional
   - ☐ Social service professional
   - ☐ Other (SPECIFY):_____

   b. Through written materials I read:

   - ☐ Brochure
   - ☐ Direct mail
   - ☐ Other (SPECIFY):_____

   c. Through social media/electronic materials I read:

   - ☐ Email
   - ☐ Telephone text message
   - ☐ Facebook posting
   - ☐ Other (SPECIFY):_____

The statements below describe attitudes and beliefs you may have about why you signed up for the health program and about your health condition(s): diabetes, hypertension, or being overweight. Please rate how much you agree or disagree with each one by placing a check mark in the appropriate box.

2. Why did you sign up for the program?

	Strongly disagree	Somewhat disagree	Neutral	Somewhat agree	Strongly agree
a. I need help managing my health condition.....	☐				
.....	☐				
.....	☐				
b. I need information on my health condition.....	☐				
.....	☐				
.....	☐				
c. The classes will be taught by a trained professional (community health worker, health educator, pharmacist)....	☐				
.....	☐				
.....	☐				
d. The class will be taught in my language.....	☐				
.....	☐				
.....	☐				
e. The materials will be written in my language...	☐				
.....	☐				
.....	☐				
f. Someone will call me to follow-up on what I learn and remind me of what I should do to manage my health.....	☐				
.....	☐				
.....	☐				
g. It is easy to get to the program location.....	☐				
.....	☐				
.....	☐				

h. It will not take a lot of my time..... ☐
..... ☐ ☐
..... ☐ ☐

i. It does not cost me anything..... ☐
..... ☐ ☐
..... ☐ ☐

Step VI. Baseline Data Collection

1. Past Medical History

a. What conditions have you been diagnosed with in the past?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

b. Have you had the following conditions within the **past 6 months**?

☐ Stroke
☐ Heart attack
☐ Chest pain
☐ Vision problems
☐ Kidney disease
☐ Peripheral vascular disease
☐ Unusual weight loss
☐ Cuts/bruises that are slow to heal
☐ Tingling numbness in the hands/feet
☐ Recurring skin, gum, or bladder infections
☐ Hospital admission due to high blood pressure/diabetes
☐ Emergency room visits due to high blood pressure/diabetes
☐ Physician's office visits due to high blood pressure/diabetes
☐ Adverse events caused by high blood pressure/diabetes medications

2. Social History:

- ☐ Smoking (|__|__| packs per day for |__|__| years)
- ☐ Alcohol (what kind?_____ how often?_____)
- ☐ Illicit drug use (such as:_____)

3. Do you have any history of an allergic drug reaction?

Drug Name:_____
Type of reaction:_____

4. Do you have a primary care physician? ***Note: If no primary care physician, please refer to Harris County Hospital District.***

- ☐ Yes
- ☐ No

5. If yes, to question #4, who is your primary care physician?

PCP Name:_____
Phone:_____
Fax:_____
Address:_____
_____

6. Is your doctor from Harris County Hospital District?

- ☐ Yes
- ☐ No

7. Are you okay with us contacting your physician to let him/her know you are participating in this program and inform them about any irregular findings?

- ☐ Yes
- ☐ No

8. Are these needed?

_____

Self-Monitoring Questions (please refer to appropriate section below):

9. Behavior – pre/post changes

Hypertension:

10. Do you have a blood pressure machine at home?

- ☐ Yes
- ☐ No

11. How often do you monitor your blood pressure?

- ☐ More than one time per day
- ☐ Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Never

12. If “Never” to question #11, what is the reason for not monitoring your blood pressure at home? (Check all that apply)

- ☐ Unable to purchase a machine
- ☐ Health related disability (e.g. arthritis, poor vision)
- ☐ Not sure how to use the machine
- ☐ Lack of help
- ☐ Time
- ☐ Not important
- ☐ Don’t know

13. On average, how often do you see your health care professional for your blood pressure?

- ☐ Every Week
- ☐ Every Month
- ☐ Quarterly
- ☐ Every year
- ☐ Never
- ☐ Don’t know

Diabetes:

14. Do you have a glucose meter at home?

- ☐ Yes
- ☐ No

15. How often do you monitor your blood sugar?

- ☐ More than one time per day
- ☐ Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Never

16. If “Never” to question #15, what is the reason for not monitoring your blood sugar at home? (Check all that apply)

- ☐ Unable to purchase a machine
- ☐ Health related disability (e.g. arthritis, poor vision)
- ☐ Not sure how to use the machine
- ☐ Lack of help
- ☐ Time
- ☐ Not important
- ☐ Don’t know

17. On average, how often do you see your health care professional for your diabetes?

- ☐ Every Week
- ☐ Every Month
- ☐ Quarterly
- ☐ Every year
- ☐ Never
- ☐ Don't know

18. Are you currently participating in any exercise program?

- ☐ Yes
- ☐ No

19. Are you currently participating in any diet program?

- ☐ Yes
- ☐ No

***Step VII. Informed Consent: Conduct informed consent and have participant sign the document.**

You are being invited to take part in a research study. This letter provides you with information about this study. You have a right to decide not to take part or to quit this study at any time, without penalty.

WHAT IS THE PURPOSE OF THE STUDY?

This study will test whether pharmacists can help participants manage their high blood pressure, diabetes, and medication use through home visits, group education sessions and telephone counseling. African-Americans, Asians, and Hispanics age 55 and older and live in Houston Housing Authority facilities will be asked to take part in this study.

WHAT SERVICES WILL I RECEIVE?

You will receive telephone and in-home counseling from a licensed pharmacist. During the visit, the pharmacist will ask you questions about your health, review the medicines you take, and teach you how to live healthier. You will also receive two health education classes facilitated by a health educator.

HOW MUCH TIME WILL IT REQUIRE?

You will receive one home visit that will last 1 hour. You will also receive two phone calls that will last 10 to 20 minutes per call. You will participate in two

group sessions that will last 45 – 60 minutes. Total study time is less than 5 hours over a 6-month period.

WHAT ARE THE BENEFITS?

You will receive medical information and services from a pharmacist and health educator, which may help you improve your high blood pressure and/or diabetes, use your medications correctly, and improve your overall health. You will receive a $15 gift card at the end of the program for completing the home visit, group education sessions and telephone calls.

WHAT ARE THE RISKS?

You will have little to no discomfort from answering questions. You may have slight discomfort when having your blood pressure taken. There may be mild, temporary pain when pricking the finger to draw blood to measure your hemoglobin A1c levels. Hemoglobin A1c is a blood test to measure your blood glucose (sugar) levels over the past 2-4 months.

There is a chance that your blood pressure or blood sugar may get very high or low while you are in this study. If this happens, you must contact your doctor.

HOW MUCH WILL IT COST?

There is no extra cost for taking part in this study.

WHAT ARE MY RIGHTS?

Taking part in this study will not affect your medical benefits, housing benefits or services. You do not have to answer any questions or get any services that make you feel uncomfortable. **All information you provide will remain confidential.**

WHO WILL TAKE CARE OF ME IF I GET HURT?

If you have any type of pain or discomfort while you are in this study, Texas Southern University is not able to offer money or pay the costs of medical care. You, your insurer, Medicare or Medicaid will have to pay for any care that is needed. The staff of the study can refer you to a local medical facility, if needed.

For more information about the study, call:

Dr. Aisha Morris Moultry
713.313.7553
or
Texas Southern University Institutional Review Board
713.313.4301

This research project has been reviewed by the Institutional Review Board (IRB) of Texas Southern University, study number _____. This study is being funded by the Department of Health And Human Services Office of Minority Health.

This study has been explained to me. I volunteer to take part in this research. I have had a chance to ask questions. If I have questions later about the research, I can ask the researcher listed above. If I have questions about my rights as a research subject, I can call the Texas Southern University Committee for the Protection of Human Subjects at (713) 313-4301 or go to http://www.tsu.edu/research. Your signature shows that you have read this consent form and have agreed to take part in this study.

Name of Participant (please print):_____

Name of Staff (please print):_____

_____ _____

Signature of Participant Date

_____ _____

Signature of Staff Date