

Building a Registry of Research Volunteers Among Older Urban African Americans: Recruitment Processes and Outcomes From a Community-Based Partnership

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Received July 13, 2010; Accepted March 11, 2011

Decision Editor: Anna M. Nápoles, PhD, MPH

Purpose of the study: An emerging strategy for increasing public participation in health research is volunteer registries. Using a community-based participatory research framework, we describe recruitment processes and outcomes in building a research volunteer registry of older urban African Americans. The specific research question examined retrospectively was: How does a community outreach partnership between older residents and academic researchers of the Healthier Black Elders Center facilitate recruitment of older urban African Americans for a research volunteer registry? **Design and Methods:** We adapted program evaluation methods, specifically, the logic model, for clarifying how community outreach health education activities supported development of a research volunteer registry of older urban African Americans. **Results:** Paralleling the 7 years in which an annual health reception was held, enrollees in a research volunteer registry

increased from 102 to 1,273 enrollees. **Implications:** Targeted outreach to underrepresented groups to build a registry of volunteers for health research may be a promising strategy for addressing recruitment disparities in African Americans' research participation.

Key Words: *Process evaluation, Logic model, Minority, Participatory research, Underrepresented groups*

Despite significant medical advancements that have yielded improvements in health and longevity of older American adults, older African Americans remain relatively disadvantaged in overall health status in comparison with the U.S. general population (Rooks & Whitfield, 2004). To address disparities in the health status of older minority adults, federally defined as underrepresented groups (e.g., African Americans/Blacks, Latinos/Hispanics,

and Native Americans/American Indians), the U.S. Department of Health and Human Services (HHS) through its Healthy People 2010 initiative called upon researchers to develop innovative recruitment strategies for increasing participation of minority persons in health activities and research (U.S. Department of HHS, 2000). Implicit in this call was the notion that the potential benefits of increased participation in health activities and research may enhance the health and well-being of older minority adults. Greater minority research participation may also lead to effective and culturally appropriate health interventions (Brown & Topcu, 2003) as well as promote generalizability of research findings to specific minority populations (Nápoles-Springer et al., 2000; Yancey, Ortega, & Kumanyika, 2006).

Although progress has been made in recruiting older minority adults into health research (see Arean, Alvidrez, Nery, Estes, & Linkins, 2003; Burns, Soward, Skelly, Leeman, & Carlson, 2008; Curry & Jackson, 2003; Dennis & Neese, 2000; Reed, Foley, Hatch, & Mutran, 2003), researchers continue to face challenges that limit representation of older minority adults in health research (Bartlett et al., 2003; Heiat, Gross, & Krumholz, 2002). Common recruitment challenges include older minority adults' fear, distrust, and suspicion of research (Freimuth et al., 2001; Nápoles-Springer et al., 2000; Sinclair et al., 2000) as well as feelings of inadequate information and lack of perceived benefits from participation in research (Nápoles-Springer et al., 2000). Other common challenges include high recruitment costs in time and money as well as unmet personnel needs in recruitment efforts (Tarlow & Mahoney, 2000), issues concerning participants' confidentiality, and issues concerning participants feeling exploited solely for recruitment purposes (Reed et al., 2003). A more recent study addressing biomarkers identified unique recruitment challenges involving African Americans, such as participants' concerns about donating blood samples (Taylor, 2009).

Despite persistent challenges in recruiting older minority adults in research, researchers have also identified successful recruitment strategies for enhancing older minority adults' participation in health research. In the current study, we describe two promising recruitment strategies for involving older minority adults in health research through health educational community outreach. These strategies include developing a community-based partnership and building a

research volunteer registry for future health research.

Regarding prior relevant literature on building community partnerships with minority communities that lead to successful recruitment strategies, Reed and colleagues (2003) found that a collaborative relationship between academic researchers and local institutions as well as involving African Americans in decision-making roles enhanced older African Americans' participation in health research. For instance, they were successful in recruiting older African Americans in the Durham Elders Project through working with local churches and involving African Americans on a community research advisory board. Similarly, in a study of African American rural women with type 2 diabetes, Burns and colleagues (2008) found that working with community members (e.g., church leaders and an advisory board of African American women with diabetes or knowledge of it) and having research team members participate in community activities were effective strategies in gaining the women's participation.

Literature further documents health registries as a valuable resource that can be used to enhance recruitment of underrepresented groups in health research. Studies report the usefulness of health registries for involving underrepresented groups in cancer research (Beskow, Sandler, & Weinberger, 2006; Bowen, Vu, & Kasten-Sportes, 2008; Skinner et al., 2008), particularly women (Sugarman, Regan, Parker, Bluman, & Schildkraut, 1999). Regarding the recruitment of older African Americans in health research, registries have been shown to facilitate their recruitment in clinical health trials (Ford, Havstad, & Davis, 2004), in genetic research (Taylor, 2009), and also in Alzheimer's disease research (Durant, Legedza, Marcantonio, Freeman, & Landon, 2011; Mody et al., 2008). Furthermore, a study found that using health registries was more effective for recruiting older African American women into genetic research than using churches or advertisement (Taylor, 2009).

In sum, prior studies on community partnerships and health registries offer insights into strategies for enhancing recruitment of older minority persons in health research. However, particularly for studies on cancer registries, successful recruitment strategies in building a health registry from a patient population may not generalize to the current study that aimed to build a research volunteer registry from a general population of older urban African Americans. Issues of generalizability, such as this one, provided justification for conducting the present study.

The Present Study

The purpose of the present study was to better understand recruitment processes and outcomes retrospectively that may have been facilitated by a community-based partnership between academic researchers and older urban African Americans. Recruitment activities within this partnership were situated within the context of a community health education outreach program of the Healthier Black Elders Center (HBEC), with a secondary goal of recruiting older African Americans into a research volunteer registry. Specifically, we describe a logic model that can be applied to understand recruitment processes and outcomes that we assumed to result in building a research volunteer registry. The specific research question addressed was: How does a community outreach partnership between older residents and academic researchers of the HBEC facilitate the recruitment of older urban African Americans for a research volunteer registry? Although not the focus of this article, our goal in developing a research volunteer registry was to provide an infrastructure for conducting pilot research studies whose results could be used to plan larger studies and health services for older urban African Americans.

The contributions of Israel, Eng, Schulz, and Parker (2005) on community-based participatory research provided a framework for this study. These authors posit that community-based participatory research should represent an equitable partnership between academic researchers and community members, where all interested parties share in every aspect of the research process, including decision making and ownership of research outcomes. They assert that engaging community members as active participants in a collaborative equitable partnership may serve to reduce power differentials between all interested parties.

Studies document that involving community residents in a community advisory board (CAB) and having researchers present while they conduct research are effective strategies for building a successful partnership and accomplishing recruitment outcomes, particularly when recruiting older African Americans (e.g., Arean et al., 2003; Burns et al., 2008; Levkoff & Sanchez, 2003; Reed et al., 2003). Furthermore, when researchers use local community sites, such as churches and community centers, to recruit older minorities into health research, the challenges of recruitment are mitigated (Burns et al., 2008; Levkoff & Sanchez, 2003; Reed et al., 2003).

Description of the HBEC

The HBEC is the centerpiece of the Community Core arm of the Michigan Center for Urban African American Aging Research (MCUAAAR), one of six Resource Centers for Minority Aging Research or RCMARs (see Ory, Darby-Lipman, Barr, Harden, & Stahl, 2000 for more information on RCMARs). The MCUAAAR, a collaborative academic research partnership between the University of Michigan's Institute for Social Research and Wayne State University's Institute of Gerontology, provides community outreach health education to older African American residents of inner-city Detroit. In employing a community-based participatory research approach, the HBEC served as the locus of health education and promotion activities for recruiting older urban African Americans in a research participant resource pool, herein referred to as a research volunteer registry. An overall goal of the HBEC is to enhance the health of older urban African Americans through community outreach health education and promotion activities consisting of year-round educational offerings and health screenings at an annual health reception. In seeking to accomplish this goal, a key objective of the HBEC is to enhance recruitment of older African Americans in health research by building a research volunteer registry.

Evaluating the Recruitment Process

Research Design and Evaluation Methods

This study used a retrospective case design. It adapted program evaluation methods for conducting a process evaluation to understanding and articulating the processes involved in enrolling older urban African Americans in a volunteer health registry. Program evaluators employ a process evaluation when they wish to describe and document a program's activities as processes leading to its expected outcomes (Royse, Thyer, & Padgett, 2010). They use a logic model as a tool for communicating with others about how a program performs at any point in its history. According to McLaughlin and Jordan (2004), a logic model may serve as an organizing framework that evaluators can use to tell a "story" about how a program has performed and what outcomes may be attributed to the program retrospectively. Furthermore, in the "gray box" evaluation that Scriven (1994) has defined as one where an evaluator can identify program components, such as

resources and activities, but not fully understand how these components operate to produce outcomes, a logic model serves as a useful tool for articulating assumptions about how program resources and activities operated to produce expected outcomes (McLaughlin & Jordan, 2004). Using a logic model as an organizing framework and conceptualizing this process evaluation study as a gray box evaluation, we clarify how key community outreach activities (i.e., health education offerings and an annual health reception) of the HBEC may lead to immediate and short-term recruitment outcomes in building a research volunteer health registry.

Procedures

The procedures for building a registry of research volunteers within the HBEC included two main steps. First, a community outreach staff person, often accompanied by a CAB member, and an older adult volunteer community resident collected contact information in a brief evaluation survey from older adults attending health education offerings. This brief evaluation survey contained questions about the quality of speakers, usefulness of the health information provided, quality of the program, demographics (e.g., age and gender) of older adults, future health topics of interest to them, and how they learned about the event. Older adults were also asked to voluntarily report their contact information (name and telephone number) and if they wished to participate in a research volunteer registry for health research. More recently, researchers decided to expand recruitment efforts for the registry to include soliciting new participants at the annual health reception. To protect confidentiality and anonymity in soliciting older adults' participation at all community outreach activities, older adults reported their contact information on a separate sheet from evaluation feedback.

Second, the HBEC used older adults' contact information to conduct a follow-up interview in order to gain their consent to enroll in the research volunteer health registry. Specifically, a HBEC's research staff or older adult volunteer trained by the staff conducted a follow-up telephone interview after identifying themselves by name and their affiliation with the University's HBEC. Prior to conducting this interview, interviewers informed older adults about the purpose of the interview: to question older adult Detroiters about their health status and health needs and create a voluntary group of potential research participants. Interviewers also

administered oral consent to each potential participant. This included informing them of the voluntary nature and confidentiality of their participation, their freedom to withdraw any answer or to end the interview at any point in the process. They were also provided information for the appropriate University Institutional Review Board (IRB) should they desire to contact them. All academic researchers, HBEC staff, CAB members, and trained older adult volunteers involved in the recruitment process completed Wayne State University's IRB Certification. Additionally, the HBEC also employed indirect recruitment procedures, including local radio and television announcements, dissemination of a semi-annual HBEC newsletter with information highlighting community outreach and research activities, and referrals by CAB members and older adult volunteers.

Logic Model: Recruitment Processes and Outcomes

A logic model in Figure 1 served as the organizing framework through which we identified community outreach activities and assessed relationships between activities and outcomes in the process of recruiting older urban African Americans for inclusion in a research volunteer registry. That is, the logic model served as a methodological and communication tool for clarifying how the community partnership activities between older community residents and academic researchers facilitated the recruitment processes and outcomes. These recruitment processes and outcomes in the logic model are represented retrospectively.

Critical elements of the logic model were resources, activities, and immediate as well as short-term recruitment outcomes. Arrows between boxes in Figure 1 suggest "causal" relationships among different elements of the logic model that we assumed led to immediate and short-term recruitment outcomes.

Resources were human and financial inputs that supported the HBEC community-based partnership comprised older African Americans, academic researchers, community outreach specialist, CAB, older adult volunteers, service agencies, and sponsors. Older African Americans could perform multiple roles, such as participate in community outreach events and serve as CAB members and older adult volunteers. Academic researchers included the HBEC director, principal investigators of the Michigan Center on Urban African American Aging Research, community core directors,

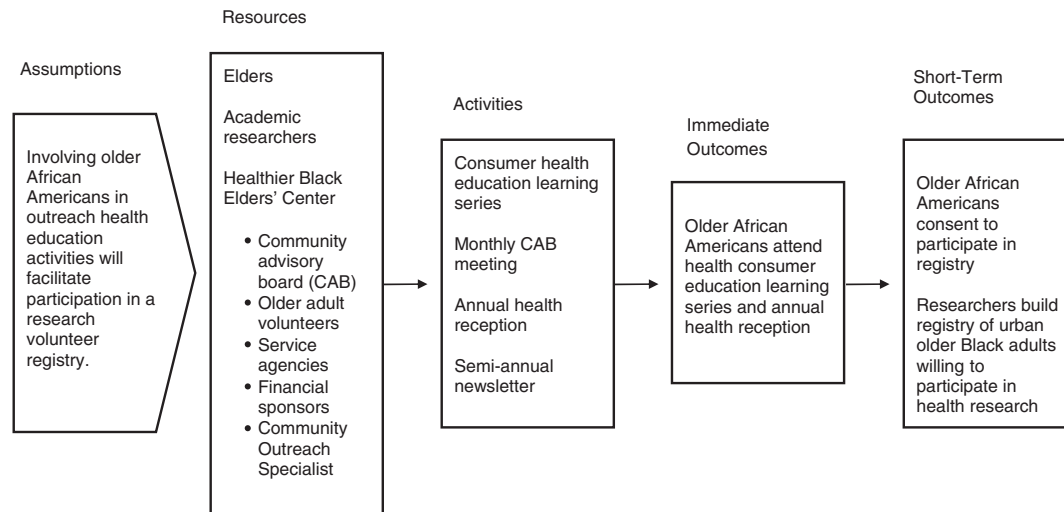


Figure 1. Logic model illustrating the recruitment process for building a volunteer registry within the Healthier Black Elders Center.

and research pilot investigators. The HBEC director, a city resident, had primary contact with the CAB and older adult volunteers, serving a mediating role between the two centers and the community. The community outreach specialist, a city resident and paid employee, was responsible for coordinating and implementing the health education offerings. The CAB consisting of 10–12 members generally comprised older African Americans—community residents, professionals, and members of service organizations. CAB members were typically selected based on their past (if retired) involvement or active involvement in a professional or volunteer role with a community service organization as well as prior work experiences with older African Americans. A CAB member's role included partnering with the HBEC in its efforts to implement consumer education offerings and the annual health reception facilitating the enrollment of older African Americans in the research volunteer registry. Additionally, CAB members served on the volunteer registry's oversight committee, assisting HBEC researchers in reviewing proposals requesting access to registry participants.

Ten to 12 older adult volunteers, recruited via CAB members and also known as senior aides, offered support, particularly during the annual health reception. Once they were affiliated with the HBEC, some older adult volunteers moved to the role of CAB member. Because of local ties to the community, the involvement of both CAB and older adult volunteers in the HBEC served to enhance the integrity of the research partnership between academic researchers and older adult

community residents, which, in turn, served to facilitate their recruitment into the research volunteer registry. Service agencies played a critical role in the recruitment process, providing health information and health screening on site at the HBEC annual health reception. Financial sponsors (e.g., Blue Cross Blue Shield of Michigan and Detroit Medical Center) made this annual health event possible through financial support that defrayed costs of the annual health reception. Media sponsors—local radio and television stations—made public service announcements and interviewed the director of the HBEC about its programs.

Activities in Figure 1 were actions or events necessary to produce expected immediate and short-term recruitment outcomes. Four key activities of the HBEC were antecedents of recruitment outcomes.

First, a series of six or more consumer health education offerings developed collaboratively between HBEC staff and CAB members occurred throughout the year at different community sites. In 2009, nine educational offerings were held at senior residential settings, local churches, social service agencies, and a community activity center—all locations within the inner city to more easily target potential enrollees for the research volunteer registry. Topics of these educational offerings included caregiving, skillful aging, aging gracefully, women's aging, and health care reform.

Second, CAB members met with academic researchers and HBEC staff at least quarterly and with directors of the Community Core at least monthly during the planning phase of the annual health reception to provide advice about HBEC activities. For example, CAB members planned and

helped execute the annual reception, providing input on speakers and topics and deciding the location.

Third, the annual health reception held in the inner-city of Detroit since 2003 focusing on health topics offered health screening and provided support to the community in return for its support of the HBEC. Registration counts and seating capacity for the annual health reception since its inception, when it attracted approximately 400 registrants, have indicated increased attendance over the seven-year period. Due to this sustained increase in attendance, HBEC staff, academic researchers, and the CAB decided in 2008 to require preregistration of attendees to prevent overcrowding and maintain program quality.

Fourth, the HBEC disseminated a semiannual newsletter to all stakeholders with information announcing health education offerings and opportunities for older African Americans to participate in health research. Also included were special articles on CAB members, volunteers, HBEC staff, and academic researchers. Newsletters were also posted on the Institute of Gerontology's Web site.

Outcomes in Figure 1 were expected results from program activities (see [McLaughlin & Jordan, 2004](#)) that included community outreach activities. Figure 1 describes immediate outcomes as the number of older African Americans attending the Healthcare Consumer Learning Series Offerings ($N = 388$) and the number of older African Americans participating in the annual health reception (estimated $N = 1,100$).

Sample and Measures

Available data on two immediate process outcome measures came from a purposive sample ($n = 541$ of approximately $N = 1,100$) of older urban African Americans (age 60 years and older) participating in the 2009 annual health reception and completing a self-administered evaluation questionnaire. Approval for data collection at the annual health reception was granted by the Wayne State University IRB. Health reception participants were predominantly African American (96.3%) and female (87.4%), with a mean age of 71.7 years ($SD = 7.4$; range = 60–98 years). One immediate process outcome measure was operationalized as those participants who reported attending or not attending the annual reception for two consecutive years. It was derived from an evaluation question asking participants whether they attended last year's reception. Another immediate process

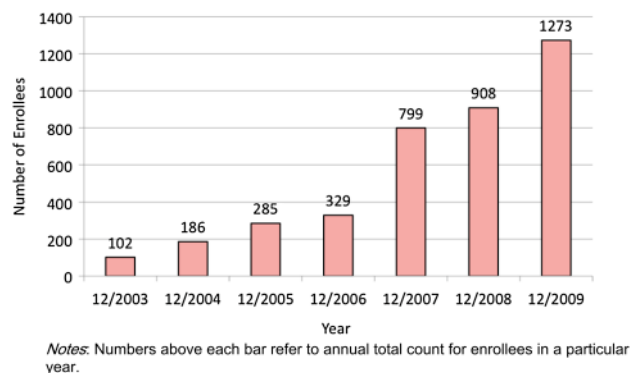


Figure 2. Annual total count for elderly enrollees in volunteer registry, ending December, 2003 through ending December, 2009.

outcome measure was derived from an evaluation question that asked participants about the number of community health learning series they had ever attended. Results of an independent sample t test showed that among older African Americans attending the 2009 annual health reception for two consecutive years (2008–2009) and those who had not attended for two consecutive years, the former group attended a significantly higher number of health education offerings than the latter group ($M = 2.5$, $SD = 1.4$; $M = 1.1$, $SD = 1.3$, respectively; $t = 10.96$, $p < .05$).

Short-term outcomes in Figure 1 were those benefits most closely associated with immediate outcomes (see [McLaughlin & Jordan, 2004](#)), which equated to gaining older African Americans' consent to enroll in the research volunteer registry. They provided an indicator for how well the HBEC accomplished its key objective—building a volunteer registry of urban older African Americans willing to participate in health research.

Results

Figure 2 shows that the annual total count of enrollees participating each year in the research volunteer registry of older adults grew each year over seven years. Paralleling the seven years in which an annual health reception was held, enrollees in a research volunteer registry increased from 102 to 1,273 enrollees, representing more than a 10-fold increase. The percentage change in enrollees between any given years was 82% for 2004, 53% for 2005, 15% for 2006, 143% for 2007, 14% for 2008, and 40% for 2009. Enrollees in the 2009 registry, 60 years of age or more, were predominantly African Americans (99.7%), women (92.5%), and ranged in age from 61 to 97 years with a mean age of 74.9 years ($SD = 8.1$).

To determine whether older African American enrollees in a volunteer registry were more or less representative of older African American inner-city Detroit residents, we compared data on gender and age of enrollees, 60 years of age and older, in the volunteer registry to a sample of African Americans in a population-based random city survey of noninstitutionalized community-dwelling older Detroit adults (Chapleski, 2002). Women were overrepresented in the 2009 registry versus the city survey (92.5 vs. 70.0, respectively). However, older African American enrollees in the registry and those in the city survey had a similar age (74.9 vs. 71.0 years, respectively).

Although not the focus of this study, data in Table 1 suggest that building a research volunteer registry facilitated the conduct of health-related research. Researchers conducting nine studies accessed and used the registry between 2005 and 2009. An example of this research is a 2005 study published in the *Journal of Transcultural Nursing* entitled “Recruitment of Three Generations of African American Women into Genetic Research” (Taylor, 2009).

Discussion

Using a community-based participatory research framework and adapting methods of program evaluation to examine recruitment processes and outcomes within the HBEC, this study addressed the question: How does a community outreach partnership between older residents and academic researchers of the HBEC facilitate the recruitment of older urban African Americans for a research volunteer registry? Overall findings about the

community outreach partnership, recruitment processes, and immediate as well as short-term outcomes pinpoint two results that may serve as part of a useful strategy for enrolling older adult urban African Americans into a research volunteer registry.

First, regarding recruitment processes as an immediate outcome articulated in a logic model, we found that older African Americans who had attended the annual health reception for two consecutive years compared with those who had not attended for two consecutive years attended a significantly higher mean number of health education offerings. Because this immediate outcome served as an antecedent of a short-term outcome—building the research volunteer registry—we speculate that this finding provides indirect evidence for linking specific community health education outreach efforts to this study’s short-term recruitment outcome. More specifically, this finding may mean that health education offerings provided an initial opportunity for academic researchers to recruit older African Americans into the volunteer registry after collecting contact information and conducting a follow-up telephone interview to gain consent for enrollment. Older African Americans’ more frequent attendance at educational offerings and their participation at an annual health reception meant greater exposure to information on opportunities to enroll in the volunteer registry. Greater exposure to recruitment information and more frequent contact with outreach staff and CAB members may have also influenced older African Americans’ decision to enroll in the volunteer registry. Although these explanations are plausible, more research is needed to establish any

Table 1. Utilization of the Volunteer Registry of Older Urban African Americans by Year, Study Title, and Participants Accessed and Used

| Year | Study title | Participants | |
|------|---|--------------|------|
| | | Accessed | Used |
| 2005 | Hypertension and Heredity: Genetic Polymorphisms in Three Generations of Urban African American Women | 180 | 45 |
| 2006 | Aerobic Functioning and Mobility Performance in Older Adults | 49 | 47 |
| 2006 | Health Disability and Cognitive Functioning in Urban Black Older Adults | 215 | 49 |
| 2007 | Assessment of Screening for Colon Cancer in the Elderly | 41 | 10 |
| 2007 | Exploring Health, Ancestry, and Lung Epidemiology (EXHALE) | 300 | 144 |
| 2008 | Comparing Health Trends of Older African Americans in Detroit with National Data | 130 | 51 |
| 2008 | Memory Training: Factors Underlying Success and Transfer with National Data | 52 | 1 |
| 2009 | Promoting Healthy Aging Among African American Elders Study | 20 | 7 |
| 2009 | Michigan Alzheimer’s Disease Research Center (MADRC) Study | 6 | 3 |

Note: Accessed = number of potentially eligible cases; used = number of cases reported as consented participants.

effects that older African Americans' participation in community outreach events may have had in influencing willingness to enroll in a research volunteer registry. For instance, as a reviewer suggested, whether older African Americans who participate in more annual health receptions also participate in more community outreach activities and whether their multiple participation in these events results in the consent to enroll in the volunteer registry are unanswered empirical questions for future examination.

It is important to place this study's immediate outcome about participation of older African Americans in multiple outreach health education activities within a community-based participatory framework. We speculate that older adult African Americans' motivation for participation in both the health education learning series and the annual health reception was likely due to the visible involvement of older adult peers on the advisory board and as volunteers. Elements of the community-based partnership involving key stakeholders, such as CAB members and older adult volunteers, may also have facilitated enrollment of older African Americans in a research volunteer registry. To a lesser degree, but no less important, such stakeholders as service agencies and financial sponsors may also have facilitated enrollment of older African Americans in a research volunteer registry.

Second, regarding short-term recruitment outcomes articulated in a logic model, longitudinal data show that the number of enrollees in the volunteer registry increased more than 10-fold over seven years. Because both the annual health reception and the registry were events that cooccurred over the same period, this finding provides credible evidence for linking the annual health reception as an immediate outcome to building a volunteer registry, a short-term outcome.

We speculate that growth in the volunteer registry over seven years may indirectly be associated with the annual health reception and the education learning series, given participants in the education learning series were eventually recruited not only as participants for the annual reception but also as enrollees for the registry. Provisional evidence about the annual health reception supports this speculation. Based on the seating capacity data for the annual reception's venue, the annual health reception attracted approximately 400 participants in 2003 when the volunteer registry enrolled slightly more than 100 participants. Continuous increases in attendance at the annual health reception

resulted in members of the HBEC CAB, acting in conjunction with volunteers, and HBEC faculty and staff preregistering potential attendees for the first time in 2008 to prevent overcrowding and maintain program quality. Preregistration and seating capacity data of the venue for the 2009 annual reception indicated an estimated 1,100 attendees. Other aspects of the annual health reception, such as the increased number of health vendors available to conduct health screenings of older adults during 2008 and 2009, may also have served as an incentive for increased participation in the volunteer registry. Socialization with older adult peers who had enrolled in the registry may have also led to an increase in number of enrollees in the registry. The large increase in enrollees particularly between 2006 and 2007, when the number of registry enrollees more than doubled, may be explained by enlistment of a research staff person that the HBEC employed to assist the community outreach specialist with timely follow-up of potential enrollees.

Limitations and Future Research Directions

In order to move this study beyond a "gray box" evaluation to a "clear box" evaluation—one in which we more fully understand how community outreach health education activities had an effect in producing recruitment outcomes (see [Scriven, 1994](#)), an experimental group design is needed. A quasi-experimental-interrupted time series design (see [Reichardt & Mark, 2004](#)) would allow for collecting baseline as well as multiple observations. This design would also allow us to test the applicability of the logic model for drawing causal inferences about how resources and community outreach activities link to immediate outcomes and how these outcomes, in turn, link to building a research volunteer registry. More research is needed to show how a volunteer registry compares with other recruitment strategies in terms of cost and effectiveness as one reviewer suggested. We did not collect systematic data on recruitment barriers. Some older adults did not consent to participate in a follow-up survey that aimed at enrolling them in the volunteer registry, even after they provided contact information at a health education event. This observation suggests a recruitment barrier. Measures of recruitment processes and outcomes were limited to data collected from an evaluation of the annual health reception. Future research should address the

collection of more and better quality measures as well as address potential recruitment barriers.

Conclusions

Despite limitations, this study leads to specific conclusions about lessons learned from efforts in building both a community outreach partnership and a research volunteer registry. The logic model specifying resources, activities, and outcomes in building a community-based partnership and a volunteer registry for health research provides a useful conceptual lens for capturing both programmatic efforts and recruitment processes retrospectively. The logic model will further serve as a useful research planning tool that will permit the present researchers to go beyond this retrospective process evaluation. Most important, they will use knowledge learned about the recruitment processes and outcomes as baseline information in planning a more comprehensive and rigorous future evaluation. For example, descriptive results for immediate process outcomes represented in the logic model will be used to examine whether the involvement of older African Americans in multiple community outreach activities may result in their greater likelihood of enrolling in the volunteer registry.

Other researchers accessed and used registry enrollees in health-related studies. Because the use of the registry for research was not the focus of the current article, future research should evaluate the registry's usage for any recruitment outcomes associated with it.

In conclusion, targeted community outreach as health education to underrepresented groups that aims to build a volunteer registry for health research may be a promising strategy for addressing recruitment disparities in African Americans' research participation. Overall findings of this study concur with prior studies emphasizing the importance of using a community-based participatory research framework in community and academic research partnerships involving older minority persons in research (Arean et al., 2003; Levkoff & Sanchez, 2003; Reed et al., 2003). When viewed through the lens of this framework, the successful involvement of older urban African Americans in community outreach activities as well as in recruiting them for a research volunteer registry is benefited by the commitment of academic researchers to engage older adult community members as role models in an equitable partnership.

Funding

This study was supported by funding under Grant P30 AG015281 to the MCUAAAR from the National Institute on Aging, the Resource Centers on Minority Aging Research and National Institute on Minority Health and Health Disparities.

Acknowledgments

We thank the CAB of the HBEC for its wise counsel, assistance, and support. We thank the anonymous reviewers of this manuscript for their thoughtful feedback on an earlier version of this manuscript. Brian Krenz, Syed Hussain, Jane Rafferty, Phyllis Stillman, Denise Stinson, and Terri Torkko provided technical support.

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