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Operation of Community Resident Groups in a Community-Based Participatory Health Promotion Program for Low-income Older Adults

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Ⅰ. Introduction

Community-based participatory research (CBPR) approaches, where community residents are engaged in the research process through partnerships with universities, have become fundamental to identifying and addressing critical health issues within community-specific contexts (Israel et al., 1998). CBPR assumes that community-researcher partnerships will build capacity and engender greater commitment among all partners to uncover social and behavioral determinants of health and to develop innovative, long-term solutions. The research questions and procedures that emanate from these partnerships can reflect the needs and priorities of the residents and their communities; and incorporate the social and cultural systems that are characterized by community residents who live in close proximity to one another, and share a common history (Israel et al., 1998; Pinto, McKay & Escobar, 2008).

The formation of functional community resident groups (CRGs), a type of steering committee or advisory board, is an indispensable asset of CBPR for community health promotion. CRGs are composed of community residents who regularly meet to define important health issues, identify the determinants of the issues, find solutions for the issues, and engage in effective individual and collective action to change these health issues at multiple levels - individual, community, organizational, and policy. The residents' indigenous knowledge and ability to identify and address community health issues is fundamental to health promotion within their communities (Pinto, McKay, & Escobar, 2008). The types and levels of health issues differ by community, and each CRG addresses such issues differently based on its environmental and social contexts. In this paper, we describe the organization and functional aspects of CRGs formed at several apartment communities in Pennsylvania, USA.

Ⅱ. Background

Project: This CBPR project was composed of 12 apartment communities and researchers from a

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graduate school of public health, specializing in community health. The 12 apartment buildings contained over 800 apartment units in total with an occupancy rate of 86%. The majority of the residents were single-living adults (91% were 55 years and older). Eighteen percent were racial/ ethnic minorities, and 91% received Social Security as their main source of income, with an average annual income of $11,128. The majority of the buildings was located in once bustling neighborhoods, but has since become economically depressed areas due to deindustrialization. Due to federal cuts in funding, apartment building managers became responsible for overseeing two to three buildings per person, which reduced the absolute amount of office hours that a manager keeps at a building.

Community Resident Groups: Community resident groups (CRGs) were organized in conjunction with the university researchers. On average, each CRG consisted of eight apartment residents; who were included based on the following criteria: 1) willingness to partner with the university researchers; 2) commitment to attend regularly scheduled meetings for discussion and planning; 3) interest in identifying priority health issues within the context of their shared environment; and, 4) dedication to determine appropriate solutions. Prior experience working with apartment-level organizations (e.g., tenant councils) was not necessary; however, potential CRG members often included elected officers of the tenant councils. All CRG meetings were open to building managers, who varied markedly in their interest and attendance. Overall, the CRGs became a venue for apartment residents to interact with one another, discuss priority health issues and solutions, engage in collective efforts to promote community health, and become agents of change in their apartment communities. Their opinions, experiences, perspectives, and knowledge helped the researchers understand and assist with addressing the complexity of health problems the residents faced.

Group Process: A CRG facilitator from the university was assigned to each apartment building to facilitate CRG meetings following a 6-step process that was previously developed by the research team (Yoo et al., 2004). The process begins with a step called 'Entry into community,' where researchers and community residents learn about each other and build relationships and trust. In this first step researchers attended social and health-related activities in the apartment community - such as games, social gatherings, exercise sessions, relaxation classes, and health fairs - in order to become familiarized by the residents. Further, this process allowed the facilitators to enter into relationship with the residents and to learn about the community from them. After becoming acquainted with the residents, discussions of the purpose and benefits of organizing CRGs along with mutual expectations, and role descriptions were conducted. The CRGs then went through the rest of the 6-step process, which are: issue identification, issue prioritization, strategy development, implementation, and leadership transition. The 6-step process guided the CRGs and facilitators in establishing agreements for collaboration, identifying and prioritizing community health issues, developing and executing solutions for these issues, and fostering community leadership.

CRG facilitators used the nominal group process of brainstorming as the main discussion strategy in CRG meetings, allowing members to share their ideas in a round-robin fashion. Ground rules were set for the CRG meetings that consisted of each person: 1) responding in turn; 2) not interrupting

one another; 3) listening respectfully; 4) trying to understand other CRG member's needs and interests; and, 5) being courteous without blaming, attacking, or using offensive language. A social ecological model was incorporated into the 6-step process as a tool for the members to use to assess problems, incremental progress and plans. Examples of the social ecological models that resulted from the brainstorming sessions can be found elsewhere (Yoo, Butler, Elias & Goodman, 2009).

Ⅲ. Methods

Data Collection: The CRG facilitators recorded information from all CRG meetings, communications and interactions with CRG members via contact logs in Microsoft Word documents and Excel spreadsheets, which served as the main source of data collection. Contact logs were a combination of field notes of observational interaction data and a written account of CRG activities and progresses (e.g., identified priority health issues and potential solutions) (Montgomery and Bailey, 2007; Mulhall, 2003) and theoretical memos of each facilitator's thinking process (e.g., ways of resolving high-rise residents' conflicts). Therefore, they provided data to make initial and continual assessments of CRG functioning and non-functioning (Montgomery and Bailey, 2007).

The contact logs consisted of six components: 1) date of visit/meeting/interaction; 2) apartment location; 3) purpose of visit/meeting/interaction and with whom; 4) any issues of concern (“red flags”); 5) main items learned, accomplished, and/or information provided; and, 6) action items and deadlines for accomplishing them. Additional data, used for triangulation and confirmation purposes, were generated from CRG meeting attendance sheets, research team meetings' minutes, the community health partnership's meeting minutes, and quarterly and annual progress reports. Researchers reviewed a total of 152 contact logs, 33 meetings' minutes, 6 quarterly reports, and the community health partnership's final report. The data time period was 21 months.

Data analysis: Data analysis was based on qualitative matrix analysis principles, which include a logical analysis for cross-classification of multiple dimensions to identify patterns in the data and matrix building for displaying such patterns (Miles and Huberman, 1994; Patton, 2000). Initial coding was performed to identify concerns, interests, decisions, actions, and accomplishments per CRG. Focal coding followed to group or link related themes within and across CRGs in terms of CRG inputs (=CRG member participation), processes (=CRG meetings), and outcomes (=CRG goals and achievements). An input-process-outcomes matrix was structured to organize the patterns of functional perspective of CRGs in order to describe group performance by focusing on the inputs and processes (Wittenbaum et al., 2004).

Ⅳ. Results

Nine out of 12 CRGs progressed to demonstrate their functional aspects. The other three CRGs were excluded from the analysis because: one was dissolved due to renovation of their building and subsequent relocation of all residents; and the other two discontinued CRG activities due to inconsistent member participation and disagreement about problem-solving methods.

Analyzed results are organized into a matrix

(Table 1). The first left column represents 'Input' in CRG functions in terms of member participation. CRGs are divided into 2 types of member participation: a 'consistent participation' type where core CRG members were identified who participated in CRG meetings regularly (7 CRGs - A, B, C, D, E, H & I); and an 'inconsistent participation' type (2 CRGs - J & L). In the second left column is a 'Process' category where CRGs are classified in terms of CRG meeting consistency. CRGs that conducted 12 or more meetings out of 18 possible meetings during the project period were classified as a 'consistent meeting' type (7 CRGs - A, B, C, D, E, H & I). Leadership, a new category that emerged during our analysis is shown in the third column in Table 1. CRGs were grouped by a type of leadership: those with preexisting leadership mostly by tenant council officers (4 CRGs -A, D, E & H) and those without preexisting leadership (5 CRGs - B, C, I, J & L). The three columns from the right contain 'Outcomes' information for each CRG in terms of: goals they identified, activities they proposed as potential solutions for the goals, and health issues associated with the proposed activities. Although CRGs identified similar goals such as healthier environment in which to reside, better access to food, and community participation and better relations, proposed activities for the goals differed by CRG.

Table 1. Input-Process-Outcome Table for Community Resident Groups

Input	Process	Leadership	CRG	Outcomes		
				Goals	Identified Activities for Goals	Related Health Issues
Members Consistently Participated	Meetings Consistently Held	Preexisting Leadership	A	Healthier, safer environment	Move permanently mounted outside bench	Safety & Injury Prevention
					Add window to side entry door	
					Mold removal in apartments	Pulmonary Health
					Improve air quality of building	
				Better access to food	Adapt food recipes for 1 person	Diet & Weight Management
					On-site food bank	
				Others	Guest speaker to discuss wills	Healthy Aging
					Letter to state representative requesting $2000 to continue funding after '06	
					Letter to state representative requesting $2000 to continue funding after '06 Sewing classes	Social Interaction

Members Consistently Participated	Meetings Consistently Held	Preexisting Leadership	A	Others	On-site bloodwork collection	Diabetes, Hypertension, Hyperlipidemia
			D	Community participation & Better relations	Organize walking group	Physical Activity
					Organize and operate weekly movie night	Social Interaction
					Strategies to increase resident cooperation	
				Others	Computer training	
			E	Community participation & Better relations	Promote health promotion services & activities in the building via memo urging residents' cooperation	Social Interaction
				Healthier, safer environment	Fix broken elevator	Healthy Environment
			H	Better access to food	Obtain food bank membership	Diet
					Organize pot luck dinners & food sale	
					On-line food survey	
		No Preexisting Leadership	B	Others	Obtain hearing aid for resident with Cerebral Palsey by contacting local/national groups	Healthy Aging
					Weight management classes	Weight Management
			C	Others	Develop medication information sheet	Chronic Disease Management
				Healthier environment	Have borough paint crosswalk in front of building	Safety & Injury Prevention
					Improved transit options for residents	
			I	Others	Development/delivery of medication information sheets for residents	Chronic Disease Management
				Healthier, safer environment	Cleaning of air vents	Healthy Environment
Member Participation Not Consistent	Meetings Inconsistent		J	Better access to food	Obtain “Cooking for 1 or 2” cookbooks (100 copies)	Diet
					Fresh fruits & vegetables delivered on-site	
				Healthier, safer environment	Obtain CO detectors	Healthy Environment

Member Participation Not Consistent	Meetings Inconsistent	No Preexisting Leadership	J	Healthier, safer environment	Check function of community room air filtration system	
				Others	Mental health services for residents	Mental Health
			L	Better access to food	Contact local food markets, farms, & co-ops for leftover fruits & vegetable donations	Diet
				Others	Set up game day for residents	Social Interaction

CRG patterns In 7 CRGs (A, B, C, D, E, H & I), member participation and meetings were consistent throughout the entire project. A core group of 3-7 residents was formed in each of these 7 CRGs that consistently attended monthly CRG meetings to identify community needs and solutions for health issues.

Four of these 7 CRGs (A, D, E & H) included tenant council officers as active participants. At each apartment building tenant council is led by 4 elected officers who serve a maximum of 2 consecutive 3-year terms. More than 50% of current and past tenant council officers maintained core roles in the 4 tenant-council-involved CRGs. Establishment of a CRG was quicker in those with tenant council officers than in those without. CRGs B, C, and I were operated by a core group of participants who consistently held CRG meetings; however, tenant council officers were not actively involved. There were 2 CRGs (J & L) where member participation and meetings were inconsistent, and tenant council officer involvement was minimal.

CRGs with preexisting leadership of tenant council officers and consistent participation by members in regularly held meetings tended to have more focused goals and follow-through of those goals. Such CRGs (A, D, E & H) set similar goals for community health such as a healthier and safer environment, increased access to fresh food, community participation and better relations among residents for community activities. Those CRGs with consistent operation without tenant council leader engagement (B, C & I) tended to have less focused goals and fewer activities related to these goals. It took a relatively longer time for this group of CRGs to execute tasks. The third group of CRGs with an inconsistent pattern of operation and lack of tenant council officers' involvement (J & L) demonstrated that their goals were similar to those of other CRG types; however, they identified and executed fewer tasks for the goals, for which it took the longest time among the 3 types of the CRGs (Figure 1).

Health issues identified The goals identified by the CRGs were broadly categorized as social systems and physical environment issues. They were in response to a collective question posed to them at CRG meetings: “what influences the health and wellbeing” of their respective communities. Rather than mentioning specific diseases as important health topics for the residents, they selected environmental issues that contribute to chronic disease management as community health priorities. Four prominent community health issues identified by the CRGs included a healthier and safer environment in and around the apartment buildings,

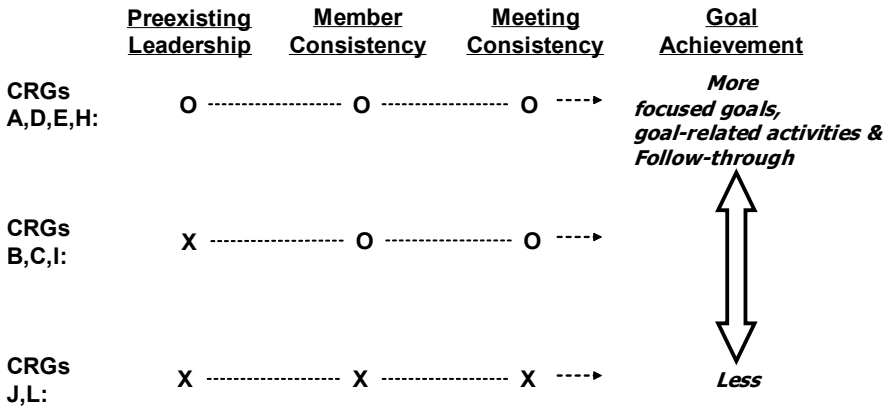

Figure 1. Community Resident Group patterns and goal achievement

better access to fresh food for the residents, community participation, and better interpersonal relations among the residents (Table 1).

CRG members were concerned about deteriorating conditions and a lower than desirable level of maintenance of their apartment buildings which were approximately 40 years old. They discussed how these conditions could affect their health in terms of breathing difficulties, the possibility of being physically injured, having limited mobility, and building insecurity. For a number of residents in their 80s, many of whom had lived in the senior apartment buildings for decades, accessibility to grocery stores was a chronic issue as the nearest grocery stores were not within walking distance. Many of these aged residents had given up driving; thus, they depended upon others to help with grocery shopping or they used nearby drug stores and convenience stores as a main source of food often purchasing canned, processed foods with higher sodium levels and lower nutritional value. In some apartment communities, the residents' efforts to organize community initiatives to address health and living concerns were fraught with distrust, rumors, and misinformation. CRGs in those apartment buildings also mentioned the stress caused by unhealthy social interactions as a primary problem, while depression was already prevalent among many elderly residents. In a few CRGs, ill-health of its core participants challenged the continual momentum of the CRG activities.

The CRGs addressed identified community health issues through internally organized activities such as convening special resident meetings, social events, by documenting building issues, and developing and distributing memos to the residents informing them about these issues and potential solutions. The CRGs also collaborated with the local housing authority administrators to determine solutions for the identified health and living issues of the residents, contacted local and state government officials to ask for support, and partnered with the university and local service agencies to implement needed health promotion programs (Yoo, Butler, Elias and Goodman, 2009).

Ⅴ. Discussion

Leadership Existing leadership, mostly by the current or previous tenant council officers at the apartment buildings, facilitated the CRG activities at

4 out of 9 apartment communities. Those CRGs were organized more quickly than others and continued meetings on a regular basis throughout the project's period. Tenant council officers were experienced in conducting meetings, were familiar with the apartment environment and its related policy issues, and knew their fellow residents and how to communicate with them. These CRGs pursued and followed through on more specific goals and activities than other CRGs. Leadership also developed as the project progressed in 3 other CRGs where tenant council officers were not as heavily involved. Residents in those apartment buildings stated that they gained confidence in addressing community health issues in group processes.

Leadership is a dominant construct of community capacity (Lempa, Goodman, Rice and Becker, 2006), and known as a facilitator for continual and increased participation by individuals (Alexander, Comfort, Weiner and Bogue, 2001). Indeed, those CRGs with established leadership, regardless of tenant council involvement, demonstrated consistent patterns of member participation and in the conduct of monthly meetings.

Consistency Consistency is another characteristic identified in the CRG functioning at both input (=member consistency) and process (=meeting consistency) levels, which reassures Wittenbaum and colleagues' (2004) argument that consistent participation and activities are important aspects of group functioning. Keeping a committed core of CRG members who consistently attended CRG meetings required a deep sense of community commitment, internal communication, and leadership. CRGs with preexisting leadership demonstrated a consistent pattern of member participation and meetings. The CRGs with newly developed leadership also demonstrated consistency in core member participation and meeting schedule.

Health issues in context Originally the CRG project was designed to promote priority health issues related to healthy aging, for example, blood pressure, diabetes, cholesterol, physical activity, depression, cancer screening, and immunizations. However, when asked to name priority health issues, CRG members identified issues that they recognized to be concerning or important in their daily living. These issues were not necessarily expressed in specific chronic disease terms. Instead, members identified the physical condition of their building, their inability to access food, and resident relations as being priority concerns. Determining health topics in the community's own context and terms is a fundamental characteristic of CBPR. By identifying and addressing the issues in the way that community members felt comfortable with and were the most relevant, this project was able to address those issues rather quickly, which subsequently served as a motivator for continued CRG efforts.

The CRGs recognized the links between what they identified as health priorities and the resultant, well-known health issues. Since many of the aged residents already had chronic health conditions, those factors influencing the management of their health seemed to be more relevant to the residents. CRG members associated their health priority with chronic health issues, for example, a healthy and safe environment with injury prevention and respiratory health; the access-to-food issue with diet and weight management; difficult interpersonal relations among residents with mental health and social interactions.

It is also notable that priority health issues selected by the CRGs were similar, but activities the CRGs proposed to address those issues varied by

apartment community. Those CRGs with consistent patterns of participation and activities with existing leadership tended to try more activities for focused priority topics, while CRGs with inconsistent functioning style demonstrated less focused patterns of actions.

Ⅵ. Conclusion

The functioning of community resident groups in the community-based participatory research reported here was determined by a qualitative analysis of meeting records, reports, and contact logs. Consistent participation by community members, a consistent pattern of group activities such as monthly meetings, and having established leadership to manage community group activities were prominent characteristics of community group functioning. Health issues and solutions to such issues identified by community resident groups were unique to community contexts and interests, as CBPR principles describe (Israel et al., 1998). Nevertheless, a 2-year period for this project was not sufficient to institutionalize community resident group activities within the communities' routine. Addressing health issues in the community members' own terms is advantageous in attracting the community's attention and motivation, yet, what is more important is to keep the momentum and to continue the efforts consistently with committed leadership. Networking and partnership building with other organizations in the community could facilitate sustaining community resident group activities by creating resources and opportunities to continue the work.

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ABSTRACT

Objectives: This paper is intended to illustrate and to discuss the organization and functioning of community resident groups (CRGs) in a community-based participatory health promotion program for healthy aging.

Methods: CRGs were convened in 12 government-subsidized apartment communities for low-income seniors in Pennsylvania, U.S.A., to promote healthy aging. Researchers facilitated CRG meetings following a 6-step process of community empowerment and utilizing a social ecological model for assessment and planning. Almost 200 project-related documents were qualitatively analyzed using matrix analysis principles such as cross-classification of multiple dimensions to identify patterns in the data and matrix building for displaying such patterns.

Results: CRGs were venues at which apartment building residents could interact, discuss health priorities, and become change agents in their building. CRG members' community health priorities were about their daily living, including building conditions, poor access to fresh food, and unhealthy resident relations. Specific patterns arose in analysis indicating that leadership withing the CRGs, consistency of meetings and participants' attendance, and ability to link health concerns to daily experience impacted the CRGs' capability to identify and accomplish their goals.

Conclusion: Community health issues and solutions to those issues identified by CRGs were unique to community contexts and interests. Consistent participation by community members, a consistent pattern of group activities such as monthly meetings, and having established leadership to manage CRG activities were prominent characteristics of community group functioning.

Key Words: Community-Based participatory research, Community groups, Community health, Health promotion, Older adults, Healthy aging.

〈국문초록〉

저소득층 노인의 건강증진을 위한 지역사회 참여형 연구에서 지역사회 주민 조직의 구성과 운영

목적: 지역사회 참여형 보건 연구에서 현장의 지식과 경험을 토대로 주요 보건문제를 파악하고 대응하기에 중요한 역할을 하는 지역사회 주민 조직의 구성과 운영상의 특성을 논의하고자 한다.

방법: 미국 펜실베이니아 주 12개 저소득층 정부임대 아파트의 노인 입주자들을 대상으로 각 아파트마다 자발적인 주민조직을 구성하여 사회생태학 모형을 활용한 6단계 지역사회 역량강화 과정을 수행하였다. 주민조직의 과정과 성과를 기록한 200여건의 문건에 대해 질적 연구 분석을 실시하였다.

결과: 2년간 주민조직 월례회의를 통하여 낙후된 아파트 건물상태, 신선한 식재료 마련, 주민 간 관계개선 등을 지역사회 건강증진의 우선순위로 선정하고, 자체적인 해결방안을 구상하여 추진하였다. 주민조직 내의 리더십, 주민조직에 꾸준히 참여하는 핵심 회원, 주민조직 회의 개최의 일관성이 주민들에 의한 자치적인 지역사회 건강증진 활동의 주요 특성으로 드러났다. 리더십이 형성되고 회원의 참여와 회의의 개최가 꾸준한 주민조직일수록 지역사회 건강증진 목표 및 관련활동이 집중적인 경향이 있었다.

결론: 리더십, 참여, 일관성 등은 참여적이고 자치적인 지역사회 건강증진을 위한 역량요인이며, 이러한 역량을 개발하고 강화하는 과정에 대한 모니터링과 과정평가의 중요성이 강조된다.

주제어: 지역사회 참여형 연구, 지역사회 주민 조직, 노인보건, 지역사회 건강증진