ABSTRACT
More than a third of cardiovascular disease (CVD) in America is primarily due to modifiable risk factors. This reflects the significant impact that patient behavior could have on health outcomes. Our solution is to develop a tool that would convert Framingham Risk Score (FRS) – the gold standard of cardiac risk assessment – into a personalized mode that best incorporates patient’s desires and abilities, and that ultimately elicits behavior change. The first phase in this project was to understand how physicians are currently assessing cardiac risk.

RESULTS/DISCUSSION
• Variability was the unifying theme throughout both focus groups. The was no consensus regarding the frequency of FRS use or the manner/situations in which it is used.
• Commonly faced barriers included patient numeracy/medical literacy, time constraints for appointments, and more acute health concerns.

FUTURE PLANS
• Our team is developing a decision making tree that would assess the specific combination for any patient in a several easy questions.
• In addition to primary care offices, the tool could be integrated into the existing infrastructure that includes online sites, mobile clinics and nurses offices, to increase awareness and reach more individuals.
• Measures of evaluation would include increased discussion with the patient about cardiac risk; quality of the discussion; patient understanding; and ultimately modification unhealthy behaviors leading to decreased CVD in the population.

METHODS
• In order to understand utilization and perceived importance of the traditional FRS, two provider focus groups were conducted – consisting of 7 and 3 individuals, respectively. Verbal consent was received from each participant.
• Participants included 6 physicians, 3 residents, and 1 fellow – all of whom are primary care providers in an urban setting.
• The focus groups were conducted in a discuss-based manner and were facilitated by the primary investigators – Dr. LaNoue and Dr. Mills.
• The discussions were recorded and then de-identified and transcribed verbatim. The transcripts were then qualitatively coded by the team utilizing the “grounded” method.
• Each transcript was coded separately, as a team. After which, a framework encompassing the information from both focus groups was established.
• The data was analyzed using nVivo 10.0.

CONCLUSION
• There must be a shift in thought with more focus placed on translating scientific knowledge and into behavior modification in patients.
• Primary care physicians need to be provided with a tool that would allow them to communicate cardiac risk in a mode that their patients can understand, in a timely manner.
• Increased emphasis on risk assessments and shared decisions can empower populations to help improving their cardiac health.

REFERENCES