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Using Focus Groups to Inform the Development of Stroke Recovery and Prevention Programs for Younger African-American (AA) Men

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Abstract

Objective—To assess perceived facilitators and recommendations for stroke recovery and prevention among younger AA men (< age 65) in order to inform the development and pilot testing of an intervention for this high risk group.

Method—Focus group methodology was used to collect data from ten community-dwelling AA stroke survivors and seven of their care partners (CPs) (N=17). Thematic analysis of session transcripts and the constant comparative method were used to generate themes.

Results—Participants cited facilitators to post-stroke care and recovery as Family Support, Stress Reduction and Dietary Changes. Specific person-level recommendations for AA men included following established stroke guidelines, use of complementary and alternative medicine, and never give up recovery efforts. Community-level recommendations included making a list of community resources available, providing support and education to care partners, using videos that feature AA men to deliver information and use AA men stroke survivors to help disseminate the information. Provider and health system recommendations included consolidation of medical bills, improving provider communication skills and making providers aware of needs specific to AA men and their families.

Conclusions—While AA men and their CPs acknowledged and welcomed learning more about the American Heart Association Stroke Prevention Guidelines, it is clear they desired approaches that addressed their specific needs and preferences as young AA men who sometimes felt devalued by their community and care providers. Specific person, community and care-system level approaches that are of perceived value to AA men offer potential to improve health outcomes and reduce health disparities.

Keywords

stroke; African-American men; disparities; recommendations

INTRODUCTION

African Americans (AA) are impacted by stroke more than any other racial groups in the U.S., with stroke having a particularly malignant effect on AA men.^{1,2} While historical social and political conditions are at the foundation of health disparities for AA men^{3,4}, risk factors (hypertension; diabetes; elevated lipids; smoking; alcohol; obesity; inactivity; metabolic syndrome) that predispose to early stroke are common in AA men and, once stroke occurs, these same risk factors complicate care and increase risk for stroke recurrence.⁵⁻⁸ The new American Heart Association (AHA) Guidelines for the Prevention of Stroke in Patients with Stroke or Transient Ischemic Attack (TIA)^{9,10} recommend management of specific modifiable risk factors, all of which are disproportionately common in AA. However, AA have low stroke risk factor awareness and low use of risk reduction therapies.^{7,11,12,13}

AA men who experience a first-ever stroke are younger (<65), have greater stroke disability, more post-stroke complications, and slower recovery compared to European-Americans (EA).⁵⁻⁸ A recent 10-year retrospective study of stroke hospitalizations in the southeastern region of the U.S. revealed that stroke hospitalization rates increased in young AA men (<65) compared with EA, which resulted in a severe and persistent racial disparity.¹⁴ Given the disproportionate burden and tremendous humanitarian and financial impact related to stroke, there is a critical need for healthcare approaches that will improve health outcomes in younger AA men who have had a stroke, and reduce recurrent/future risk for stroke. Unfortunately, there is only a limited literature that has specifically focused on improving engagement in post-stroke care for AA men stroke survivors^{1,15} and no prior study, to our knowledge, has specifically elicited the insights of younger AA men who have dealt with stroke about the facilitators of their health.

In previous work, we identified perceived barriers to post-stroke recovery for younger (<65) AA men as stress related to “being a black man” (perceived discrimination), frustration, depression, and functional limitations (memory, vision, speech, mobility, fine motor skills). Other barriers that were identified were inadequate stroke knowledge, poor provider/patient communication and difficulties with healthcare access.¹⁶ While these findings suggest important care approaches for AA men, additional information is needed on the target population’s perceived facilitators and recommendations for post-stroke recovery and secondary prevention practices, so that consideration of these factors can be integrated into effective interventions. We conducted a qualitative analysis of facilitators and recommendations for post-stroke recovery and prevention practices in younger (< age 65) AA men who experienced a first time stroke or TIA. Findings will help inform the development and pilot testing of an intervention for younger AA men stroke survivors that is part of a National Institute of Health Funded Study, on reducing health disparities in male minorities (Grant Number: R21NR013001-01A1; Sajatovic, PI).

METHODS

Study Design

We used focus group methodology to collect data from homogenous groups using a predetermined semi-structured focus group guide.

Sample and Setting

Ten AA survivors of ischemic stroke or TIA were enrolled within 6 months of discharge from an acute stroke program or within 6 months of Emergency Department/physician visits for a TIA. Men who have had a TIA were included in our sample as they are at particularly high risk for stroke and could provide additional input into the development of the interventional phase of the larger study. To be eligible, participants needed to be self-identified AA males age < 65 years, have a planned or recent home discharge, and have a Barthel Index score of > 60.^{17,18} Given the fact that AA stroke survivors are more likely to be discharged to home rather than to a rehabilitation facility,¹⁵ spouses/family are likely to be involved with post-stroke care. Therefore, having an available care partner (CP) to assist in program participation was preferred but not required. We enrolled seven CPs. Participants were recruited from a tertiary care medical center acute stroke unit, local primary care clinics, and specialty stroke care programs in Northeast Ohio, USA. Community locations with a focus on venues expected to yield enriched populations of AA (select churches, community centers and free health events) were also used for recruitment purposes. The study was approved by the local Institutional Review Board and all participants provided written informed consent.

We held the focus groups in the evening in a small conference room of the participating institution and a light supper was served. A moderator (MS) facilitated the focus group discussions using a semi-structured interview guide. Two facilitators (CB, AP) recorded observations regarding group dynamics, monitored the recording, and reviewed statements at regular intervals during the discussion. A debriefing session between the moderator and facilitators after each session provided an opportunity for sharing first impressions and summarizing key findings. Each session was then compared with previous ones to confirm existing themes and note new ones so that, if necessary, modifications in the focus group guide could be made. Three focus group sessions, comprised of AA men and available CPs, were conducted until little new information was generated.¹⁹ All focus group participants later became part of an advisory board to assist in the refinement of a stroke intervention for AA men.

Sample Characteristics

Stroke/TIA Survivors—Mean age of AA male stroke/TIA survivors was 53 (range =34-64). Seven had an ischemic stroke and three had a TIA. Mean Barthel index was 95.5 (SD=7.6). The highest level of education completed was post-graduate (n=1); college (n=1); incomplete college education (n=1); high school (n=5); and some high school (n=2). One of the men was employed full-time; three were retired and six were unemployed.

Care Partners (CPs)—All seven CPs were AA women, mean age 54 (range=49-61. Five CPs were wives, one a fiancée and one a niece. The highest level of education completed was post-graduate (n=1); college (n=2); incomplete college education (n=1); and three completed high school. Two women were employed full-time; two were retired; and three were unemployed.

Qualitative Data Collection and Analysis

Focus group discussions explored personal, family, and community factors relevant to post-stroke care and recovery among AA men and their CPs. Facilitators to modifiable risk factor reduction guidelines, as described by the American Heart Association/American Stroke Association (AHA/ASA).^{9,10} as well as facilitators for overall recovery, were also explored. Participants provide their views on what would be the most desirable and practical recommendations for a stroke recovery program for AA men. The semi-structured interview guide used to focus the discussion listed the main topics to be covered and the specific topic-related questions to be asked. For example, under the topic, “facilitators to post-stroke recovery and prevention,” the following question was asked: “What sort of things can help you in managing and preventing another stroke?” The guide also included some examples of follow-up questions or probes such as “would you explain further,” “please describe what you mean,” and “would you give me an example.”

All focus groups were audio recorded and transcribed verbatim. Transcript-based methodology^{20,21} was used to analyze all data. In this method, the researcher uses the transcription, itself, as the source of the textual data to be analyzed. We used a thematic content analysis approach to data analysis, encompassing open, axial and sequential coding, and the constant comparative method to generate constructs (themes) and elaborate the relationship among constructs.^{20,22}

Three qualitatively trained investigators (CB, MS, JC) independently coded each transcript to ensure consistency and transparency of the coding; discrepancies were resolved by discussion. We then constructed a coding dictionary that included mutually exclusive code definitions. Coding structure was reviewed after a preliminary analysis of a sub-sample of transcripts, and the dictionary was refined through comparison, categorization and discussion of each code’s properties and dimensions.²² Significant statements and themes attached to the codes enabled identification/characterization of perceived facilitators. Results of the coding and analysis were presented to the focus group members at a subsequent advisory board meeting where they were invited to critically evaluate and comment on findings.²³

RESULTS

Analysis of the focus group transcripts generated two major domains of facilitators to post-stroke care and recovery: 1) Personal Level Facilitators, and 2) Family/Community Level Facilitators. The former included trying to stay motivated to persevere in following guidelines and recommendations targeted to individuals who have had a stroke.^{9,10} The use of techniques such as meditation and yoga to reduce stress was also mentioned. The latter included emotional support and help with activities of daily living provided by family and

friends. Additional analysis generated three major domains of recommendations for implementing an ideal intervention targeted to AA men: 1) Personal Level Recommendations, 2) Community Level Recommendations, and 3) Healthcare System/Provider Level Recommendations.

Personal Level Recommendations

Table 1 shows themes, descriptive codes, and illustrative quotations emerging from Personal Level Recommendations. We classified these recommendations into three categories that reflected the personal issues that helped our respondents during stroke recovery and that they wanted reflected in the intervention: a) Following the AHA/ASA Guidelines, b) Explore Alternative and Complimentary Methods, and c) Never Give Up.

Following the AHA/ASA Guidelines

Medication adherence: Medication adherence was a commonly identified recommendation:

“Make sure you take your medication. Take it at a regular time, same time every day.” (Respondent 3)

Participants were also concerned about keeping track of the side effects of the medications:

When I go to my appointment I have all of my medications written out and underneath them I say this has this effect on me, and that has that effect on me.” (Respondent P1).

Smoking Cessation: Smoking cessation was also identified as a topic to address in stroke recovery and prevention, although some participants were still struggling with this habit:

“I’m trying to wean myself off cigarettes. I have to do it, but it’s hard. I’ve got to cut down, don’t want to die. Don’t want to have another stroke!” (Respondent 8.)

Nutrition/Dietary Changes: Changes in nutrition and dietary practices were recommended:

“Take a look at your overall eating habits, and you know, back to the vegetables, back to the fruits, salads, you know, not the heavy red meats just poultry, chicken and fish. Try not to over fry because everybody likes fried foods.” (Respondent P2)

Personal anecdotes about making lifestyle changes around food were offered:

“We don’t go out to restaurants like we used to because I want to know what they’re putting in that food. We used to go out to eat all the time, but now I like to cook!” (Respondent P3)

Keeping Medical Appointments: It was agreed that keeping medical appointments was important:

“Making sure you keep doctors’ appointments is very important. Checking, making sure that you know the date and proper time and you leave enough time to make sure that you’re there on time.” (Respondent 5).

Explore Alternative and Complimentary Methods—Alternative and complimentary methods such as yoga, meditation/visualization, and herbal supplement as adjunct, or replacement therapies, for traditional post-stroke medications was mentioned and shared by several members of the group.

Herbs, Vitamins and Supplements: Many complained about the side effects of the doctor-prescribed medications they were taking and were looking for something more “natural” to take:

“Instead of the things that the doctor prescribes. I would be looking for something that’s more natural rather than drugs; something that doesn’t make you sleepy or tired.” (Respondent 9).

One participant highly recommended his regimen of vitamins and herbal supplements as an adjunct to his prescribed medications:

“What I also do is when I take my medicine early in the morning, I also add a little vitamin Centrum plus 50. I take that, and I take ginseng and I’m a diabetic so I take cinnamon and I take magnesium, because magnesium and cinnamon has lowered my sugar tremendously. First I was getting the injections then I went to the pill, and since I’ve been taking the cinnamon and magnesium they took me right off the medications.” (Respondent 2)

While this group of AA men were generally supportive of endorsement of complementary and alternative treatments, there was friendly advice from some members of the group about using these substances without checking with their medical provider:

“I just wanted to say ask your doctor about the ginseng because I had a friend who had high blood pressure already and he bought a small bottle of it (ginseng). When he took it to his doctor I think the doctor told him that ginseng raises your blood pressure sometimes. (Respondent 1)

Never Give Up—One man who had a stroke and had been initially severely impaired recalled his long road to recovery through perseverance and having a positive attitude:

“I had lost all my cognitive skills; I couldn’t walk or talk. Lost everything so it was like kindergarten all over. They had their own rehab center at the hospital so I was going down there daily and started in the morning. Every day I started with a little comic book then a little reading book. Worked at it every day cause I knew I had to just fight back, fight back. I have always been persistent in that rule, never get down. I never give up. From reading flash cards, to cartoon characters, to picking the names of animals from dog or cat sounds. It was pretty dramatic but I hung in there. I knew I could beat it. I never gave up on myself. I got through it. I finally learned to talk!” (Respondent 1)

Members of the group felt very strongly that stories like this should be shared during any proposed intervention for stroke survivors in that it could inspire others to take a more positive approach in their own recovery.

Community Level Recommendations

Table 2 shows themes, descriptive codes, and illustrative quotations emerging from Community Level Recommendations. We classified these recommendations into the five categories that reflected the issues that the participants wanted embedded into any proposed program for stroke recovery and prevention: a) Provide List of Community Resources, b) Provide Care Partner Support and Training, c) Educate Program Personnel About AA men, d) Make a Video, and e) Train/Use AA men Who Have Been There Help Deliver the Program.

Provide List of Community Resources—Participants agreed that having a list of community resources was necessary in helping them in the recovery process. As can be observed in Table 2, fitness centers/gyms, Yoga and Tai Chi places were recommended. Other community resources that were recommended included Clergy/Lay Counsellors:

“I’ve gone through family counseling with the pastor. Sometimes people need someone; they want that person to come in and pray or to just counsel or to just talk with.” (Respondent 5).

Podiatrists were recommended as well as places that offered arts and crafts to reduce stress:

“They should also provide some sort of resource for out posting services. I found a visiting podiatrist that would come in, but I just happened to bump into her,” (Respondent CP4)

“Sometimes people who have artistic talents, offer them something that keeps the mind occupied, that’s calming to them.” (Respondent 4)

Provide Care Partner Support & Training—CPs shared the stress and burdens they faced during their partners’ recovery period and recommended that any intervention should include CP support and training:

“The CPs need somebody to talk to, because it’s a struggle to try to deal with something that you’re not familiar with, that never happened to you. Dealing with someone’s anger is not easy. You have to be a very strong person. You really do have to put your own stuff somewhere. Give support to the CPs. Have training for the CPs on how to deal with stroke victims!” (Respondent CP5)

Male stroke survivors agreed:

I think they should talk to the CPs, too. They have a lot of input on everything.” (Respondent P4)

Educate Program Personnel about AA Men—In our previous research,¹⁶ we found that younger AA men felt that just being an AA man was stressful and AA men got mainly negative attention and little information on stroke risk factors. The men in our groups recommended that any program dealing with stroke recovery and prevention include personnel that were well versed in the psychological, societal, and medical issues faced by AA men:

“First you have to know something about Black people in order to run a program for Black men. If you don’t know anything about Black people then, you’re just talking mumble jumble to us. If you don’t know what we go through in this day and age, it’s just talk!” (Respondent P6).

This suggestion makes clear the importance of providing healthcare that recognizes the needs of persons from diverse backgrounds. It also highlights the importance of AA men in the healthcare workforce as cultural insiders in caring for other AA men.

Make a Video—Most of the AA men did not remember what transpired during their stroke-related hospitalization and did not recall or understand many of the post-stroke discharge directions. They had no idea what physical and psychological challenges lay ahead for them and recommended making a video about what to expect during recovery. The video could educate stroke survivors and family and lessen their fears about what to expect. Survivors and CPs alike stated they were interested in participating in this video to talk about their own recovery issues as well as stress the importance of following the AHA guidelines:

“We could make a video or something that we could show other people what to expect from a stroke and stuff. A video that you can hand out as a disc. A lot of people won’t be able to, or will not go to the Red Cross for information, but if they can just bring it home with them, it would be no excuse for not being able to understand.” (Respondent P2)

Train/Use AA Men Who Have Been There to Help Deliver the Program—Along with the idea of using real stroke survivors and CPs in the video, there was consensus that they also should be used as peer educators in the intervention itself:

“It takes another person that had a stroke to tell another person that you need to take your medication, to change your diet and make your doctor’s appointments.” (Respondent P1)

It was further suggested that hearing stories or “testimony” from others who have had a stroke or TIA could help others in making the right healthy choices in stroke recovery and prevention:

“Sitting down just like this and talking about things with people who also had a stroke or TIA, it helped me.” (Respondent 7)

Healthcare System Provider Level Recommendations

Table 3 shows themes, descriptive codes, and illustrative quotations emerging from r/ Healthcare System/Provider Level Recommendations. We classified these recommendations into the three categories that reflected the issues that the participants wanted addressed by healthcare systems and providers: a) Consolidate Medical Bills, b) Increase Provider Communication Skills, and c) Provide More Information about Stroke and AA Men.

Consolidate Bills—The avalanche of post-stroke medical bills for the care some participants received was overwhelming to survivors and CPs alike. The participants were

not merely expressing frustration about the cost of health care, but that they envisioned a more streamlined, organized approach to billing as a way to help the overall stroke recovery process. Recommendations for hospitals and healthcare systems to address this issue were strongly suggested as can be seen in Table 3.

Increase Provider Communication Skills—Previously cited provider barriers to stroke-related recovery and prevention by AA men and their CPs included providers use of difficult to understand medical terminology and perceived indifference to patients' needs.¹⁶ Improving provider communication skills was strongly recommended:

“You know there’s something that is going to have to be done about teaching doctors how to communicate with patients because we have to be on the same level, on the same playing field.” Respondent 4

Provide More Information about Stroke and AA Men

Risk Factors: Except for what was shared in the focus groups, most of the participants knew little or nothing about the risk factors for a stroke:

“I’m still trying to figure out exactly why I had a stroke in the first place!” (Respondent P7) and wanted their provider to “Sit down and talk to me like you’re doing now in this group.” (Respondent P5).

Providing numbers on AA men’s risk for stroke was also recommended:

“You know, 80% of people who have a mini stroke, have a major stroke. I mean that’s a serious number right there and doctors don’t tell us that information. (Respondent P6)

Scared Straight: Some of the men and their CPs felt that providers needed to be more aggressive in imparting information about stroke risk factors by:

“Scaring us into doing the right thing and not doing the wrong thing. Show pictures of lungs of someone who smokes. Don’t sugar coat it!” (Respondent P8)

Information on Medications: Encouraging physicians to provide more information on medications was a common recommendation:

“The way I think you can help is when you prescribe medicines, explain what it is and what it’s supposed to do. Don’t just give them a whole bunch of pills and send them home and say take these. So what if I don’t take them, what’s it supposed to change?” (Respondent P5)

Although verbal provider explanations about medications were important, there was agreement for the need to provide written information as well:

“There needs to be a pamphlet that lists every single medication; what can go wrong, what can happen, what’s the symptoms?” (Respondent P3)

DISCUSSION

AA men and their CPs suggested facilitators to address the perceived barriers to post-stroke recovery that they had identified previously.¹⁶ They then made many practical for implementing these facilitators into strategies that would address post-stroke care and prevention practices. The men made it clear that there are many things they can do themselves to improve their health and reduce stroke risk. Across the set of helpful behaviors they emphasized the importance of taking responsibility for one's health behaviors, including keeping medical appointments and knowing the ingredients and preparation style of foods they consume. Participants appreciated the support of family and friends, but felt that the healthcare system and health providers could do more to connect stroke survivors to available resources and to support and communicate with families in managing their lives after stroke.

Based on our findings, we concur with previously published recommendations that interventions seeking to improve the health and illness self-management of racial and ethnic minorities should include a focus on health knowledge and problem-solving skills and on working with patients to identify their self-perceived best strategies for healthy living.^{24,25} Additionally, hearing "real life" stories from others who had experienced a stroke was an inspiring and affirming experience for our participants. They felt that involving AA stroke survivors as peer educators in post-stroke care could inspire others to take a more positive approach to their own recovery. According to Dennis,²⁶ peers can be effective in empowering and motivating people with chronic diseases and, as someone who "*has been there*," are able to normalize the illness experience, promote hope and belief in the possibility of recovery, and increase feelings of empowerment and self-esteem.

Many of our key findings parallel those of prior qualitative work investigating hypertension management among AA.^{24,25} Participants in our study felt that knowing the causes of stroke was important for them to be able to take health care actions. Similarly, Obedegbe²⁵ found that knowing more about hypertension and how hypertension treatment recommendations work, was perceived as an important prerequisite to taking action. These findings are consistent with the social cognitive theory of health behavior change.²⁷ A focus on the "mechanism of action" of both prescribed medicines and lifestyle changes can help individuals integrate recommended treatments and lifestyle changes into their lay explanatory models of disease. This focus, thereby, increases the expectation of a positive health outcome and the likelihood that a patient will take action.

In prior studies of hypertension,^{24,25} researchers have suggested the importance of social support from family and the necessity of positive interactions and effective communication with healthcare providers as did the participants in our study. Other researchers have suggested that communication can influence health outcomes through a variety of pathways, and patient-clinician communication has a vital link to patient healthy behaviors.²⁸ Additionally, health professionals themselves have recognized the need for better communications with patients from diverse racial and ethnic backgrounds.²⁹ Racially concordant health care visits have been demonstrated to lead to greater patient satisfaction and higher ratings of participatory decision making.³⁰ In addition to training healthcare

providers in more effective communication, future behavioral interventions could empower patients to learn better ways of communicating with their providers.

This qualitative study is the first to inductively identify facilitators and recommendations for culturally sensitive stroke recovery interventions for younger AA men and their CPs. There are, however, some limitations. The small sample size and the conduct of the study in a single urban area limit the generalizability and impact of the study findings. AA men with stroke and TIA from other parts of the country may have different experiences in recovery and different types of encounters with the healthcare system. The use of CPs as focus group participants could potentially have been a deterrent to the AA men's ability to be forthcoming about their concerns and ideas about stroke-recovery and prevention issues. However, we found the verbal action between the men and their CPs promoted open and honest dialogue that led to clarification of themes. An additional limitation of our study is that these men were fairly independents as reflected in their mean Barthel Index scores. Our findings may not be generalizable to AA male samples who are more functionally impaired and dependent on external sources for care.

These limitations are offset, to some extent, by use of rigorous qualitative research methods.¹⁹⁻²² The self-report method is direct and versatile. If we want to know what people think, feel, believe and experience, the most direct means of gathering information is to ask them. This method of collecting data yields information that would be difficult, if not impossible, to gather by other means. To increase validity and accuracy, findings were confirmed with participants at a follow-up advisory board meeting.²³ Despite limitations, our findings have important clinical implications for health care providers.

Clinical Implications

Specific aspects of the study that may have particular relevance to younger AA men include the fact that, while AA men and their CPs acknowledged and welcomed learning more about what experts and clinicians have to recommend for optimal stroke recovery and future risk reduction, it is also clear that they desired approaches that addressed their specific needs and preferences as younger AA men. According to Jack et al.,³¹ understanding patients' cultural perspectives can lead to more productive partnering between provider, patient, and community health resources that support adherence and improved health outcomes.

Alternative and complementary treatments were often used as an adjunct to standard medical care, and AA men in our sample desired an accepting and flexible approach that allowed alternative treatments within an AHA guidelines regimen. Making stroke recovery personal and salient to the needs of AA was a recurring theme among our participants. Specific techniques of using videos and peer-support delivered by AA men are practical and readily generalizable.

Paralleling the person-focused elements, AA men advocated for community links that AA men and their families could and would actually use. It is not enough to tell individuals to exercise. This guideline concordant recommendation needs to be accompanied by specific details on where and how fitness activities that could be accessed in a given community.

Health care systems and providers need to include community services information and linkage in addition to more general fitness instructions.

In conclusion, AA men with stroke/TIA and their CPs can provide valuable input on appropriate and generalizable approaches to reduce stroke disparities. Care that goes beyond clinician-centered or hospital-based guidelines to focus on the AA man, his family, and his community may potentially help rehabilitation programs and providers improve outcomes and reduce disparities in younger AA men.

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Table 1
Personal Level Recommendations for a Targeted Intervention for Post-Stroke Care and Recovery for AA Men and their Care Partners (N=17)

Themes and Categories	Illustrative Quotations from Respondents
Following the AHA/ASA Guidelines	
<i>Medication Adherence</i>	<i>"And take the meds regularly; I think that's important!" Respondent CP3</i>
<i>Smoking Cessation</i>	<i>"I would advise them to not smoke!" Respondent P8</i>
<i>Exercise/Rehab</i>	<i>"Rehabilitation and exercise. Make sure you get both of those. I never missed one of my physical therapy sessions, or my cognitive skills sessions. A lot of times it was like I forced myself to do it to try to get back." Respondent P1</i>
<i>Nutrition/Dietary Changes</i>	<i>"Have to make sure to watch the fast food. I just think they 're probably not the best thing for us." Respondent 5</i>
<i>Keeping Medical Appointments</i>	<i>"One of the things I would recommend people to do is make sure you make those doctors' appointments." Respondent P4</i>
Explore Alternative and Complimentary Methods	<i>"Everyday I meditate and I visualize myself being perfect and not having anything wrong with me anymore. I think that helps probably more than the doctor or the high blood pressure medication." Respondent 3</i>
Never Give Up	<i>"Keep being positive, keep working on your skills and you will have some success." Respondent 1</i>

Table 2
Community Level Recommendations for a Targeted Intervention for Post-Stroke Care and Recovery for AA Men and their Care Partners (N=17)

Themes and Categories	Illustrative Quotations from Respondents
Provide List of Community Resources	
<i>Fitness Centers</i>	<i>"My gym is only \$10 a month and they have personal trainers and occupational stuff there." Respondent P1</i>
<i>Yoga Places</i>	<i>"Yoga is very important so a list of community centers that offer yoga." Respondent CP5</i>
<i>Tai Chi</i>	<i>"I recommend Tai Chi. It's a common and good exercise that you can actually do in a chair!" Respondent P2</i>
<i>Other</i>	
Provide Care Partner Support & Training	<i>"Sometimes the care partners need somebody to talk to because it's a struggle to try to deal with something that you aren't familiar with." Respondent CP3</i>
Educate Program Personnel about AA Men	<i>"Before you start a program you've got to know something about Black people and what they're going through!" Respondent P6</i>
Make a Video	<i>"We could come together and make a video of us talking about what they can expect after the stroke and other things." Respondent 4</i>
Train/Use AA Men Who Have Been There to Help Deliver the Program	<i>"People who have already have had a stroke can tell you what to do and not to do; what things helped them recover and deal with it. They're the educated ones. Respondent P2</i>

Table 3
Healthcare System/Provider Level Recommendations for a Targeted Intervention for
Post-Stroke Care and Recovery for AA Men and their Care Partners (N=17)

Themes and Categories	Illustrative Quotations from Respondents
Consolidate Bills	<i>"Another helping factor would be bills that are consolidated into 1 or 2 categories instead of 5-6 different bills every two days coming in the mail." Respondent CP2</i>
Increase Provider Communication Skills	<i>"Doctor's need to learn to communicate with patients. Half the time I don't know what he's talking about! Respondent P10</i>
Provide More Information about Stroke and AA Men	
<i>Risk factors Scared Straight Medications</i>	<i>"Doctors have to understand us black males as far as what medications to use, our risk factors, our lifestyle, what rules to adopt." Respondent P9.</i>