

Health Promotion for Older Adults Living in Public Housing Authority Properties

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Introduction

The Comprehensive Health Education Foundation (C.H.E.F.[®]) has been working with Public Housing Authorities across Washington State to improve the health of Housing Authority tenants. For example, C.H.E.F. has worked with Tacoma, Spokane, and Vancouver Housing Authorities to make it easier for public housing residents to eat healthy foods and be active. Projects in these three Housing Authorities include community kitchens and gardens, walking groups, zumba and hip-hop classes, and peer-to-peer support programs. In addition, C.H.E.F. has collaborated with Pacific Northwest Regional Council of the National Housing and Redevelopment Officials to help Public Housing Authorities across Washington adopt and implement smoke-free or no-smoking policies.

Providing health education and health services to individuals and families who live in Public Housing Authority properties has the potential to further health goals and improve living conditions for current and future residents. Because public housing communities are geographically distinct neighborhoods, they are ideal arenas to change the community conditions for health. In Washington State, thirty-eight Public Housing Authorities serve over 120,000 households. Their residents have incomes at or below 200% of the poverty level, and are disproportionately ethnic minority, disabled, or mentally ill. However, because they have housing, they have the stability necessary to address their health issues.

Residents of public housing have very high rates of chronic disease. For example, in September of 2009 the Tacoma-Pierce and Clark County Health Departments conducted healthy living assessments in two Housing Authority developments: New Salishan in Tacoma and Skyline Crest in Vancouver. Table 1 provides a description of the residents' major self-reported health problems compared to state averages for the same conditions.

Finally, many Public Housing Authorities have large populations of older adults. For example, Tacoma Housing Authority has seven properties specifically designated for older adults and disabled residents, and older adults are scattered throughout Tacoma Housing Authority's other properties (i.e., 25% of Salishan's residents are older adults). Similarly, over 20% of Vancouver Housing Authority's residents are 62 years of age or older.

Table 1 - Major self-reported health problems of Salishan and Skyline Crest residents compared to the general population in Washington State.

Salishan	Skyline Crest	State prevalence rates
<ul style="list-style-type: none"> • 64% told by a medical professional they have at least one major health problem • Reported being told by a medical professional that they had a following major health condition: <ul style="list-style-type: none"> ○ High blood pressure (34%) ○ Chronic pain (29%) ○ Mental/emotional disorder (18%) ○ Diabetes (10%) ○ Substance abuse (50%) ○ Child with asthma (29%) 	<ul style="list-style-type: none"> ▪ 93% report having at least one major health problem • Reported major health condition: <ul style="list-style-type: none"> ○ High blood pressure (38%) ○ Chronic pain (57%) ○ Mental/emotional disorder (47%) ○ Diabetes (26%) ○ Substance abuse (50%) ○ Arthritis (41%) 	<ul style="list-style-type: none"> • High blood pressure (24%) • Chronic pain (n/a) • Mental/emotional disorder (9%) • Diabetes (7%) • Substance abuse (14%) • Arthritis (25% diagnosed)

In sum, Public Housing Authorities have a large population of older adults. Their residents have high rates of chronic disease and, by definition, are the victim of significant health disparities. Responding to this, Washington’s Aging and Disability Services Administration’s (ADSA) established the goal of disseminating the Chronic Disease Self Management Program (CDSMP) and other evidence-based practices to older adults who live in Public Housing Authority properties and their surrounding communities.

To meet this goal ADSA contracted with C.H.E.F. to identify components of an effective CDSMP implementation strategy for older adults living in publically supported housing and their surrounding neighborhoods.

Methodology

ADSA and C.H.E.F. determined that the most effective way to meet this goal was to conduct focus groups with older adults who live in Housing Authority properties. The goal of these focus groups was to identify residents’: a) health concerns, b) current methods of staying healthy, c) interest in participating in health activities or programs, d) barriers to participating in such activities and, e) thoughts about effective recruitment strategies. In addition, ADSA asked C.H.E.F. to gauge the receptiveness of Public Housing Authorities to a) having outside agencies provide services to their residents, and b) having members of the surrounding community receive services on Public Housing Authority properties.

ADSA and C.H.E.F. decided to hold these focus groups in four communities: Spokane, Tacoma, Vancouver, and Walla Walla. Each has a strong Public Housing Authority and Area Agencies on Aging agency. Combined they cover significant parts of the state including eastern Washington, western Washington (one in the Puget Sound area, and one in southwest Washington). In addition, Tacoma and Walla Walla currently receive funding from Communities Putting Prevention to Work to implement the Chronic Disease Self Management Program.

Data Collection Sources and Procedures

ADSA and C.H.E.F. identified key leaders from public housing and Area Agencies on Aging in each of the targeted areas. They invited these leaders to collaborate in the development of the interview guide, recruitment of focus group participants, and management of local logistics. Appendix A includes a list of these leaders.

ADSA and C.H.E.F. determined that all focus group participants would either a) have a chronic disease, b) care about someone who has a chronic disease, or c) be concerned about developing a chronic illness themselves. They also decided to give all focus group members a \$25.00 gift card to a store in their area (i.e., Safeway, WalMart, etc.) as a way to thank them for their participation. C.H.E.F. held conference calls with each site's key leaders to establish a local process for managing the focus group logistics. These local leaders decided on the site, date, and time of the group; the gift card that would be most highly valued by the participants; and divided responsibility for managing the logistics. See Appendix B for the Conference Call Agendas and Appendix C for the Participant Recruitment Flyer.

Focus Groups

ADSA and Dr. Kathy Burgoyne from C.H.E.F. developed the first draft of the focus group interview guide and sent it to ARRA grant partners for their input. The final interview guide included two major sections: general health and Chronic Disease Self Management Program and included the following major questions:

- a. What are some of your health concerns, problems, illnesses, and struggles with your health?
- b. What do you do to stay healthy and independent?
- c. What would help you to be healthier and more independent?
- d. What challenges do you face in taking care of your health?
- e. Would you and the people you know be interested in attending healthy-living classes and activities if they were held in your building? If so, what would we have to do to make it successful?

See Appendix D for a copy of the interview guide.

Because the purpose of this study was largely exploratory and there was not a clear understanding of the social dynamics, Dr. Burgoyne used an iterative process to refine and further generate questions during data collection. After each focus group, she refined the interview guide, adding questions and prompts where participants had raised unexplored but important topics. For example, nearly all of the

participants in the first focus group indicated that the lack of reliable transportation was a major barrier to participating in health related activities. Consequently, she added additional probes to better understand the specific difficulties transportation poses for older adults who live in Public Housing Authority properties.

Dr. Burgoyne conducted four, ninety-minute focus groups in September and October 2010. Table 2 describes the demographics of each group.

Table 2 – Demographics of Focus Group Participants

	Spokane	Tacoma	Vancouver	Walla Walla
Number of participants	11	10	10	10
Race/ Ethnicity	9 Caucasian 5 Slavic	9 Caucasian 1 Southeast Asian	9 Caucasian 2 Russian	10 Caucasian
Gender	7 Female 4 Male	9 Female 1 Male	8 Female 1 Male	9 Female 1 Male
Age	Not provided	Not provided	1 – 55 to 65 7 – 66 to 75 2 - 76 and over	6 – 55 to 65 2 – 66 to 75 2 - 76 and over
Live with a chronic disease	Not provided	Not provided	9 yes	1 – no 2 – unknown 7 - yes
Living	All live in the same building	<ul style="list-style-type: none"> • 2 in one development • 2 in a different development • 2 in a different development • 4 in scattered sites 	All live in the same building	All live in the same development
Translator	Yes	No ¹	Yes	None needed

Participants in each of the focus groups gave permission for the conversation to be audio recorded. C.H.E.F. staff transcribed each audio tape.

Informal Interviews

¹ Russian residents planned to attend the focus group, but the translator never arrived.

Dr. Burgoyne held informal interviews with key leaders from several Public Housing Authorities. Within a larger discussion about the intersection between health and housing, Dr. Burgoyne inquired about their receptiveness to: 1) community agencies providing services to housing residents in Housing Authority buildings, and 2) having community members attend health-related activities held in Housing Authority buildings. These conversations took place either immediately before or after one of the focus groups or during the Housing Washington Conference held in Tacoma in October 2010. See Appendix E for the list of housing officials who talked to Dr. Burgoyne about these issues.

Because the purpose of these conversations was exploratory, Dr. Burgoyne used an iterative process to refine and generate further questions. After each conversation, she jotted down notes about what she learned and noted new topics or questions that had been raised. For example, the first interviewee noted that the source of financing used to build a development could influence whether or not a Housing Authority could allow an agency to provide services to people other than Housing Authority tenants. This topic was explored further in subsequent interviews.

Data Analysis

The Walla Walla, Spokane, and Vancouver focus group participants were homogeneous. In each of these groups, the participants lived in the same building or development. Most, if not all, of the group members knew one another, some quite well, and they had common reference points. For example, in Walla Walla all of the members knew how far it was to the mailboxes and what it was like to walk to them in the winter snow. Similarly, all members of the Vancouver group knew about the problems with the property being old and, from their perspective, not adequately cleaned.

In contrast, the Tacoma focus group was quite heterogeneous. The participants lived in numerous buildings and developments throughout the city. Most did not know one another and their experiences varied widely. In fact, only three pairs of participants lived in the same housing development. Consequently, there were far fewer areas of commonality among the Tacoma group members than there were in the other groups. For example, almost everyone in Tacoma had stories about waiting a long time for Para Transit/Dial-a-Ride to pick them up. Only one participant who lives in one Tacoma housing development told of being harassed by teenagers while waiting to be picked up and being too afraid to use the service any more. Participants' experiences within their housing unit were extremely diverse, for some participants told of getting together to watch movies in a common area within their development. Others talked about open hostility and bids for control among residents of the same floor. Some participants described a welcoming atmosphere in their building while other talked about gang activity.

Within-case analysis

The difference in the homogeneity of the focus groups created analytical problems. Dr. Burgoyne conducted a within-case analysis on each focus group. She analyzed each group's transcript to assess overarching patterns and themes. The frequency each theme was mentioned and the number of participants who mentioned it was noted. The homogeneous make-up of the Spokane, Walla-Walla, and Vancouver groups lent themselves to this kind of within-group analysis. The heterogeneous make up of the Tacoma group did not. Out of the ten Tacoma focus group participants there were three pairs all of whom came from different developments, and four individuals who came from scattered sites

across the city. The experiences of the Tacoma participants differed so widely that it was difficult to find areas of commonality. In short, it was clear that we were comparing apples to apples in Spokane, Walla-Walla, and Vancouver, but not in Tacoma.

Cross-case analysis

After the within-case analysis was completed, Dr. Burgoyne conducted a cross-case analysis, comparing and contrasting themes across cases, identifying strong and weak themes in each group, and keeping a summary sheet for each. The tallies reflected the importance of each theme for each group. The goal was to identify themes that ran across multiple cases and may indicate commonalities across housing communities. Once again, the differences between the groups made including Tacoma in a cross-case comparison difficult. Therefore, the findings from the Tacoma group were used solely to confirm findings from the other groups. For example, participants in Spokane, Walla Walla, and Vancouver mentioned problems with transportation. The fact that multiple Tacoma group participants also mentioned them added weight to the conclusion that a lack of reliable transportation creates a significant barrier to public housing residents' participation in health activities or programs. A table comparing the responses of Spokane, Walla Walla, and Vancouver participants is in Appendix F.

Limitations of Data

The small sample size limits the ability to generalize results to the broader public housing community. Social desirability and recall bias are also limitations to take into consideration when viewing the survey results.

Findings

As discussed above, the small number of participants at each site reduces the reliability of results when attempting to generalize findings to properties owned by Public Housing Authorities located throughout the state. Nevertheless, the findings do create a coherent picture of the health needs of a significant number of older adults who live in Public Housing Authorities' properties.

The findings are divided into three sections. The first section, *Current Situation* directly below, includes a description of focus group participants' perception of their current health situation. The second section, *Desired Future*, begins on page 12 and focuses on the participants' desired future, including their thoughts about having a Chronic Disease Self Management Program in their building or development. In the third section, found on page 14, is Housing Authority staffs' receptiveness to having community agencies provide services to their residents and having members of the surrounding community receive these services on Public Housing Authority properties is explored.

Current Situation

The older adults who attended the focus groups had an overwhelming number of chronic diseases and other health problems. This may be because of the way in which the participants were selected. However, the research suggests otherwise. For example, the Hope VI Panel Study surveyed residents in five public housing developments in various cities and found that of adults, 48% were obese, 17% had diabetes, 39% had hypertension, and 6% had a history of stroke.ⁱ This reinforces the theory that public housing residents experience a disproportionate number of health problems.

Health Status

All of the focus groups participants were eager to talk about their health problems. Many believe that other people do not want to hear about their difficulties and therefore they rarely disclose the extent of their sickness, vulnerability, and pain. Their five most frequently mentioned health problems, in descending order, included: heart problems, hearing problems, poor mobility, depression, and diabetes. Their heart problems ran the gamut of severity with high blood pressure being their most common ailment. Several participants had had surgery related to their heart problems including having a pacemaker inserted to regulate an irregular heartbeat and having a stint put in to address poor blood flow related to artery disease.

Like many older adults, the participants struggle with their loss of hearing. Complaints about people yelling at them or treating them as if they were stupid were common in all four groups. Participants mentioned a number of safety issues that relate to their hearing impairments. For example, several people in one group talked about a recent fire in their building. Some people with hearing problems did not know what to do when the fire alarm went off. Their fellow residents tried to tell them where to go and what to do, but the hard-of-hearing residents found it difficult to understand the directions. The hearing residents were reluctant to slow down and repeat what they were saying. Fortunately, the fire was minor and no one was hurt. However, it left the hearing-impaired residents feeling afraid and vulnerable and the other residents bewildered and concerned.

Problems with mobility were also prevalent in all four groups. Numerous participants talked about problems with their knees, hips, and feet. Well over half were told by a medical professional that they have arthritis or suspect that they do. Some have had joint replacement surgery. Others want to have the surgery, but their doctor told them they were too old. The participants cope with their limited mobility in a number of ways including using friends, canes, guide dogs, and wheelchairs to help them get from place to place. Nearly all are afraid of falling and breaking a bone. Participants frequently mention a sense of sadness and loss when discussing their mobility problems. As one participant said, "I miss running, now I can't do it." Another woman sighed, "I'm just bitter because I can't do what I used to do."

A sense of depression, anger, and isolation were common themes in all of the groups. In Tacoma, one participant silently wept through much of the group. Participants' feelings were often related to the sense that they were no longer needed or productive, which left them feeling listless and unmotivated.

Also frequently mentioned was diabetes. This is the disease that many residents seemed to fear the most. As one woman said, "You really don't want to have diabetes. Listening to other people with

different health issues you learn what to look for, you learn to have compassion for people. Diabetes is very deceiving, because you go a long time with it.”

Other health problems that were mentioned included managing multiple medications with several participants managing over a dozen pills a day; chronic pain that results in being uncomfortable and irritable 24-hours-a-day, seven-days-a-week; gastro-intestinal problems; skin and other cancers; strokes; vision problems; sciatica; hypoglycemia; kidney disease; osteoporosis; fluid on lungs; asthma; and post traumatic stress disorder.

Efforts to stay healthy and independent

Although the severity and types of health problems were consistent across the groups, there was little consistency within or across the groups when it came to the participants' efforts to stay healthy and independent. The most commonly mentioned vehicle for staying healthy and independent was having an informal network of support with fellow residents. This sense of interconnection was almost palpable in the Spokane, Vancouver, and Walla Walla groups. Comments such as, “If anything would happen to me there's lots folks [to] rally around me, “ or, “Everybody helps you out here when you're down,” or “ On our floor, [if] you don't see someone, we're checking on them,” were frequent. This was particularly true in Vancouver and Spokane where the participants all live in the same building. In Walla Walla residents talked about supporting one another, while simultaneously bemoaning the fact that they did not know everyone in their development.

Participants in all of the groups knew they ought to eat healthy food and exercise, but few of them did. Although some residents said they ate healthily, only one could describe what a healthy diet was. Approximately one-third of the participants mentioned exercise, with walking being their most frequent form of exercise. A couple of participants in Vancouver walk two of miles a day. Large differences exist in the exercise patterns of younger and older participants and between those living in urban and rural settings. Younger participants who were mobile or had a car went places to take exercise classes. One such Walla Walla participant explained that she got a grant to use the YMCA facilities at a significantly reduced fee. In order to get this privilege she had to provide a doctor's referral and, to maintain the privilege, she has to attend regularly. The Walla Walla participants who rely on public transportation responded with a mix of irritation and envy. They pointed out that it takes two buses to get to the YMCA from where they live. The Para Transit shuttle goes to the YMCA, but riders have to prove that they need the service to qualify.

Participants who lived in urban neighborhoods where activities were close by were far more likely to exercise. For example, several participants in the Vancouver group attend, “*Anytime Fitness* across from the park” where they take a variety of classes including Chi Gong and Yoga. Members of all four groups knew about health classes and activities that were offered in their communities at places like a medical group, local food bank, or the Washington State University Extension Office. Yet, here again, transportation was an issue for the residents who do not have a car and must rely on public transportation.

Health Information

The overwhelming majority of participants in all groups get their information about health-related issues from the medical establishment. This includes information about ways to stay healthy and active. One participant said, “I only trust my doctor. My doctor said there are too many people practicing medicine without a license, like giving people medical advice because it works for them.”

A few residents mentioned that they get health information from the near-by community center, The Washington State Extension Office, the Senior Center, and the food bank. Others mentioned getting information from internet websites and magazines. However, nearly everyone gets information from one another. If they hear contradictory information about health issues from their various sources, they turn to their doctors or other health professionals for “the truth.” A minority of participants “follow [their] own instincts. You know if that pill makes your body feel icky.”

Barriers to being healthy and independent

The majority of participants found negotiating the ins and outs of their medical condition and the medical establishment to be their biggest health barrier. Nearly a third of the participants found it “a significant challenge” to manage the multiple medications they take and to make sure they all work together. In two groups, the participants seemed to compete with one another to see who was taking the most medication with one participant saying he takes thirty-two pills a day. Another participant said, “I have my own pharmacy in my house” and others admitted they did too.

The cost of health care was another barrier to being healthy. One participant said, “Medicare just plain sucks. Their costs, what they cover, what they don’t, it’s sad. They can’t or won’t cover it. They only cover part of it, like 70-80%. We’re on Social Security, how are we supposed to pay for that other part?” It is also difficult for some of the housing residents to qualify for services. As one group member said, “My problem is I make too much money to qualify for a lot of those things, but not enough to be able to do them. The guidelines keep me out of them. Prices keep going up, but our incomes don’t. If you’re poor enough, the state picks it up, but if you make \$100 or \$50 too much you don’t qualify.”

Barriers to participating in health activities/programs

Participants in all four communities overwhelmingly report that the lack of reliable transportation is the single biggest obstacle to participating in health activities, classes, or programs. They would like to go to various activities, but the bus schedule makes things impossible to get to, especially at night. In addition, people often have to take multiple buses to get where they need to go. By the time they arrive, they are too tired to care. Even people with caregivers find it difficult to get around because their caregivers are not paid to provide transportation. In sum, the lack of reliable, efficient transportation makes it difficult for the residents to take care of life essentials like food shopping or going to doctor’s appointments much less going to a class or the pool. This is especially true in Spokane and Walla Walla in the winter when, “snow removal in the neighborhood is a problem.”

In all of the focus groups participants complained about their community’s version of Dial-a-Ride or Para Transit. They universally complain that the ride doesn’t come on time and they don’t wait for people once they arrive. One participant eloquently explained, “I would wait for them to get me to the doctor’s office, then wait at the doctor’s office until you’re called, and then go down and wait for [Dial-a-

Ride] to pick me up. They have a 45 minute window to pick you up, but you have 5 minutes after they arrive to get there or they'll leave." She continued, "When we get older, we need to have patience. Maybe we lost all our patience. We're always having to wait for something. When I am sick and feel like I am dying, I do mind waiting."

Expectations. Second only to transportation is the participants' sense that other people do not understand their situation. People expect them to be able to do things that they are not capable of doing. For example, many programs require that you attend every session in order to be in the program. However, the participants explained, they have good days and bad days. Some days they are capable of getting up and moving around, and other days they have too much pain to be active. When they tell this to professionals who are generally under 50, they seem to dismiss them. They think the pain older adults experience is the same as the pain they experience, something they can easily overcome with a little time and effort. However, the older adults remember what life was like when they were younger, and their current experience is different. It is frustrating for them that they cannot make the younger generation understand what it is like. Therefore, because they know they cannot meet the expectations, they just do not sign up.

Regulations. In a similar vein, the housing residents believe that rules and regulations seem reasonable to healthy people, but are experienced as unrealistic and burdensome by people who are sick. One participant explained, "The Housing Authority makes things so hard. They gave me a pile of papers, they made me take it to the post office, it had to be postmarked, then I had to take the papers back to them. That's the way it is with entitlements. It's a lot of rules, a lot of running here and there, everybody has their own thing that they want; being poor is a full-time job." Similarly, one Housing Authority requires residents to come over and get the key to the community center when they are hosting an event. Even though the Housing Authority Office is just a few blocks away, getting there is difficult for people who have limited mobility. Therefore, the expectation that residents will pick up the key to the community room inhibits some people from using the facility.

Even regulations that make sense from a legal or esthetic perspective can create health barriers for residents. One participant gave the following example, "I have exercise equipment in my garage that I can't use because there's no place to use it! I asked if there was some place we could put it so we could use it and anybody could use it, but maintenance people said there is a problem with liability issues. Somebody might get hurt." Consequently, the equipment stays packed away. Similarly, some participants expressed a desire to garden but the Housing Authority regulations forbid it. "We can't even buy a flower and plant it; it has to be in a pot."

Cultural Differences. Cultural differences between people who live in the same building or development leads to isolation, which is a barrier to being healthy. One Russian woman explained, "In Russian culture, when people ask how you are, they are used to saying I hurt here and there, but not here. Here you say I'm fine." After several months of living in her current residence, she realized people had stopped talking to her because they were afraid they would have to listen to all of her complaints. She can laugh about it now, but for a long time the realization that everyone seemed to avoid her was deeply painful.

Many people who live in Housing Authority properties come from other countries and have encountered severe challenges. Some are refugees. Others left their families and everything they owned to escape bone-crushing poverty or discrimination. All of the immigrant participants spoke about how hard it is to learn a new language when you are an adult. Not only is learning the words difficult, but having to translate every word as it is spoken is exhausting. Many feel overwhelmed by the apparent expectation that they, “must learn [the] entire English language,” while there is no expectation that the English speaking residents need to learn even a single word of their language.

In some cases, there is open hostility toward non-English-speaking residents. One person explained, “There is a complete divide. We smile at them, we wave. They speak Spanish and Arabic. They have their own parties. This upsets me – they come down here [to the community center] and use this space for their parties.” Another resident said, “No one can plant anything here except for the Mexicans. That guy was not supposed to plant those sunflowers, but [the Housing Authority] won’t say anything to him.”

However, in some buildings, the residents are seeking to bridge these cultural and linguistic divides. In one focus group it was clear that the English- and Slavic-speaking residents were making a concerted effort to get to know and understand one another. A couple of the English-speaking residents had begun an English Learner Language class in the building. Although the primary emphasis was on teaching the Slavic residents English, the teachers have made an effort to learn some Russian as well. In this focus group the members asked to go around the group and have each person tell the group about the job s/he had before they came to public housing. By doing so, they were able to get a sense of the gifts and talents each person brought with them. Being able to share something of themselves was profoundly moving to the Slavic residents and appreciated by all.

Logistics. Cost, time, and comfort are also barriers to participating in health-related activities or classes. A number of people commented on how expensive community classes are. Seventy dollars a month for a YMCA membership or for a fee to an eight-week class at the medical center is too expensive for most of the residents. The participants also mentioned that classes are often scheduled at night, usually from seven to nine p.m., to accommodate the needs of people who work. This excludes them because either their eyesight is not good enough for them to drive at night or there is no good public transportation at that time of day. Finally, the participants find the chairs that are provided in most classes to be very uncomfortable and they just cannot sit in them for two hours.

Ageism. Most of the participants feel dismissed everywhere they go. As one participant said, “We’re of a certain age and we’re whiny old people who do nothing but complain. They think that we’ve lost our marbles. And that’s how 90% of people who are under fifty treat us.”

Desired Future

In the following section I describe what the participants would like to see and their thoughts about having the Chronic Disease Self Management Program held in their building or development and how to best position it for success.

Overall

Several of the participants would like to see their building or complex run more like a retirement home or assisted living facility complete with an Activity Director and a van that would provide reliable transportation. Many of them have lived in their building for a long time and have aged in place. When they first came to the Public Housing Authority, they didn't need a lot of support, but as they have gotten older their needs have increased. They are not ready for a nursing home, but they need more care than is typically available through the Housing Authority.

Most of the focus group participants were comfortable getting their health information from their doctors' offices. However, they would like to see some kind of centralized place, such as the Senior Center, where they could get reliable information that they know is accurate. Several participants mentioned that they would like to see a senior telephone hotline within their buildings or development. This hotline could be used as a system for checking on people (i.e., we haven't seen you in a couple of days, are you doing alright?) as well as a way to pass on information about various health emergencies (i.e., it is flu season so be sure to get your shot).

By an overwhelming majority, the focus group participants would love to see community agencies offer health programs, classes, and activities in their building or development. Some of the activities they would be most interested in having included falls prevention classes, exercise classes like Tai Chi, exercise classes for people in wheelchairs, community gardens, and social activities. Because of the participants' sense of isolation, social activities are greatly desired. As one person said, "I'd like to see us have a game night or craft night. Make a music group – have some fun!"

The focus group members thought it would be nice if the program or classes were proven effective, but it is not necessary. A slight majority of the participants felt like proven programs would have more credibility than those that had not been well researched. Nevertheless, most people would, "try things that aren't proven if they won't hurt me."

Finally, no matter how much the participants would like to have programs in their buildings, they cannot be expensive. Five dollars per class with a maximum of \$20 a month was the most people could see themselves paying. Even at this level the participants would have to choose between paying for the class and paying for medication.

Chronic Disease Self- Management Program (CDSMP)

Most of the participants were interested or very interested in having a CDSMP in their building, but they wondered if it could be successful. In all of the focus groups participants reported that the turnout in their building or development for a wide range of activities has not been good. In order for CDSMP to be successful, the service providers would have to be willing to, "start small and build up." If the first series of classes went well and people liked them, news of it would spread by word-of-mouth. Over time the positive reaction of the residents would combat the pervasive cynicism many have, as reflected in one person's comment, "What could I learn at my age?"

Success Factors. The focus groups participants believed the following factors would significantly influence the success of CDSMP:

- Time and location are most important. The program must be offered within the Public Housing Authority building or development. If people have to rely on public transportation, they will not come. The classes should be given during the day. It may help to schedule the class around the standing doctor's appointments of the people who are most interested in attending. Many of the residents who have chronic disease schedule their lives around these regularly scheduled appointments.
- Offer the class in multiple languages, or at very least have a translator present at every session. There are large differences in translator's skills and in presenters' ability to work with a translator. The experience can be awkward, stilted, and frustrating, or smooth and rewarding. It all depends on who you get and the group members' willingness to be patient. Some Housing Authorities have translators that they regularly use. These individuals know the community and residents and are the most fluent and conversant.
- The person teaching the class makes a big difference. The focus group members suggested not using someone who was very young or age-ist. Nearly all of the participants relayed incidents where they felt like professionals talked down to them or conveyed the idea that elders were stupid.
- For some participants a two hours class is too much. Several suggested limiting it to one hour per session and increasing the number of sessions per class.
- Several people suggested that it would be ideal for the class members to be able to "go at their own pace" Some people were afraid they would not be able to keep up with the rest of the class. Others said they were not healthy enough to attend every class. However, everyone wanted to make sure they would not be left behind.

Promotion. The focus group members also had numerous ideas about the best way to promote CDSMP. Every building has its own way of communicating with its tenants. One has a monthly resident meeting that has an average attendance of 25-30 people. Some buildings or developments have a newsletter, and everyone has some kind of a board where announcements are posted and a community resource rack. All of these vehicles can be used to get the word out. Whenever possible, all communication should be provided in multiple languages, depending on the languages spoken in the housing community. Finally, people like to be personally invited to things. One person suggested using a telephone tree to give people a one-on-one invitation.

The focus group participants suggested that the more specific you can be about what will be covered in CSDP the better. People are a bit suspicious. They want to know that the program will address something that directly relates to their lives and will benefit them. Otherwise, it may not seem worth the effort to come.

Regardless of the promotion efforts, in all likelihood, the turnout for the first CDSMP will probably be small. The best publicity will come from people who have gone through the program and found it

worthwhile. In this way, word-of-mouth is the best publicity. However, to be successful you have to make sure that your presenter does not talk down to people, translation is provided, the setting is comfortable, and, wherever possible, the individual needs of the participants are taken into account.

Receptiveness of Housing Authorities

In the following section, I focus on the receptiveness of Housing Authorities to 1) have community agencies provide services to housing residents and 2) having community members attend health-related activities that are held in Housing Authority buildings. Without exception, each Housing Authority staff thinks it would be wonderful for community agencies to provide CDSMP and other evidence based programs to their residents. By law they are not allowed to become an assisted living provider, but they see many of their older adult residents struggle with multiple health problems and they worry about their inability to address their needs as they 'age in place.' It would be a relief to know that other agencies and organizations in the community want to serve their residents; Housing Authority staff is open to finding ways to work together.

Some Housing Authorities already work with multiple community agencies and these agencies either currently provide or have provided services to Housing Authority residents in the buildings where they live. For example, Northeast Community Center has provided summer recreation camps in one of Spokane Housing Authority's properties. Some of the largest Housing Authorities house community agencies or programs on their properties. For example, King County Housing Authority gives one service provider a two-bedroom apartment to provide family support and educational services to their residents. Similarly, Tacoma Housing Authority is currently exploring ways it could house a few library programs in their Salishan property rather than see these programs disappear when the local library branch eventually closes.

This is not to say the Housing Authorities do not have any concerns about welcoming in agencies. Many people have the misconception that Housing Authorities can provide funding and staff for a variety of programs. This is simply not the case. Housing Authorities have very limited staff and budgets. Only the largest have any community service staff at all, and those who do are stretched close to the breaking point. Over 85% of Housing Authorities have a small staff that includes central administration, property managers, and maintenance.

Some Housing Authorities worry that other agencies will place too many demands on them and in doing so, will become a problem rather than a solution. For example, one local Public Health Department pressured their local Housing Authority to adopt a smoke-free policy. After the policy was adopted, the health department was not available to help residents with smoking cessation services or to help the Housing Authority when tenants violated the policy. The Health Department's suggested solution was to "evict the smokers." This did not sit well with the Housing Authority who is dedicated to ending homelessness. They would not evict a mentally ill person who has been smoking for fifty years without a great deal of thought and effort to find better alternative. This experience and others like it make some Housing Authorities a bit cautious about opening themselves up to another organization.

Even with the full support of a Housing Authority, implementing CDSMP will be met with a few challenges. Much of the success or failure of CDSMP will depend on the receptiveness of individual

property managers who are the primary link between the service provider and the residents. Most do not have background or training in health or human services, and may not think CDSMP is very important. Their willingness to help with resident recruitment, set up a clean and comfortable place to meet, and answer questions will vary from building to building. It is not unlike working with schools. The School Board and Superintendent's Office determine whether the district will support an activity, the building principal determines how the activity will be put in place, but ultimately it is the secretary, janitor, and teacher that determines how welcome an 'outsider' will be.

That being said, most Housing Authorities could offer some assistance to agencies, such as Area Agencies on Aging, who would like to offer CDSMP on the Authorities' properties. They could and would provide access to a room, put up posters to recruit residents, and invite an agency representative to attend their monthly resident meetings. The property manager could encourage residents to attend or even send out a reminder each week to the people who had signed up.

Inviting community members

Inviting members of the surrounding community to participate in a CDSMP on a Public Housing Authority property is a far more difficult issue and will take some careful dialogue between Area Agencies on Aging and the local Housing Authority. Some, although by no means all, of Public Housing Authorities' properties are located in challenging neighborhoods with concentrated poverty and crime. To maintain the safety of their residents security is a significant issue. In some locations, community members have mis-used Housing Authority property. For example, one Housing Authority had a computer room for its tenants. Unfortunately, community members snuck into the building and broke the computers. The Housing Authority did not have the funds to replace them so there are no computers for the residents.

Another issue each Housing Authority will have to address before they can welcome community members to participate in programs is liability issues. If the program's community publicity says it is being held at a Housing Authority location does the Housing Authority have extra liability? Does this mean they have to have a staff member on-site while the program is taught? If a senior falls, and breaks a hip, will the Housing Authority be liable? What is their exposure to potential lawsuits? Does their insurance company have any coverage limitations that would inhibit the Housing Authority's ability to open classes to the broader community? The answer to these questions will have to be explored in individual discussions. Housing Authorities care about the residents of the surrounding community and want positive publicity in the community. However, they cannot put their tenants or the Housing Authority at risk in order to meet a community need that is outside of their scope. It would need to be clear that the provider is "not an agent or employee of the Housing Authority." A Memorandum of Understanding or Hold Harmless Agreement will be needed.

Finally, it may be difficult to get people who live in the community to come to a program at a Housing Authority building. Some community members hold negative stereotypes about the people who live in Housing Authority properties, and/or have negative feelings about the Housing Authority itself. On some level, they do not want to be thought of as being one of "those people" (i.e., free-loaders, poor, welfare cheats, etc.).

Discussion

As discussed above, the small response rate reduces the reliability of results when attempting to generalize findings to the larger public housing community. Nevertheless, the findings do provide initial baseline data that will provide stakeholders an opportunity to implement initiatives and programs that are wanted by the older adult residents.

Clearly, older adults who live in Public Housing Authority buildings are more vulnerable than most older adults. They are poor, disproportionately of ethnic and racial minorities, and have an unduly large dose of health challenges. No one agency or set of services can adequately address all their needs. If we want these older adults to be as healthy and independent as possible, it will be necessary for multiple sectors to work together on their behalf. Community agencies, housing providers, and residents all acknowledge this. Yet the barriers to doing so are real.

Many of the services that these older adults need are available in the surrounding community. Medical centers, senior centers, community centers, food banks, YMCA's, and University Extension Offices are just a few of the organizations that provide health and wellness activities that older adults need. However, older adults who live in Housing Authority properties have difficulty accessing these services. The biggest barrier to access is transportation. The transportation system cannot get as many people where they need to go in a timely manner given the resources they have or are likely to have. The other significant barrier is cost. Older adults who live in Public Housing properties cannot afford even a modest fee for such services.

Overcoming these barriers appears to require bringing the services for the older adults to the places they live. However, to be successful these services will need to be tailored to the needs of the population. What seems reasonable to an able-bodied older adult seems unattainable to a poor, older adult who is juggling multiple chronic conditions. Even the requirement that they attend every session for six weeks may be asking more than can reasonably be expected. In addition, many housing residents have experienced a lifetime of being marginalized and patronized. Community providers will need to build trust with the residents before they are willing to commit to attend a new program. In short, providers will have to start small and maintain their commitment over time if they want to be successful.

Finally, Housing Authorities and Area Agencies on Aging have missions and institutional priorities that overlap but are not the same. The "primary mission [of Housing Authorities] is housing assistance." The mission of Area Agencies on Aging is "to promote the emotional, social, and physical well-being of older adults." Both organizations are deeply committed to their missions, and while they see value in what the other provides it is not of utmost importance. Even the languages they speak differ. Housing Authorities talk about residents being at 30% of median income while Area Agencies on Aging talks about clients being under 200% of poverty. Housing talks about properties funded by tax credits or Housing and Urban Development and the different requirements of both. Area Agencies on Aging talks about the requirements of Medicare and Medicaid. Both fluently speak in acronyms that the other does not understand. Still, both share a commitment to the same people and they have much to gain by working together. Each provides a service that the other needs to be more effective.

Appendix A

Key Leaders

Spokane

- Steve Cervantes. Director, Spokane Housing Authority
- Nick Beamer. Director, Aging and Long Term Care of Eastern Washington
- Lucy Lepinski. Director of Assets, Spokane Housing Authority

Tacoma

- Lisa Zahn. Association Manager, Salishan, Tacoma Housing Authority
- Mary Syslo-Seel. Program Manager, Tacoma Housing Authority
- Barbara Myers. Pierce County Human Services, Aging and Long Term Care
- Aaron VanValkenburg. Pierce County Human Services, Aging and Long Term Care
- Bob Gleich. Tacoma Housing Authority

Vancouver

- Connie Sherrard. Resident Initiatives Program Manager, Vancouver Housing Authority
- Jeanne Holiday. Elderly Services Coordinator, Vancouver Housing Authority
- David Kelly. Executive Director, Southwest Washington Area Agency on Aging

Walla Walla

- Renee Rooker. Executive Director, Walla Walla Housing Authority
- Lori Brown, Director. Southeast Washington Long Term Care
- Mary Cleveland, Coordinator. Aging and Disability Resource Center

Conference Call Agenda

1. Welcome & Introductions

2. Call Purpose

To have a conversation about:

- The Aging and Disability Services Administration (ADSA), Chronic Disease Self-Management Program (CDSMP) project.

Organizing and conducting a focus group with seniors in your community to determine interest and approaches that would work to implement CDSMP (and other evidence-based disease prevention programs) within public housing and in the communities where they are located.

3. C.H.E.F. & ADSA Partnership – Background Information

CDSMP Project Goal & Measurable Outcomes

Goal: To develop a plan to disseminate Chronic Disease Self Management Program (CDSMP) to older adults living in public housing and the communities where they are located.

Measurable Outcome: Identify components of an effective CDSMP implementation strategy for adults living in publically supported housing and their surrounding neighborhoods.

Objective: Identify effective dissemination approaches of healthy aging programs, especially CDSMP, within public housing and their surrounding communities.

CDSMP Project Goal & Measurable Outcomes (continued)

Tasks:

1. Identify 2 Housing Authorities within the four targeted AAA service areas and 2 outside of these areas that are eager and have the necessary infrastructure to implement CDSMP.
√ Done – Pierce, Clark, Walla Walla, and Spokane
2. Develop and implement a plan to recruit older adults living in publically supported housing and their surrounding neighborhoods to participate in a focus group.
3. Facilitate focus groups with older adult public housing residents to understand opportunities and barriers to implementation of CDSMP and other Evidence Based Disease Prevention (EBDP) programs.
4. Participate in statewide sustainability work.
5. Create a report that describes effective dissemination approaches of healthy aging programs, especially CDSMP, within public housing and their surrounding communities.

4. Focus Group Conversation

Objective

Kathy Burgoyne, C.H.E.F., will facilitate a two-hour focus group with ten seniors who are living with chronic diseases to determine their interest in, and the approaches that they think would work best to implement a Chronic Disease Self Management Program (and other evidence-based disease prevention programs) within public housing and the communities in which they are located.

Focus Group Preparation – Questions to Think About & Then Discuss During the Upcoming Call

4a. Where is the best location (e.g., comfortable room in a public housing site or community site, outlet for a tape recorder) and when is the best day and time (e.g., are there current activities that draw seniors) to hold a focus group?

4b. What is the best way to recruit 10 seniors (public housing residents and seniors in the surrounding neighborhood) living with chronic diseases? How long will it take to recruit the seniors (e.g., 1 week or longer)?

4c. Who can help with the recruitment; how many seniors do you think you can recruit?

4d. What is the right gift card for the seniors (\$25; is there a nearby grocery, etc.)?

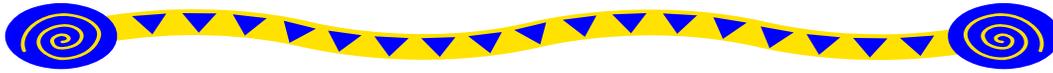
4e. What is C.H.E.F.'s role? Kari Lewis (C.H.E.F. support); Kathy Burgoyne (finalizes focus group questions, leads focus groups, provides gift cards; can provide flyer with information, analyzes, and writes/shares focus group report).

4f. What else should we be thinking about (e.g., regarding the seniors, is there anything we should be aware of, the focus groups, translation availability, other)?

4g. What questions or other recommendations do you have?

5. Thank You & Closure

Recruitment Flyer



Are You A Person Who...

- ◆ Wants to stay healthy?
- ◆ Enjoys connecting with neighbors?
- ◆ Likes to participate in activities?
- ◆ Likes to talk about health and wellness?
- ◆ Likes to connect people to resources?

Did you answer YES to any of these questions?

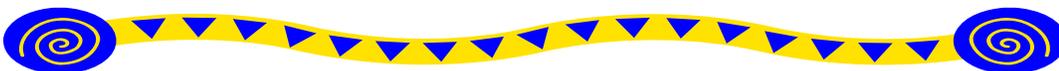
If so, you are a great fit for a community conversation that will be held on Friday, September 17, 2010 at **TBD Building, TBD Room**, from 10:00 a.m. to Noon.

Walla Walla Washington Housing Authority and Comprehensive Health Education Foundation are hosting a small group conversation for up to ten older adults to talk about health promotion programs and how to best bring them into low-income and public housing communities. We'd love to hear your ideas on how to make health and wellness programs accessible and successful.

Share your thoughts and ideas with us . . .

- Refreshments will be provided
- \$25 Safeway gift card will be given to show our appreciation

Please fill in the backside of this card and return it to Renee Rooker, Executive Director, Walla Walla Housing Authority by September 10th. If you have questions, please call Renee at 509-527-4611. Thank you!



Appendix D

Interview Guide

I believe that all of us in this room either have a long term illness like diabetes, asthma, or heart disease, care about someone who has this kind of illness, or are concerned about developing one. Today we are going to talk about what might make living with a long term illness easier. I am going to write up your ideas and the ideas of older adults in Tacoma, Spokane, and Vancouver and share them with DSHS, local Housing Authorities and local Area Agencies on Aging. Then they will work together to see if they can meet your needs.

General Questions

1. What do you do to stay healthy and independent (physically and socially)?
2. In addition to the illness itself, what difficulties do people who live with a long term illness or chronic disease face? (access to care; lack of information; disease specific; isolation)
3. Thinking about the long term illness or disease that you or your friends are coping with, what kind of information would be useful to you? (disease specific; how to successfully live with it; resources; activities; insurance)
4. Where or from whom would you like to get this kind of information? (doctor office; books/magazines; friends; internet; your kids; classes)
5. Are there interesting health activities or health classes offered nearby your home?
 - a. What types?
 - b. Do you participate? Why or why not? (location; language; cost)
6. If a program is proven by research to be helpful and/or is recommended by a health professional, are you more likely to participate?

7. What types of health activities or health classes do you think would be popular if it were held in your housing complex or near-by?
8. What should someone do if they want to meet the health needs of people from other cultures; are those who speak other languages considered?
9. How much are people willing to pay for health activities or health classes?
10. Are there other kinds of interesting community programs that are offered near your home? If so, what makes them so good/successful? (literacy; mobile health; food bank)
11. Are there examples of community programs that were offered near you that failed to get much participation? If so, why weren't they successful?

CDSMP Questions

1. Would you attend a series of six small group workshops, with other older adults from your community, to discuss health management issues such as talking with your health care providers; stress management; diet and exercise; and medication management?
 - a. Why or why not?
2. Would it make a difference if you knew that it had helped other older adults to stay healthy and independent (physically and socially)?
3. How would you promote health management workshops like this within your housing community? (Health providers, housing communication, housing association)
4. Where and when should these sessions be held to get the most people to attend?

Appendix E

Housing Conversations

- Renee Rooker. Executive Director, Walla Walla Housing Authority
- Michael Mirra. Executive Director, Tacoma Housing Authority
- Nancy Vignec. Director of Community Services, Tacoma Housing Authority
- Steve Cervantes. Executive Director, Spokane Housing Authority
- Lucy Lepinski. Director of Assets, Spokane Housing Authority
- Art Noll. Development Director, Spokane Housing Authority
- Jan Wichert. Director of Employee and Resident Services, Vancouver Housing Authority
- Connie Sherrard. Resident Initiatives Program Manager, Vancouver Housing Authority
- Ron Oldham. Executive Director, Association of Washington Housing Authorities

Comparison Tables

Question	Spokane	Tacoma	Vancouver	Walla Walla
<p>What are some of your health concerns, problems, illnesses, and struggles with your health?</p>	<ul style="list-style-type: none"> • Diabetes • Heart problems • Mobility issues <ul style="list-style-type: none"> ○ Osteoarthritis ○ Osteoporosis • Depression and loneliness <ul style="list-style-type: none"> ○ Not needed ○ Not productive ○ Not motivated • Breathing, lung disease, COPD • Poor Nutrition • Safety issues, such as fire drills and other unknown procedures, and who to contact for different information 	<ul style="list-style-type: none"> • Heart problems • Diabetes • Safety issues • Depression and loneliness. Feeling like you are not needed. • Mobility issues • Uncomfortable or in pain 24/7 • COPD 	<ul style="list-style-type: none"> • Hearing • Heart <ul style="list-style-type: none"> ○ Pacemaker/ irregular heartbeat ○ High blood pressure ○ Heart disease ○ Artery disease • Mobility <ul style="list-style-type: none"> ○ Use a cane, ○ Use friend as a Guide Dog ○ Knees, hips, feet ○ Arthritis • Depression/Anger • Diabetes • medication together, 8 to 32 pills a day • Uncomfortable 24/7, pain management • Gastro-intestinal problems • Skin cancer • Stroke • Vision. "I can only see you if you're in front of me" • Sciatic nerve • Hypoglycemia • Kidney disease • Bone loss, osteoporosis • Anemia • Fluid on lungs • Asthma • Inflamed lymph gland • Cost of medications 	<ul style="list-style-type: none"> • Health issues <ul style="list-style-type: none"> ○ Strokes ○ Heart attacks ○ COPD ○ Diabetes ○ Osteoporosis ○ Liver cirrhosis ○ Muscular problems, ○ Neuropathy ○ Skeletal problems (from injuries) ○ Arthritis • Mobility • Doctors won't operate on those who are "too old"

Question	Spokane	Tacoma	Vancouver	Walla Walla
Barriers	<p>Language</p> <ul style="list-style-type: none"> • Difficult if speak a different language • Dangerous (Fire alarm example) • Russians feel must learn entire English language, Americans do not learn Russian • Older people have harder time to learn languages • Isolation is problematic. Need a sense of community 	<ul style="list-style-type: none"> • Transportation (all who do not have a car). <ul style="list-style-type: none"> ○ Bus service is sporadic. It doesn't go to all of the places people need to go. It takes a long time to get anywhere because you have to transfer so many times (i.e., it takes all day to do one simple thing). ○ Dial-a-ride <ul style="list-style-type: none"> ▪ Doesn't come on time. You have to wait a long time. People have been harassed while waiting (i.e., a woman was teased by a group of teens while she waited. She felt threatened and afraid. Now she is frightened to use the service and wants to move to a different THA property in a safer part of town). ▪ Drivers don't wait. If you are not there within 5 minutes, they leave. Therefore people just sit and wait – maybe for an hour or more. • Isolation is pervasive and people long for a sense of 	<ul style="list-style-type: none"> • Transportation • SeaVan <ul style="list-style-type: none"> ○ Long wait. Have 5 min. to get there or they'll leave ○ Medical transport is better • The doors here suck. They either slam on you or they take forever. Need one of those buttons that holds the door open • Doctors do overmedicate a lot • Cost - You have to cut down on your food, etc. because you have to pay for medical and prescriptions • "Medicare just plain sucks." Their costs, what they cover, what they don't... • Amount of medications and making sure it all works together. "I have my own pharmacy in my house" 	<ul style="list-style-type: none"> • Transportation is a problem. <ul style="list-style-type: none"> ○ Dial-a-Ride does not come on time ○ Van does not wait for you • Mobility <ul style="list-style-type: none"> ○ Walk difficult in the winter, especially ○ Access • Community room. You have to go to office to get it. The bus doesn't go close to the office, so it's hard to get there • Make too much money to qualify for a lot of those things, but not enough to be able to do them • Time. Program from 7-9:00 at night but there's no transportation <p>Cultural issues</p> <ul style="list-style-type: none"> • A complete divide. "We smile at them, we wave" • "No one can plant anything here except for the Mexicans" • Dependence • Communication & consistency • It's easier to stay home than to come here to the center <p>Regulations</p> <ul style="list-style-type: none"> • Exercise equipment that I can't use because there's no place. "I asked if there was some place we could put it so we could use it..." • Liability issues

		<p>community</p> <ul style="list-style-type: none">○ In some THA complexes/developments/floors there are many activities and friendships. People look out for one another and do things together. Many participants expressed a poignant desire to live in one of these properties. They are angry at THA because they make it difficult to transfer from one building to another. Everyone knows where the good places are.○ In some THA properties there is open hostility between neighbors. There are bullies that intimidate other residents. It is either their way or no way.○ Some residents do not feel safe in their building (i.e., one person had a gang member live in her building He was eligible because of his disability. His friends came day and night selling drugs. THA evicted him but because they had to follow due process, it took a long time).		
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		<p>Other participants talked about thefts and other petty crimes in their complex.</p> <ul style="list-style-type: none">○ Another talked about how hard it was to get the police to come to their development. They don't enforce no trespassing or restraining orders.• Language<ul style="list-style-type: none">○ It is difficult to be involved if English is not your first language.• Medicare. Their costs, what they cover, what they don't...		
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Question	Spokane	Tacoma	Vancouver	Walla Walla
<p>What do you do to stay healthy and independent? Both in your body and in your emotions?</p>	<ul style="list-style-type: none"> • Healthy eating • Exercise, walk dog • Keep mind busy <ul style="list-style-type: none"> ○ Read ○ Computer ○ Learning to play piano • Positive attitude 	<ul style="list-style-type: none"> • Walking <ul style="list-style-type: none"> ○ Answers varied by which THA property the individuals lived in. Some properties have attractive, safe places to walk that include both sidewalks and trails. Other properties are in areas of town where people do not feel safe walking. ○ Other areas may be safe from crime, but they do not include sidewalks. ○ Few places appropriate for people who use a walker. • Keep busy. <ul style="list-style-type: none"> ○ Read. ○ Visit with friends ○ Computer 	<ul style="list-style-type: none"> • It's really about having the community here <ul style="list-style-type: none"> ○ "If anything would happen to me there's lots folks rally around me" ○ "Everybody helps you out here when you're down" ○ "Our floor, don't see someone, we're checking on them" • Walking • Classes <ul style="list-style-type: none"> ○ Anytime Fitness across from the park ○ Chi Gong, Yoga, modified for seniors • PT for six months 	<ul style="list-style-type: none"> • Walk <ul style="list-style-type: none"> ○ to the mailbox, which is not too bad in good weather, but difficult in the winter ○ Walking. "I walk about 2 miles a day or at least try to. We need to get a group together to walk" • Physical therapy • Care-giving for others. "We need to check on each other too" • Water aerobics and going to the pool • Work out at the Y, on the machines • Bowling

Question	Spokane	Tacoma	Vancouver	Walla Walla
Where do you get good information about illnesses you struggle with?	<ul style="list-style-type: none"> • Doctors and nurses • WSU Extension Office has nutritionists bring boxes of food and they can teach how to prepare healthy food, especially to shut-ins • Cooking class at food bank 2x a month • Community center has brochures • Translators prepare an advanced directive to post on apartment door for emergency personnel • It is important to have someone who can check on you • Physical therapists can teach fall prevention 	<ul style="list-style-type: none"> • Doctors and nurses • Word of mouth, from one another • Local brochures at the Senior Center <p>Does your doctor talk to you about nutrition, or is it all about medication?</p> <ul style="list-style-type: none"> • No • Yes about what I do for exercise 	<ul style="list-style-type: none"> • “I only trust my doctor” • “I follow my own instincts. You know if that pill makes your body feel icky. You have to listen to your own body” • “The pharmacist was good about answering questions for you” <p>Does your doctor talk to you about nutrition, or is it all about medication?²</p> <ul style="list-style-type: none"> • “My doctor is asking what I do for exercise in addition to my medications” • “Yes, I’ve had classes on diabetes, strains, how to handle stress, what you need to do. PTSD after Vietnam” • “My eating habits are so limited. Smoking is my only relaxation!” 	<ul style="list-style-type: none"> • Doctors • Classes at medical group. Program from 7-9:00 at night but there’s no transportation • Dial 211 for information, but it’s not helpful for community services • Word of mouth • Computer websites/internet • <i>Prevention</i>, other magazines, and books • Local brochures at Senior Center <p>Where do you want to get information?</p> <ul style="list-style-type: none"> • Centralized place, such as the Senior Center • Senior telephone hotline <p>Do you get contradictory information?</p> <ul style="list-style-type: none"> • “Yes! I go back to my doctor”

² The interviewer probed areas that were not included in the interview guide when the participants indicated a desire to address an additional topic.

Question	Spokane	Tacoma	Vancouver	Walla Walla
<p>What kinds of activities are offered in greater neighborhood? What's available?</p>	<ul style="list-style-type: none"> • Cooking classes • Pinochle, but no one shows up • Community center • Garden 	<ul style="list-style-type: none"> • Movie night in the development • Card games • Community center classes (e.g., Korean Women's Association) • Classes <ul style="list-style-type: none"> ○ Most were not involved in community activities. ○ One person had a car and was a Group Health member. She took a variety of classes at Group Health including CDSMP, which she spoke very highly of. • Another figured out how to work the system. He knew where to get free or low cost classes (e.g., YMCA), which buses to take to get there, how to get passes, etc. • Community Garden 	<ul style="list-style-type: none"> • There's about maybe 30 people out of 150 who participate • Here in [name of building], we are under a different label. We are called "62 and over, independent living". A lot of those people with 24-hour care are left over from when they had assisted living. You cannot force them to leave. They aren't able to take care of themselves; they get around-the-clock care-giving. 	<ul style="list-style-type: none"> • Tai chi & tai chi for people in wheelchairs • There's a celiac class for people who can't eat wheat, that's at Walla Walla General • St Mary's has a health rehab for stroke, diabetes, heart attacks; they ask your needs but don't call you back. And then they have classes at night. And there's nothing close, so transportation is a problem • "I do water aerobics, but sometimes they kick me out, but there's a class at Wheatland village for \$25" • "I also got a grant to go to the Y. They will give free or reduced fees with a doctor's approval. You do have to go. It does take 2 buses to get there"

Question	Spokane		Vancouver	Walla Walla
Would like	<ul style="list-style-type: none"> • Fall prevention classes or exercise classes • Social 	<ul style="list-style-type: none"> • Fall prevention class • Exercise class that is easy on your joints • Social events 	<ul style="list-style-type: none"> • Social • Falls prevention 	<ul style="list-style-type: none"> • Tai chi & tai chi for people in wheelchairs • Build an exercise room • Garden plots • Game night or craft <ul style="list-style-type: none"> ○ Make a music group – have some fun! ○ People isolate themselves • We need an activity director • “We live alone and love our own space, and if I don’t want to do my dishes today, I don’t. But I don’t always want to be alone. We as a community haven’t met everybody. We meet those who go to the mailbox”
Barriers to participation	<p>No transportation available</p> <ul style="list-style-type: none"> • Symphony has buses for some communities • Bus schedules and rescheduling make some things impossible to get to, especially at night • Grocery store or other stores and shopping • Doctor appointments or other appointments (Caregivers not paid to provide transportation) • Snow removal in neighborhood is a problem 	<ul style="list-style-type: none"> • No transportation available • Nervous to be out at night • Cost • Often too tired to be motivated to go out and do anything. 	<p>Different reasons:</p> <ul style="list-style-type: none"> • People are involved with their families, so they don’t need the activities • The ones who like their privacy and don’t want to be bothered • The language barrier • Handicapped and they can’t be involved. “Like me, I love to play cards, but I can’t shuffle” • “When I first moved in here, we had potlucks, sewing circles, breakfasts, and people came; but not so much now” • The new people coming in are younger, in their 60’s and they don’t cook • These chairs are not comfortable to sit in for 2 hours 	<ul style="list-style-type: none"> • They have classes at night • Nothing close, so transportation is a problem

Question	Spokane	Tacoma	Vancouver	Walla Walla
If there were to be some of the classes you are interested in, what would be a reasonable price to charge?	<ul style="list-style-type: none"> • 25 cents • \$5.00 • Different classes charge different price • A dollar a week • Teachers should be willing to volunteer, or get credit as an intern/student • Donations taken per class 	<ul style="list-style-type: none"> • 25 cents • \$2.00 • Donations per class 	Blank = no responses	<ul style="list-style-type: none"> • \$69/month per person too expensive • "I think \$5/class is something we could afford maybe 3-4 times a month"
If we were to bring in health activities or classes, would it matter if they had been proven by research?	<ul style="list-style-type: none"> • No • I would not attend, as I already attend another • Yes. Information would have credibility 	<ul style="list-style-type: none"> • Yes. You would know that the information was correct. • No. Science doesn't have all the answers. Now they are learning that many of the things our mothers told us are true. Sometime science has to keep up with our own wisdom 	Blank = no responses	<ul style="list-style-type: none"> • It would be nice if they were proven. It helps! (3) • We do things because we have no other options • I will try things that aren't proven if they won't hurt me
CDSMP?	<ul style="list-style-type: none"> • Very interested • Would classes be in multi-languages? What could I learn at my age? With a language barrier? 	<ul style="list-style-type: none"> • Very interested • Classes would need to be held in multi-languages. 	<ul style="list-style-type: none"> • If people think it's going to help them, they'd come, just to see what it does for them • To learn their diets, eating habits, exercise correctly, communication 	All say they'd be interested

Question	Spokane	Tacoma	Vancouver	Walla Walla
Would people come?	<ul style="list-style-type: none"> • Time and location are important, due to other appointments • Day time • 2 hours is too much; maybe only one hour • Be specific about what will be covered in classes • No one very young, or age-ist, as they can convey the idea that elders are stupid • Do not talk down to them 	<ul style="list-style-type: none"> • We have language barriers. Not everybody speaks English. <ul style="list-style-type: none"> ○ THA provides translators at their meetings. They use the same translators on a regular basis. Those people know us and do a better job. ○ One person said THA has a machine that can simultaneously translate something into multiple languages. ○ It would be best if you had classes for specific language groups. So a Korean speaker teaching the class in Korean. Translation is difficult. It slows everything down, particularly when you have to translate everything into several different languages. • It depends on how I am feeling that day. Some days the best I can do is get out of bed. If I feel like I am dying I just can't go anywhere. • Time and location are important <ul style="list-style-type: none"> ○ Doctor's appointments are the top priority. Everything else has to 	Blank = no responses	<ul style="list-style-type: none"> • Some days yes, some days no. It depends on things • Perhaps have a telephone tree, and invite people to do things one-on-one • We have language barriers. Not everybody speaks English

		<p>be scheduled around them. This makes it hard to schedule a class or activity that works for everyone. Different people have their doctor's appointments on different days</p> <ul style="list-style-type: none">○ Day time, many feel like it is not safe to be out at night. Night begins around 5:00 p.m..		
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Question	Spokane	Tacoma	Vancouver	Walla Walla
How much interest is there in this building?	<ul style="list-style-type: none"> • In the past, the turnout has not been good among English speakers • Start small and build up • They are not healthy enough to attend on a regular basis • <40 show up for potlucks, and that's as much as you'll get • You can reasonably expect up to 15 to attend 	<ul style="list-style-type: none"> • Start small and build up. • People are kind of stuck in their ways. They know what they want and what they like. It is hard to get them to try new things. • In some of the properties you could expect up to 15 to attend. In others you would be lucky to get one or two. • People have to get use to the idea. There is a lot of distrust. Sometimes people just find it hard to believe that something is really for them. • In some locations there is a sense that if something is for one ethnic group then it is not for another. For example, the Koreans have taken over the garden. No one else feels like they are welcome or that the garden is for them 	<ul style="list-style-type: none"> • There's a lot of people who need help with their diabetes and if there was a class to go to on a weekly basis, that might just trigger [interest] • I would love to come to a class for anything. I have horrible chronic pain 	<ul style="list-style-type: none"> • I think a lot of it is mental health • Don't have to leave or go out • Things need to be scheduled during the day • Could go at your own pace • A program that is low cost, about \$5.00/session is what you could afford

Question	Spokane	Tacoma	Vancouver	Walla Walla
What is best way to inform you of what's going on?	<ul style="list-style-type: none"> • Newsletter! • Posters, board announcements • Translation needed! • Word-of-mouth • Community resource rack, with info in both languages 	<ul style="list-style-type: none"> • Word of mouth the best way to get things out • Posters, board announcements. It really depends on what it is. For example, people pay attention when the sign-up sheet is put up for plots in the garden. People line up to request a plot. But almost anything else you put up gets ignored. It depends on whether people are interested in it. • Translation needed! You have to translate into Korean, Cambodian, Laotian, and Russian. 	<ul style="list-style-type: none"> • A person to come to our resident meeting every month. It averages 25-30 who come to the meeting, and it would get the news out to them • The news would travel by word-of-mouth • If the first one worked and people like it then it might spread by word-of-mouth. • we do post signs 	Word-of-mouth the best way to get things out

Question	Spokane	Tacoma	Vancouver	Walla Walla
Are there other things you would like to say?	<ul style="list-style-type: none"> • It depends on themselves to turn out for classes • Have someone in complex be responsible to check on others • Have medical/nursing students come in once a month to check blood pressure, oxygen levels, weight, etc. Perhaps they can get credit • Many men have had strokes, and they do not understand about blood pressure • Stronger individuals make for a stronger community, so individuals need to work on themselves to make themselves stronger in mind, spirit, and body • Become interested in the world at large • Foster grandparent program • Reach out to others • Take walks and take interest in surroundings to combat depression 	<ul style="list-style-type: none"> • Have someone in complex be responsible to check on others • Have medical/nursing students come to check blood pressure, oxygen levels, weight, etc. • We feel like if we complain to THA we put our housing at risk. They are “the man” and have a thousand rules that we have to live by. But you can’t get them to do anything for you. 	<ul style="list-style-type: none"> • They think that we’re just crabby old people • “We’re of a certain age and we’re whiny old people who do nothing but complain. They think that we’ve lost our marbles. And that’s how 90% of people who are under 50 treat us” • “That’s a big issue too, when we go over with an issue or complaint, you see it in their eyes, “you’re just a whiny, old person who should be thankful you have some place to live.” And that is how they treat us” 	Blank = no responses

Carlos Manjarrez, Susan Popkin, Elizabeth Guernsey, Poor Health: Adding Insult to Injury for Hope VI Families. June 2007, Urban Institute. Washington, DC.