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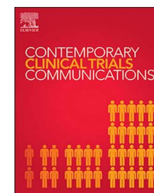

# Recruitment and baseline characteristics of the Community of Voices choir study to promote the health and well-being of diverse older adults

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A R T I C L E I N F O

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A B S T R A C T

*Objective:* To describe the recruitment and baseline results of the Community of Voices study that aims to examine the effect of a community choir intervention on the health and well-being of older adults from diverse racial/ethnic and socioeconomic backgrounds.
*Method:* Using community-based participatory research methods, we recruited adults age 60 and over from 12 Administration on Aging–supported senior centers in San Francisco into a 2-arm cluster-randomized controlled trial of the community choir intervention. Multiple outreach methods were used. We tracked outreach, screening, and recruitment metrics and collected demographics and baseline outcomes via community-based, interviewer-administered surveys and performance measures of cognition, physical function, and psychosocial variables.
*Results:* The study contacted 819 individuals, screened 636, and enrolled 390 diverse older adults over a 42-month, phased recruitment period. The mean age was 71.2 (SD = 7.3), and the majority were women. Two-thirds of the sample are non-white, and 20% of participants reported having financial hardship.
*Discussion:* Outreach and recruitment methods used in the Community of Voices trial facilitated enrollment of a large proportion of minority and lower-SES older adults in the final sample. Similar recruitment approaches could serve as a model for recruiting diverse racial/ethnic and socioeconomic older adults into research.

## 1. Introduction

Adults age 65 and over are the fastest growing segment of the American population. By 2033, older adults are projected to represent 20% of the U.S. population, and this will be the first time in history when older adults outnumber persons younger than age 18 [1]. By 2040, nearly half of older adults are expected to come from non-white racial/ethnic backgrounds [2]. Minority older adults are at high risk for poor health outcomes [3–5]. Socioeconomic disparities also disproportionately affect non-white older adults. In 2014, 19% of African Americans, 18% of Latinos, and 15% of Asians age 65 and over lived in poverty, more than twice the rate for older non-Latino whites (8%) [6]. Our current health and social systems are not well prepared for these dramatic changes in demographics. Novel and cost-effective approaches are needed to keep this increasingly diverse older adult population active and engaged. This can include development of interventions delivered in local community settings that promote their health and well-being.

The challenge is to design and evaluate health promotion interventions that are appealing and appropriate for this increasingly diverse older adult population. Engagement in the arts (e.g., singing, acting, dancing) is a promising approach to help keep older adults active and engaged in meaningful ways and that can be culturally tailored. Two reviews found that that participating in the arts may have multiple, positive health benefits for older adults [7,8]. The studies reviewed document how engaging in the arts may address critical challenges in aging, such as improving quality of life and cognition and reducing loneliness and falls. In addition, arts interventions are relatively low cost to deliver in community settings and can be culturally tailored to take into account the background of participants. Most arts interventions, such as choir singing, involve multiple engagement components (e.g., social, physical, cognitive). There is evidence that such multi-

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modal interventions are particularly effective for promoting health [9–12].

To evaluate the effectiveness of such novel interventions for older adults requires the ability to recruit diverse minority and lower-socioeconomic status (SES) older adults into research studies. Recruitment of minority and low-SES older adults has been a persistent challenge, and they continue to be underrepresented in health research [13]. Community-based participatory research (CBPR) methods are increasingly being used to help design culturally relevant studies and recruit and enroll persons from underserved populations [14]. CBPR approaches have been found to help recruit and retain diverse participants in research [15,16]. Recruitment of minority individuals into clinical trials using CBPR are typically more successful than studies that do not [17].

The Community of Voices study used CBPR methods to recruit older adults from a broad spectrum of racial/ethnic and SES backgrounds into a cluster-randomized controlled trial designed to examine the effects of a community choir program on cognitive, physical, and psychosocial outcomes [18]. Study recruitment began in February 2012 and was completed by August 2015. The purpose of this manuscript is to summarize the outreach, recruitment, and baseline results of this trial.

## 2. Methods

### 2.1. Overview of study design and intervention

A detailed description of the study protocol is summarized elsewhere [18]. Briefly, 12 senior centers were randomly assigned to either begin the Community of Voices choir intervention immediately or wait six months. Outcome measures were collected at baseline (prior to starting the intervention), 6 months (end of randomization phase), and 12 months (one year after enrollment). The choir intervention was culturally tailored for each senior center based on the ethnic/racial backgrounds and singing experiences of their clientele. It was designed to promote health and well-being by focusing on three hypothesized engagement components (i.e., physical, cognitive, and psychosocial). Participants in the study attended weekly, 90-min choir sessions (44 weeks) led by professional music directors at senior centers. The trial is registered at U.S. National Institutes of Health (ClinicalTrials.gov): #NCT01869179 (registered 9 January 2013).

### 2.2. Study screening and recruitment

The outreach and recruitment approach was developed and implemented in collaboration with the local Administration on Aging (AoA) and a network of AoA-supported community centers (Department of Aging and Adult Services or DAAS of San Francisco County). DAAS supports a large network of senior centers throughout San Francisco and serves older adults from diverse racial/ethnic and SES backgrounds. We recruited adults aged 60 and older from each of the 12 senior centers. The sampling frame included persons already attending each senior center and those within each of the senior center's geographic service area. Similar to our previous work recruiting ethnically diverse, lower-SES adults [16,19], we used multiple methods (e.g., flyers, presentations, word-of-mouth, and radio) shared with the senior centers and local community organizations, utilized a research team that reflected the diversity of the community (including bilingual and bicultural research associates), and completed all recruitment and screening assessment procedures in the ecommunity at each of the senior centers. The research team spent three months (2–3 days per week) on-site at each senior center to answer questions about the study and complete the screening and enrollment process. The research team passed out flyers and answered questions during events at the senior centers (e.g., food tabling, ongoing classes) and shared information with organizations (e.g., senior housing, libraries) in the geographic service area of each senior center. The study protocol, consent forms, and outcome measures were approved by the Institutional Review Board at the University of California, San Francisco.

Through these outreach methods, interested individuals were invited to attend an informational meeting about the study at the senior centers or to provide their name and phone number to be called by a staff person to discuss the study over the phone. The choir intervention content, duration, study procedures, risks, and randomization procedures were explained in English or Spanish, and questions were answered. For those who attended an informational meeting and expressed interest in the study, a screening assessment was done in person. For those reached by phone, screening began on the phone using the identical screening script used for the in-person screening assessments except that the cognitive screen was done in-person during the start of the baseline assessment because it required responses on paper.

### 2.3. Eligibility criteria

Inclusion criteria were aged 60 and over, self-report (confirmed by research associates) of adequate visual and hearing acuity (with assistive devices), and English or Spanish fluency sufficient to complete study assessments (self-reported fluency in either language) including bilingual and monolingual Spanish speakers. Exclusion criteria included having a self-reported diagnosis of dementia or Alzheimer's disease or significant cognitive impairment (score of 0 or 1 on the Mini-Cog) [20]; having a serious medical or mental health condition that would limit participation in the study; and planning to move out of the area within 12 months. Persons who were already regularly singing in a choir (e.g., weekly) during the past six months were also excluded.

### 2.4. Demographic and health status variables

For individuals who began the screening interview, we collected five demographic variables: age, sex (male/female), language of screening interview (Spanish/English), ethnicity (Hispanic/Latino or not Hispanic/Latino) and race (American Indian/Alaskan Native, Asian, black/African American, Native Hawaiian/other Pacific Islander, white, and other).

All participants signed and were given a copy of the consent form along with a copy of the Bill of Rights for Research Participants before beginning the study. During the baseline assessment and after written consent was obtained, we collected additional demographic variables, including educational level, marital status (four categories), and nativity (yes/no born in a foreign country). Financial hardship was assessed by asking about problems paying for food, monthly bills, medical visits, or prescribed medications in the past 12 months. Hardship was indicated by endorsing difficulty paying for one or more of the items.

Regarding music background, we asked whether they previously sang in a choir as an adult (yes/no). We also asked participants to rate their overall music ability (poor, fair, good, very good, or excellent) and whether or not they could read music notation (yes/no). Music background was not considered for inclusion in the study, and our goal was to enroll participants with a range of musical abilities.

Self-rated health was assessed using a standard scale (five categories ranging from excellent to poor) and asking whether a doctor or other health professional had told them they had any of 11 different chronic conditions, adapted from the CDC's National Center for Health Statistics. Chronic conditions were categorized into seven physical health conditions (diabetes, heart disease, hypertension, stroke, cancer, arthritis, and emphysema/bronchitis/asthma) and one mental health category representing depression or anxiety. A total count of chronic physical health conditions ranged from 0 to 7. We also asked about health insurance (none, public only, or any private). Sleep quality was assessed using a single question about overall sleep quality in the past month (four categories ranging from very good to very bad) [21].

Three yes/no questions assessed shortness of breath [22]. Based on the published scoring algorithm, scores ranged from 3 to 6 with higher

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