

# Engaging Community-Based Veterans' Organizations in Health Promotion Programs

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Community organizations, such as churches, clubs, and senior centers, can be important locations for health programs. However, little is known about the organizational factors that influence participation and engagement in health programs. To learn more, we evaluated a community-based program designed to help US military veterans better manage their high blood pressure. The program involved training a pair of veterans to deliver health-related presentations at their local units. We found that factors such as larger meeting attendance size, rural location, age diversity, and member enthusiasm were positively associated with both a willingness to participate and a high level of engagement in program activities. **Key words:** *community-based participatory research, health promotion, hypertension, secondary prevention, self-management, social support, veterans*

OVER THE LAST 40 YEARS, the United States has seen a growing trend of community organizations using group representatives to promote health among their membership.<sup>1</sup> As community organizations are increasingly viewed as a viable outlet for health promotion activities, many research efforts have been directed toward examining program development, implementation, and outcomes. Less attention, however, has focused on examining the organizational and environmental features of community organizations that are associated *with participation* in health promotion activities. Similarly, few studies have investigated how organizational and environmental factors influence the degree of *member engagement* once the initial decision to participate has been made.

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To begin to fill this gap, we designed a mixed method descriptive evaluation that examined organizational and environmental characteristics of the local units, or “posts,” of community-based veteran service organizations (VSO) that did or did not participate in a health promotion project. This evaluation was conducted as part of our health promotion project called POWER (*Posts Working for Veteran’s Health*). POWER emphasized peer leader (PL) training and VSO support for veterans at risk for high blood pressure and other chronic diseases. The results of our evaluation may help guide organizations that initiate health and wellness programs for their members as they seek to maximize participation and engagement.

## BACKGROUND

### Power description

POWER is a peer-led educational program that is part of a community-academic partnership between the Medical College of Wisconsin and the Wisconsin departments of

VSO: the Veterans of Foreign Wars (VFW) and the American Legion. We collaborated with statewide leadership of the VFW to design, implement, and evaluate the program. Because many members of the VFW also belong to the American Legion, we included 2 Legion posts that expressed interest in participating during the recruitment phase. A brief overview of the POWER program is presented in the following paragraphs; a more complete description has been published.<sup>2</sup> The Clement J. Zablocki VA Medical Center's (ZVAMC's) institutional review board approved the project and study protocols.

#### **Post recruitment**

In 2005, letters were mailed introducing the POWER program to 54 VFW posts located within a 50 mile radius of the ZVAMC in Milwaukee, Wisconsin (Figure 1). Follow-up telephone contact was made with 51 posts, offering to attend a monthly post meeting and describe a program to improve members' ability to self-manage their hypertension; 35 (69%) of these posts invited us to visit. One or 2 members of the POWER team then made in-person presentations at these posts, pointing out the importance of hypertension as a health problem, emphasizing the importance of a patient's active role in chronic disease self-management, describing the POWER program, and answering questions about hypertension and other chronic diseases. These visits lasted approximately 20 minutes and concluded with an invitation for the post to participate in POWER. The presenter emphasized that 1 or 2 members of participating posts would be trained to implement the project at their post, a role we refer to as "peer leader." We noted that PL training would require 24 hours of the PLs' time over 12 to 18 months. Participating posts also had to agree that they would support efforts to recruit members to be involved in a study of the program's effect on blood pressure and hypertension self-management skills. One month after the visit, we followed up with post leaders to determine whether the post wanted to

participate in POWER and if they had been able to identify volunteer peer leaders. We stopped our recruitment activities after we reached our target enrollment of 15 posts; all posts that identified peer leaders were able to participate.

#### **PL training**

Peer leaders were post members who volunteered to help fellow post members develop hypertension self-management skills. Most PLs were either endorsed by the post's top elected officer, known as the post commander, or held this position themselves. Peer leaders were required to regularly attend post meetings. Peer leaders did not need to have any prior health training. We provided PLs with \$200 each year during their 2 years of participation, to compensate their training time and travel costs, as well as \$100 for the time and travel costs of an initial 8-hour training session.

We conducted all PL training in group sessions, starting with an 8-hour session that covered project design and logistics in detail and introduced concepts important to hypertension self-management and helping peers within social settings. This was followed by a series of 90- to 120-minute training sessions, referred to as mini training sessions (MTS). Topics included the role of PLs, how to prepare for and present health topics, and practical knowledge of communication and support principles, as well as an introduction to a variety of hypertension self-management topics. Each MTS focused on one or more self-management messages that the PL would deliver to their peers attending subsequent post meetings. Self-management topics included diet and exercise, medication use and adherence, working with health professionals, and basic hypertension knowledge.

At each MTS, we gave PLs a script, handouts, and accompanying material for the self-management topics they would present. Scripts were 10 minutes in length and consisted of the objectives for the topic, action steps for the presenter, and a verbatim

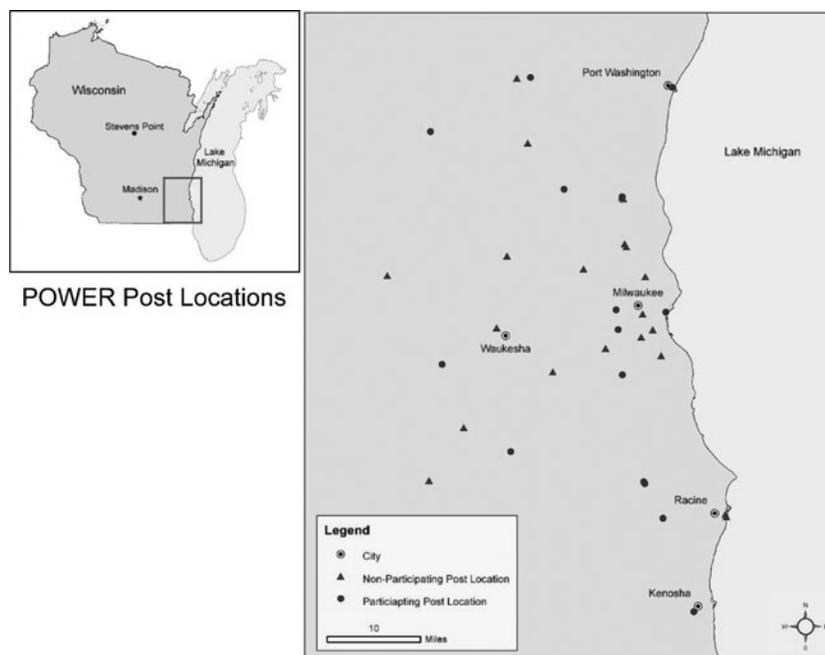


Figure 1. POWER post locations.

narrative of the topic for the peer leader to use during the presentation. Although we provided brief didactic presentations of background material, the MTS instructional methods emphasized demonstrations, guided practice, and interactive discussions to share ideas and resolve challenges.

## METHODS

### Data collection: Reasons for not participating

At the time of our initial telephone contact, if the post declined a visit, we asked if there was a reason. We recorded all reasons, without attempting to prioritize them. Similarly, if posts explicitly declined to participate, we collected a reason. If our post contact did not provide a reason, or did not return calls, we classified the reason as lack of interest.

### Data collection: Post characteristics

For posts that we visited, at the time of the initial visit, one of the presenting POWER

staff collected data on post characteristics using a structured observation form. The form included 5 open-ended and 16 closed-ended items.

We used these data to generate potential predictors of participation and engagement, including characteristics of the meeting we attended and general post characteristics. On the basis of our initial visit, which occurred at a regular monthly post meeting, we recorded *meeting attendance* as a simple count. We used *distance* from the ZVAMC as a surrogate for progressively less urban locations within the region. We generated a variable for *age diversity* by subtracting the age of the youngest from the age of the oldest member in attendance. We rated age diversity as “low/moderate” when this was less than or equal to 34 years of age and “high” otherwise. We created a variable for *post enthusiasm* by combining the items “general enthusiasm/spirit” and “health-focused communication open/genuine.” Both of these items were scored as low, moderate or high. We rated posts that received a “low” score in either

category as “not enthusiastic.” We categorized the *number of questions* asked as none, 1 to 3, and more than 3.

We also collected characteristics of the physical space, but these generated insufficient variability for analysis; the vast majority had a bar on site and abundant military/organizational symbols and none had health promotion information in evidence. We could not examine the impact of having (1) a post newsletter, (2) a women’s auxiliary, or (3) a contact person for health related matters, because of excess missing data.

Two raters reviewed a random set of five of 33 data forms (15%) to check for interrater reliability. Among a pool of factors that required coding, agreement was 91% between the 2 raters; kappa, a measure of agreement adjusting for chance, was 0.865.<sup>3</sup> The kappa statistic ranges from  $-1$  to  $1$ , with values  $> 0.8$  considered to represent “almost perfect” agreement,  $0.6$  to  $0.8$  “substantial,” and  $0.4$  to  $0.6$  “moderate.”<sup>4</sup>

### Outcomes

We sought to determine the influence of post factors associated with the outcomes of (1) post participation and (2) post engagement in the POWER program. Our analysis of post participation focused on the 35 posts that we visited, 15 of whom participated; we refer to the remaining 20 as “nonparticipants.” Two of the initial visits to nonparticipating posts were atypical—an informal “drop-in” visit, and a special holiday luncheon; we did not collect data at those visits, leaving 18 nonparticipant posts for our participation analysis.

For our analysis of engagement, we used a systematic process to divide participating posts into “more engaged” and “less engaged” posts. Four POWER staff independently ranked each post for how actively it participated in POWER activities. This included both the degree of PL involvement (eg, attendance at MTS) and post activity (eg, PL report of post activity, study staff impressions from direct observation during visits to posts).

We then ranked these posts on the basis of the mean rank. After discussing this final ranking (but before analysis), the same 4 staff members divided the posts into 8 “more engaged” and 7 “less engaged” posts. Thus, for our primary analysis, we compared (1) 15 “participant” and 18 “nonparticipant” posts and (2) 8 “more engaged” and 7 “less engaged” posts.

We used the Statistical Package for the Social Sciences (SPSS) 16.0, Chicago, IL for data analysis. We compared posts using means for continuous variables and proportions for categorical variables. Because of our small sample size and the multiple comparisons we made, we do not report formal tests of significance.

### RESULTS

Among the 19 posts that declined a visit, most said that there were too few members who came to meetings to be worth POWER staff time. However, several declining posts reported that the members “already had doctors” and declined the visit for that reason. Nonparticipant posts did not participate because (1) the members were not interested ( $n = 15$ ), (2) they could not identify peer leaders ( $n = 2$ ), or (3) the members thought health issues were already well addressed ( $n = 2$ ). For one post that included only active members of a National Guard unit, POWER staff and post leadership decided that the POWER program would not fit with the post organization. Higher meeting attendance, greater distance from the ZVAMC, and high post enthusiasm were associated with participation in the POWER project. Contrary to our expectation, the number of questions asked during the initial visit was not associated with participation (Table 1).

Among participating posts, meeting attendance was NOT associated with degree of engagement. As with participation, greater distance from ZVAMC and high post enthusiasm were associated with more engagement, while the number of questions at the initial visit was not. Greater age diversity was associated with more engagement (Table 2).

**Table 1.** Relationship of Post Characteristics to Participation in POWER<sup>a</sup>

Post Characteristic	Participants (n = 15)	Nonparticipants (n = 18)
Meeting attendance (mean, SD)	21 (12)	16 (8)
Distance in miles from ZVAMC (mean, SD)	22 (13)	18 (12)
High age diversity, n (%)	8 (53)	14 (78)
High post enthusiasm, n (%)	9 (60)	6 (33)
Number of questions at initial visit		
None, n (%)	8 (53)	13 (72)
1-3 questions, n (%)	2 (13)	1 (5)
More than 3 questions, n (%)	5 (33)	4 (22)

Abbreviations: POWER, Posts Working for Veterans Health; ZVAMC, Zablocki VA Medical Center.

<sup>a</sup>See text for definitions of high age diversity and high post enthusiasm.

**Table 2.** Relationship of Post Characteristics to Level of Engagement in POWER<sup>a</sup>

Post Characteristic	More Engaged (n = 8)	Less Engaged (n = 7)
Meeting attendance (mean, SD)	21 (14)	20 (7)
Distance in miles from ZVAMC (mean, SD)	27 (15)	18 (12)
High age diversity, n (%)	7 (88)	1 (14)
High post enthusiasm, n (%)	6 (75)	3 (42)
Number of questions at initial visit		
None, n (%)	4 (50)	4 (57)
1-3 questions, n (%)	1 (13)	1 (14)
More than 3 questions, n (%)	3 (38)	2 (29)

Abbreviations: POWER, Posts Working for Veterans Health; ZVAMC, Zablocki VA Medical Center.

<sup>a</sup>See text for definitions of high age diversity and high post enthusiasm.

## DISCUSSION

The use of group representatives in community health promotion programs is widely recognized as a strategy to improve the health of individuals and their communities.<sup>5</sup> Faith-based organizations, neighborhood associations, and community-based senior and youth centers are common types of organizations that accept and/or pursue health programs for their members.<sup>1,6-10</sup> However, many such organizations *do not* participate in health promotion programs, even if invited to do so. The present study begins the process of identifying organizational and environmental features that influence participation and engagement in health programs. We believe this is

the first study to examine these issues, which are key to current efforts to develop such programs and for understanding their potential impact.<sup>11</sup>

We found that posts with higher meeting attendances were more likely to participate in POWER, but that meeting attendance was not associated with level of engagement, once a post decided to participate. Larger posts may view participation as more worthwhile because a larger audience will be impacted by the program. Greater group size equates to greater resources (eg, time and membership contributions) to support wellness activities. This finding is consistent with literature on health promotion in worksites and faith-based organizations that show fewer wellness

programs supported by smaller organizations because of limited resources.<sup>6,12-14</sup> On the other hand, once a post was in the program, the attitude and skills of the selected PLs may have been more important than post size—indeed, a smaller post may have had fewer competing priorities within a meeting, making it easier to implement POWER activities.

Although having a greater age range among attendees (age diversity) did not influence participation, it was associated with more engagement. This may reflect influence of age outliers at either extreme. Since older members in the post were generally long-time members, they often acted in leadership roles. Research team members noted anecdotally that some older post leaders stated their unwillingness to change their current health habits, attributing their declining health to “old age.” This perception of aging is common, and was likely more common among World War II era veterans in their mid-80s.<sup>9,10</sup> According to Sarkisian et al, “older adults who have low age expectation and attribute age-associated condition to old age are more likely to be sedentary,” thus resulting in poorer health outcomes.<sup>10(p1842)</sup> These influential members may have dissuaded the post from participation in this innovative program.<sup>15</sup> Conversely, Wells et al posit that participation in community-based initiatives can stem from the motivation to improve oneself and enhance the welfare of the group.<sup>16</sup> Given that a key tenet of both the VFW and the Legion is to provide support for one’s “comrades,” greater age diversity may have been an asset among participating posts, as younger veterans enthusiastically supported efforts to improve health outcomes among older veterans, many of whom die or become disabled each year. We also heard older veterans discuss the possible recruiting benefits of attending to the health interests of younger veterans, especially those recently returning from active duty.

We found that posts that were more distant from ZVAMC were more likely to participate in POWER, and were more engaged with the program once participating. Since the ZVAMC

is near the urban center of Milwaukee, more distant posts are in more rural locations. Rural areas have fewer comprehensive health centers and less opportunity for organized health initiatives.<sup>17</sup> Samuels et al<sup>18</sup> note that rural areas are characterized by greater incidence of chronic disease, greater uninsured rates, and fewer available physicians. With fewer resources and opportunities available, rural post veterans may have seen POWER as a way to improve the health of their fellow veterans and their families, as well as an opportunity that could benefit the community.

Finally, we found that when post members were enthusiastic about post activities, the post was more likely to participate in POWER. Although these posts were often very busy with other projects, they were also more likely to take on new ones—in this case, the POWER program. Once enrolled in POWER, these same posts were strongly engaged and demonstrated a dedicated commitment to POWER. As previously mentioned, many posts are devoted to the collective well-being of the group and providing support to group members. Enthusiastic posts may have viewed POWER as a way to support the health interests of the group, therefore displaying a greater level of interest in the program at the initial visit. The lack of association between number of questions at the initial presentation and participation or engagement is notable. However, a single interested post member could generate many questions, while the post in general was not interested. Similarly, the level of interest needed to ask questions when a physician is visiting one’s post is far less than that needed to become a peer leader, which may have been a barrier even in posts where the primary issue was lack of interest.

### Study limitations

We acknowledge several limitations to applying these results in other settings. First, all posts were drawn from a single geographic area in Southeastern Wisconsin; it is not clear the results would be similar outside this region. Similarly, while our focus

on VSO posts avoids confounding by different organizational types, allowing us to examine other organizational characteristics, it does limit generalizability to other types of community organizations. Finally, it may be that results would differ if the clinical focus was not hypertension, and the intervention was different.

We also note limitations to the internal validity of our approach. First, although 15 is a large number of participating organizations compared with most community-based interventions, it is still too few for meaningful statistical analysis. Larger studies are needed. Although our initial letter went to every VFW post in the target area, the Legion posts were not randomly selected to participate. However, eliminating the 2 Legion posts that participated would not materially change our findings (both were relatively near ZVAMC and had medium attendance). Also, the distinction between less and more engaged posts was based on subjective rankings by POWER staff. However, these rankings were made before examining

any of the predictor variables we present in this analysis. Finally, data collection was confined to a single site visit, which restricted completeness of the data set and may have limited the accuracy of reported post conditions.

## CONCLUSION

We believe that these preliminary findings suggest factors that should be considered when developing health promotion projects that aim to take advantage of the built-in structure and support available in community organizations. We believe that further research is needed to confirm these findings and extend them to additional organization types, disease conditions, and interventions. We fully expect that other investigators will find additional factors that are equally or more important. Ultimately, these relations and knowledge can be used to guide intervention development to maximize the participation and engagement of community organizations in health promotion activities.

## REFERENCES

1. Hinton A, Downey J, Lisovicz N, Mayfield-Johnson S, White-Johnson F. The community health advisor program and the deep south network for cancer control: health promotion programs for volunteer community health advisors. *Fam Community Health*. 2004;22(6):20-27.
2. Hayes A, Morzinski J, Ertl K, et al. Preliminary description of the feasibility of using peer leaders to encourage hypertension self-management. *Wis Med J*. 2010;109(2):85-90.
3. Robson C. *Real World Research*. Cambridge, Massachusetts: Blackwell; 1993.
4. Sackett DL, Haynes RB, Tugwell P. *Clinical Epidemiology: A Basic Science for Clinical Medicine*. Toronto, Ontario, Canada: Little, Brown and Company; 1985.
5. Rosenthal EL, Brownstein JN, Rush CH, et al. Community health workers: part of the solution. *Community Care*. 2010;29(7):1338-1342.
6. Edwards J. INSPIRE curriculum delivered in a faith-based setting. *Fam Community Health*. 2010; 33(2):117-122.
7. Parker VG, Coles C, Logan BN, Davis L. The LIFE project: a community-based weight loss intervention program for rural African American women. *Fam Community Health*. 2010;33(2):133-143.
8. Phelan EA, Cheadle A, Schwartz SJ, et al. Promoting health and preventing disability in older adults: lessons from intervention studies carried out through an academic-community partnership. *Fam Community Health*. 2003;21(29):214-220.
9. Sarkisian CA, Prohaska TR, Wong MD, Hirsh S, Mangione CM. The relationship between expectation for aging and physical activity among older adults. *J Gen Intern Med*. 2005;20:911-915.
10. Sarkisian CA, Prohaska TR, Davis C, Weiner B. Pilot test of an attribution retraining intervention to raise walking levels in sedentary older adults. *JAGS*. 2007;55:1842-1846.
11. Lorig KR, Sobel DS, Stewart AI, et al. Evidence suggesting that a chronic disease self-management program can improve health status while reducing hospitalization: a randomized trial. *Med Care*. 1999;37: 5-14.
12. Kegler MC, Hall SM, Kiser M. Facilitators, challenges, and collaborative activities in faith and health partnerships to address health disparities. *Health Educ Behav*. 2010;9:1-15.

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13. Carnethon M, Whitsel LP, Franklin BA, et al. Worksite wellness programs for cardiovascular disease prevention: a policy statement from the American Heart Association. *Circulation*. 2009;120:1725-1741.
14. Thompson SE, Smith BA, Bybee RF. Factors influencing participation in worksite wellness programs among minority and underserved populations. *Fam Community Health*. 2005;28(3):267-273.
15. Rogers EM. *Diffusion of Innovations*. 5th ed. New York, NY: Free Press; 2003.
16. Wells R, Ward AJ, Feinberg M, Alexander JA. What motivates people to participate more in community-based coalitions? *Am J Community Psychol*. 2008;42:91-101.
17. Goins RT, Williams KA, Carter MW, Spencer SM, Solovieva T. Perceived barriers to health care access among rural older adults: a qualitative study. *J Rural Health*. 2006;21(3):206-213.
18. Samuels ME, Xirassagar S, Elder KT, Probst JC. Enhancing the care continuum in rural areas: survey of community health center-rural hospital collaborations. *J Rural Health*. 2008;24(1):24-31.