

**NATIONAL INSTITUTE OF SENIOR CENTERS (NISC)**

**NEW MODELS OF SENIOR CENTERS  
TASKFORCE**

**FINAL REPORT**

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## **Aims of the Study**

The New Models Taskforce was created by the Delegate Council of the National Institute of Senior Centers (NISC) in 2006. The aims of the Taskforce were to:



- Identify examples of new models in the senior center field
- Envision senior centers of the future
- Position NISC as the leader in defining the 21st century senior center
- Disseminate what we learned

## **History of the Taskforce**

The idea for a New Models of Senior Centers Taskforce was initiated by NISC Chair, Bob Pitman. The Taskforce was created in March 2006 and Peter Thompson was appointed as the Chair of the Taskforce. The Taskforce was developed by recruiting senior center leaders from around the country via the NISC network. This helped ensure the breadth, experience, and wisdom of the senior center field was represented on the Taskforce. The research project was launched in the fall of 2006 and data collection continued through January 2007. Data analysis was conducted in February 2007 and an initial report was presented to NISC Delegate Council in March 2007. A preliminary final report was presented at the ASA-NCOA Joint Conference in March 2008. At that time Kathy Sporre was appointed co-chair of the Taskforce to help lead completion and dissemination of the report. This final report was submitted to NISC in March, 2009.

## **Membership of the Taskforce**

- Comprised of 21 members - included 6 NISC delegates; 2 former delegates
- Geographic Distribution of Taskforce Members:  
Arkansas, Connecticut, Georgia, Indiana, Maryland, Michigan, Minnesota, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Utah, Virginia, Washington.
- Significant diversity in terms of size, funding, structure and Rural, Suburban, Urban representation.



## **Senior Centers: A Literature Review**

### *A) The Evolution of the Definition of Senior Centers*

Senior centers have evolved in terms of their purpose and grown more sophisticated in the nature of services provided over the last 6 decades. Starting with the William Hodson Senior Center established in 1949 in New York, senior centers have expanded their programs and services and have managed to diversify the clientele served. This change can be illustrated more clearly by tracing the evolution of the definition of senior centers over the century.

In the aftermath of the White House Conference on Aging in 1961, Maxwell (1962) defined senior centers as:

“A program of services offered in a designated physical facility in which older people meet at least two days or more each week under the guidance of paid leaders performing professional tasks. The basic purpose of senior centers is to provide older people with socially enriching experiences which would help preserve their dignity as human beings and enhance their feelings of self-worth” (as cited in Krout, 1998, p.2).

After the enactment of the Older Americans Act of 1965, the “program of services” as referred to by Maxwell was further refined by Frankel (1966) who defined a senior center as:

“A physical facility open to senior citizens at least five days a week and four hours a day, year round, and operated by a public agency or a non profit organization with community planning which provides under the direction of paid professional leadership three or more of the services for senior citizens listed below:

1. Recreation
2. Adult Education
3. Health
4. Counseling and Other Services
5. Information and Referral Services
6. Community and Voluntary Services” (p. 23).

A scrutiny of the language and terminology of this definition reveals the influence of the Older Americans Act of 1965 and its description of services to be funded under this law (OAA, 1965). Each of the six services listed was funded by the OAA through various Titles, but the OAA did not identify all the services as being provided by senior centers alone. The stipulation that a senior center be in operation year-round and at least 5 days a week was in response to the funding requirements of the Act, while the need for a public or private nonprofit agency to include communities in planning for services was inspired by the OAA’s emphasis on localized policy planning. The OAA envisioned that local citizens (the community elderly and the others) would be in the best position to decide and define the need for specific services and help prioritize the needs for the funding agencies.

The Older Americans Act was amended several times from 1965 to 2000. However, the term "multipurpose senior centers” was first used in legislation in the Amendment of 1973. Under Title V, Section 501(c), legislators and policy makers addressed the need for the establishment and continued support of multipurpose senior centers and defined a senior center as “a community facility for the organization and provision of a broad spectrum of services

(including provision of health, social and education services and provision of facilities for recreational activities for older persons” (OAA, 1973, Title V). The 1978 amendments to the OAA referred to senior centers as possible “focal points” in the delivery of services to the elderly for the first time thus emphasizing the need and significance of senior centers in public policy.

The National Institute of Senior Centers was established in 1970 and elected a delegation of representatives to represent the senior center lobby at the White House Conference on Aging in 1971. As the membership of NISC grew and the need to spell out the function and form of senior centers increased, the NISC offered the following definition in 1978, following another amendment to the OAA:

“A senior center is a community focal point on the aging continuum where older persons as individuals or groups come together for services and activities which enhance their dignity, support their independence, and encourage their involvement in and with the community” (Lutz, 1993, p. 2).



The NISC identified the types of programs and services provided by senior centers to include services and activities in such areas as education, creative arts, recreation, advocacy, leadership development, employment, health, nutrition, social work and other supportive services. The areas of leadership development and employment for the elderly were inspired by funding provided directly under the OAA for such programs. Nutrition programs were also emphasized for low-income elderly and rural populations under the Amendment of 1973 and senior centers were contracted to serve congregate meals in their facilities. Title XX of the Social Security Act that addressed the needs of individuals (not just the elderly) with limited income and means of support was also utilized for the funding of nutrition programs at senior centers. Current amendments to the OAA (2000) have prompted

senior centers to expand their definition and diversify their programs and services. The current definition of a “multipurpose” senior center describes the center as a focal point for the delivery and coordination of a combination of programs and services, which may include:

- meal and nutrition programs
- information and assistance
- health and wellness programs
- recreational opportunities
- transportation services
- arts programs
- volunteer opportunities
- educational opportunities
- employee assistance
- intergenerational programs
- social and community action opportunities
- social daycare
- adult daycare
- Ombudsman program
- Support services for caregivers (AoA, 2000).



As stated earlier, many senior centers have expanded their services and programs in order to qualify for greater funding from public sources, especially through the OAA appropriations. Many senior centers that have been identified by their local AAA’s (Area Agencies on Aging) as focal points, and are required to provide a comprehensive list of programs and services either directly or through the establishment of linkages and service contracts with other community-based organizations. The reason the author is reiterating the terms of the OAA and its subsequent amendments is to highlight the evolution of public perception of senior centers, their purpose, and their relevance to the aging services field.

### *B] Types of Senior Centers*

The 1960’s and 1970’s witnessed the greatest expansion of senior centers in the history of this country. Frequently authors have referred to this period as the “golden age” of the senior

center movement. As the number of senior centers grew, so did the diverse nature and types of programs and activities offered by them. The senior centers themselves were diverse and differed from one another in terms of facilities, operations, funding, services offered and clientele served. Many writers and researchers have attempted to classify senior centers in order to differentiate and understand the nature and significance of senior centers.

Jordan (1978), an architect, wrote in his report on senior center design that senior centers could be classified upon the basis of their physical facilities. They could be identified as donated, shared, renovated, or new (Krout, 1998, p. 6). Maxwell (1962), quoted earlier for his groundbreaking definition of senior centers, classified them on the basis of number of services offered as either single service or multi-service (p. 5). Leanse and Wagener (1975) differentiate between senior centers based on size of facility, as well as the diversity of services and programs offered. They classified senior centers as multipurpose senior centers, senior centers, senior clubs or programs with special activities for the elderly (p. 39). Ralston (1983) based her classification on the nature of services offered such as multipurpose senior centers, congregate meal/nutrition sites or senior clubs (p. 80).

Cohen (1972) wrote a report for the National Council on the Aging in which he suggested specific criteria to differentiate and classify senior centers. The three criteria proposed are: activities generated (activities, services, individual services and casework or a combination); administrative (centralized, decentralized, combined or multiple location of services and/or facilities); and origin of services (center staff only or center staff and other agencies) (p. 14).

Taietz (1976) identified two basic types of senior center models: the social agency model and the voluntary organization model (p. 219). Litwin (1987) concurred with Taietz (1976) and believed that each model of a senior center served a unique but different purpose: the voluntary

participation model of senior center (such as senior clubs) provided older persons access to social and recreational opportunities, while the social service agency model focused on providing much needed services to the poor and frail elderly (cited in Wagner, 1995, p. 5). Krout (1998) agreed that the social service agency served primarily the poor and disengaged populations that are in need of services to meet their basic survival needs. On the other hand, he added that the voluntary organization model tended to attract relatively affluent, better educated and socially active elderly populations. This model focused on recreational and educational programs that allowed for greater self-expression and social action (p. 98).

### *C) The Age Divide in Senior Center Utilization*

The population of people aged 65 and over has steadily increased in the last century. According to the U.S. Bureau of the Census (2000), in 1900, people over 65 accounted for 4% of the total U.S. population. In 2002, this cohort group accounted for 12.4% of the total U.S. population, which are approximately 35 million people (AARP, 2002). While in 1900, one in every twenty-five Americans was aged over 65, in 1996; one in every eight Americans was aged over 65. By 2030, the population aged 65 and over will account for roughly 20% of the total population (Hooyman and Kiyak, 1998; Wacker, Roberto & Piper, 2003).



Since the growth in the population of the elderly has not been rivaled by any other age group in the U.S. in the last 100 years, several reasons have been attributed to this expansion. According to Hooyman and Kiyak (1998), the life expectancy of Americans has increased steadily from 47 years in 1900 to 79.5 years for women and 72.5 years for men in 1996 (p. 10).

It is estimated by AARP that life expectancy for individuals will increase to 82.6 years by the year 2050 (p. 10). The authors attribute the increase in life expectancy to the advances in medical technology, drop in infant mortality rates and rapid improvement in health care for the general population.

With the growth in the general population of people aged 65 and older, there is also a greater awareness of the differences within this cohort group. Some gerontologists have created specific categories to describe the various sub-groups within the elderly population. For instance, Beisgen and Kraitchman (2003) identify the following segments of the elderly population based on age:

- 1) *The GI generation*: Born between 1901 and 1924, their history included World War I and the Great Depression. These individuals are civic-minded, a generation of achievers with a powerful work ethic and a sense of duty.
- 2) *The Silent generation*: Born between 1925 and 1945, their history included World War II, the Korean War and the Cold War. This cohort experienced civil rights, sexual liberation, steadily rising affluence and the highest birthrates in U.S. history. Their nostalgia for youth has fueled a booming market in dietary aids, health and fitness activities, plastic surgery and social activities encompassing adventure.
- 3) *The Baby Boom generation*: Born between 1943 and 1960, they will become the largest group of elderly cohorts. They have been witnesses to the Vietnam War, Woodstock and Watergate. This group has experienced the narrowing of sex-role distinctions, dual-income households, and higher levels of education and income and better standards of living than their predecessors (p. 30).

Binstock (1994) subdivided the elderly population into the following three categories:

- 1) Young Old (65-74 years)
- 2) Old-Old or Middle Elderly (75-84 years)
- 3) Oldest Old or the Frail Elderly (85 and older) (p. 21).

Currently, the young old comprise 56% of the total elderly population, while the oldest-old comprise 11% of the population. However, this demographic distribution is likely to change in the coming decades. As people live longer and healthier lives and the baby-boom generation ages, in the year 2050, the young-old will comprise 44% of the total elderly population. The biggest increase will be in the population of the frail elderly who will comprise 23% of the elderly population (AoA, 2002). Thus, any programs or

services offered to the elderly population will have to take into account the differences within the aging cohort, as well as the specific needs of each sub-group. Gerontologists argue that the oldest-old represent the population of the elderly in greatest need for supportive services that are



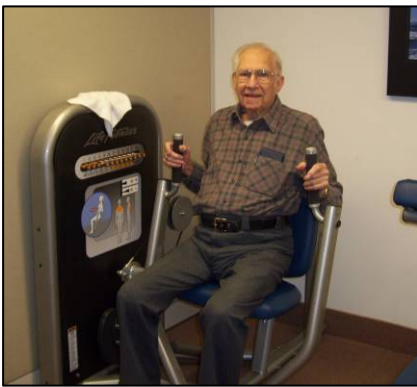
routinely provided by senior centers. They point out that the younger generation of the elderly (the young-elderly) is relatively more affluent, better educated and less in need of social services (Foot & Stoffman, 1998). They believe that senior centers must develop and implement programs and services that address the needs of this older sub-group of the elderly (Lutz, 1994, p. 2). However, senior center directors and administrators argue that if they focused their resources on serving the needs of the frail elderly, they would lose their younger cohorts, and as a result, their centers would cease to exist when the current membership became immobile or passed on.

There is no clear answer to the question of the relationship of age to senior center participation. Several studies have produced conflicting results. Some researchers found that senior center participants were primarily in their 60's (Storey, 1962; Harris and Associates, 1975). Other studies indicate that the "young-old" are under-represented in senior centers. Several researchers have found that current senior center participants comprise the middle-elderly (75-84) and their older cohorts (Aday, 2003; Beisgen & Kraitchman, 2003; Krout, 1990; Miner, Logan & Spitz, 1993; Wacker, Roberto & Piper, 2003). With respect to the oldest-old (aged 85 and over), Cox and Monk (1990) reported that the average proportion of frail elderly among senior center participants was 10% (p. 144). None of the studies described here have specifically explored the age differences between participants and non participants, or the impact of age upon senior center involvement. However, some studies that did explore the relationship of age to senior center participation found no significant differences in age between users and non-users ((Demko, 1979; Krout, 1983; Tuckman, 1967). These latter studies, however, have been conducted using small samples of older adults in single communities.

#### *D] The Growing Diversity of the Elderly and Senior Center Utilization*

Concurrent with the growth of the elderly population, there will be greater heterogeneity and diversity among this group of people aged 65 and over. Currently, 5.6% of Hispanic Americans and 8% of African Americans are aged 65 and over (AoA, 2002). But according to Hooyman and Kiyak (1998), "the proportion of older persons is expected to increase at a higher rate for the non-white population, partly because of the large proportion of children in these groups, who unlike their parents and grandparents, are likely to reach old age" (p. 18). According to Beisgen and Kraitchman (2003), the minority elderly currently comprise 21.8% of

the OAA- Title IIIB service recipients (p. 4). There is a growing body of research regarding the acculturation patterns of immigrant elderly which shows that a significant majority of minority elderly prefer to live in homogenous, urban neighborhoods (Appleby, Colon & Hamilton, 2000). Wagner (1995) believes that this growing ethnically and racially diverse population will provide new challenges to the aging network to create programs that are culturally sensitive and take into account the special needs and differences between the various ethnic groups (p. 18). Nelly Urbach recommended to the National Council on the Aging that intercultural sensitivity training be provided at senior centers to “enhance mutual understanding and respect among different cultural groups” (p. 24). She also added that senior centers needed to develop programs that are



specific to linguistic and ethnic groups as well as increase interaction among various ethnic, religious and racial groups (p. 24). Both authors (Wagner & Urbach) also argue that senior center staff and administrators be trained in cultural sensitivity and must reflect the ethnic and racial diversity of the populations they wish to serve (1995).

The studies regarding minority elderly utilization of senior centers have been inconclusive. Several researchers have found that race was not a significant predictor of participation (Miller, et al., 1996; Calsyn & Winter, 1999; Demko, 1979; Tuckman, 1967). However, Wacker, and Blanding (1994) reported that the degree of participation of minority elderly varied greatly and was dependent on the location of the senior center (p. 12). Ralston and Griggs (1985) studied the impact of race, gender and socioeconomic status on senior center utilization. The authors concluded that Blacks were significantly more committed than Whites to attend senior center programs and that the “lack of interesting programs” was major obstacle to

senior center utilization among the White respondents (p. 99). The study also revealed that African American seniors were significantly more committed to attending senior centers if activities they suggested were offered (p. 107). The authors proposed that senior centers create programs for elderly African Americans that take into account their culture, socioeconomic status, specific needs and kinship ties. They argued that senior center planners take into account not only the heterogeneity of the aged population as a whole, but also the diversity within the aged sub-groups (p. 111). The results of this study were also corroborated by other researchers who found that African Americans were slightly more likely than Caucasians to be senior center users (Harris & Associates, 1975; Mitchell, 1995; Netzer, et al., 1997; Ralston, 1982, 1983, 1984, 1991). Most of the studies cited here comprised of a limited sample of respondents who were active participants in senior center activities (Harris & Associates, 1975; Mitchell 1995; Ralston, 1984, 1991). Two studies undertaken by Ralston (1982, 1983) examined the differences between attendees and non-attendees, with specific emphasis on Black constituents. However, the generalizability of these two studies is limited as they were conducted with a small sample of respondents (N=100) and were restricted to small enclaves of Black constituents in parts of Illinois and Iowa. Netzer, et al. (1997) conducted telephone surveys of approximately 1,000 elderly members of a community to ascertain the level of participation in senior center programs. Their questionnaire ascertained if the respondents were likely to attend senior centers or utilize their services based on their demographic characteristics. However, none of these studies explored the relationship between the availability of culturally diverse programming and the racial and linguistic background of the staff upon the degree of participation among the minority elderly. Most studies reveal that the population of seniors who are bilingual or fluent in a language other than English is growing rapidly. Several researchers have identified the

significance of the growing Hispanic elderly population in the U.S. and their need for linguistically diverse programming (Miles, 1999; Torres-Gil, 1990; Wyckle & Ford, 1999). Researchers have also cautioned senior center administrators to not consider all Hispanic or Asian elderly as one homogenous group, but rather as an amalgamation of differing customs, traditions, values, beliefs, interests, languages, religions and practices. A study comparing the utilization patterns of Hispanic American elderly focused their attention on the Mexican, Puerto Rican and Cuban populations in the U.S. The authors concluded that while there are some basic similarities among these groups, in the areas of the importance of knowledge, need, and income levels, differences were demonstrated between their predictive power and complexity of the



social service utilization models for the three immigrant groups. In other words, there were significant differences in the patterns of attendance and participation in senior center activities among the three immigrant groups studied. The authors summarized that the differences in income, education levels, and economic factors impacted upon the degree of participation among the minority elderly (Starrett et al., 1989, p. 24). Roy, Dietz and John (1996) found that use of senior center programs and congregate meal services were highly correlated for Hispanic elderly. They believed that the Hispanic elderly were more likely to attend a senior center if it provided congregate meals on-site and offered opportunities for socialization with members of their own communities (p. 79). The researchers employed a secondary analysis technique by utilizing data gathered by the 1988 National Survey of Hispanic Elderly People. While this study identified the types of services that Mexican American senior center participants may require or utilize, it did not identify the

reasons for non participation among a large proportion of Mexican elderly, and if any culturally appropriate programming was being offered. Lai (2001) found that Asian elderly were more likely to attend senior centers if they were located in their own neighborhood, offered recreational and acculturation programs in their native languages, and if they themselves were in relatively good health (p. 72). However, this study was limited to a small sample of 97 participants (mainly Chinese immigrants) who participated in a senior center with specific Asian programming and bilingual staff. This study needs to be replicated in other neighborhoods with larger proportions of Asian elderly from diverse cultural and ethnic backgrounds. Nevertheless, this study underscores the need for diverse and culture-specific programming for the diverse elderly population.

Lack of transportation, adequate facilities and relevant programming has been cited as reasons preventing senior center utilization by minority elderly (Downing and Copeland, 1980; Harris and Associates, 1975; Miko & Sanchez, 2001). Other studies conducted by researchers also revealed that the availability of an ethnically diverse staff increases the likelihood of diverse programming and the level of participation among the minority elderly (Ralston, 1991; Wacker, Roberto & Piper, 2003; Wagner 1995). Surveys of senior center administrators have concluded that a culturally sensitive leader is key to the diversification of programs and services in order to increase levels of participation among the minority elderly (Cox, 1991; Dhoomer, 1991; Pardasani, 2004a). One of the chief limitations of these studies is that they do not explore how senior center administrators and leadership have responded to the growing ethnic diversity of the elderly population, or describe the steps taken to create culturally appropriate programming.

### *E] Marital Status, Income and Education and Senior Center Utilization*

With respect to marital status of participants in senior centers, Leanse and Wagner (1975) found a larger number of users were widowed (45%) than non users (31%) (cited in Ralston, 1982, p. 225). Additionally, recent studies of senior center utilization corroborated the earlier findings that most senior center participants are likely to be widowed or single (Aday, 2003; DFTA, 2002). However, other studies conducted show no significant difference in marital status of users and non users (Krout 1983).

Consistent studies have shown that senior center users had lower incomes and levels of education than the current generation of baby boomers (Krout, 1983; Pardasani, 2004c; Turner, 2004).



### *F] The Geographical Distribution of the Elderly and Senior Center Utilization*

The states with the largest percentage of population aged 65 and over are Florida, Pennsylvania, Iowa, Rhode Island, West Virginia, North Dakota, South Dakota, Nebraska, Missouri, Connecticut and Massachusetts (AoA, 2002). Hooyman and Kiyak (1998) summarize that 50% of all persons aged 65 and over live in 9 states: California, Florida, New York, Pennsylvania, Texas, Ohio, Illinois, Michigan and New Jersey (p. 20). Even in the states with a higher than average population of elderly, the distribution of the population is not even. The authors report that 30% of all elderly live in metropolitan areas, 44% live in the suburbs and 26% live in rural areas (p. 20). Due to this unequal distribution of elderly in the country, different suburban

counties, metropolitan and rural regions are faced with the challenge of creating and funding programs and services that meet the needs of the elderly populations in their respective jurisdictions. Area Agencies on Aging, and city, state and federal governments need to respond to the diverse and growing demand for services and programs. Smiley (1995) believes that senior center administrators and lay leadership must collect and analyze demographic data and use needs-assessment tools to determine the relevance and significance of services being currently provided. The results of such studies would also enable senior centers to distribute their resources in a more creative and cost-efficient manner (p. 30).

A study by Sela (1986) found that 32% of a national sample of senior centers was located in rural areas. However, the author pointed out that when the geographical distance of a senior's residence from a senior center was factored in, accessibility to the center had a significant impact on participation among the rural elderly (p. 10). Taietz (1970) conducted an extensive survey of 1280 elderly constituents in 144 New York communities in the form of personal interviews. The goal of the study was to examine the importance of community structure and individual attributes in explaining variances in social integration among the elderly. He found that rural elderly were more likely to participate in nutrition programs at a senior center (34%) than their urban and suburban counterparts (4%) (p. 22). He concluded that this may be a consequence of greater community involvement and interaction among the rural elderly than their rural counterparts. However, May et al., (1976) found no difference in levels of participation between rural and urban elderly (p. 2). While the studies cited here reveal significant differences in the nature and degree of participation between the rural and urban elderly, they have not adequately addressed the interests and needs of the suburban elderly population (a growing segment of the population)

A study of senior centers and participants in rural communities was conducted by Havir (1991) to help identify the criterion for serving this hard-to-reach population. The author identified senior centers in three towns in rural Minnesota and conducted interviews with 70 participants and 42 non-participants. Results revealed that the centers that had been successful in attracting clients and maintaining its membership, had created unique and specialized programs that focused on socialization and relaxation. Formal structures such as those found in the organization of urban centers were avoided. The author concluded that the senior centers in rural areas need to be closely linked to the local community and culture. Havir (1991) urged



administrators of senior centers to create programs and organizational models best suited to each individual community rather than to select a universal model of service (p. 370). This study was significant as the author provided models of service that could be duplicated by senior centers located in rural regions in other parts of the country to increase the level of participation among their elderly constituents. A related study analyzing the case management needs of the rural elderly concluded that most

services were provided in an unlicensed setting with little or no coordination among agencies in a given rural region (Krout, 1993, p. 33).

Kirk and Alessi (2002) evaluated the impact of rural senior centers on the emotional and practical issues affecting their consumers and found that a majority of participants lived alone and identified socialization and meals as the two most important reasons for participation (p. 61). They surveyed 182 participants in four senior centers in rural Louisiana and 93 non-participants from the same region. While this study was instrumental in highlighting the positive effects of

senior centers, it did not explore reasons for participation or non-participation. In the opinion of this author, it is important to examine why some elderly constituents do not utilize senior center services despite the significant benefits to their physical and emotional well-being. Shagoury (1995) also reported that loneliness, information about available services, and the availability of affordable transportation had a significant impact on the levels of participation among rural elderly (p. 41). Calsyn and Winter (1999), however, reported that the elderly in urban regions were more likely to attend senior centers than their rural counterparts, and unlike the rural elderly, they tended to have greater frequency of social contacts outside the senior center and indicated lower levels of loneliness (p. 58). The researchers conducted telephone interviews with 4,903 people aged 60 or older in the state of Missouri. This study identified the differences in the levels of participation among the rural and urban elderly, but did not examine the reason why individuals who experience loneliness and have limited socialization opportunities do not attend senior centers. This finding is contrary to other studies that have shown that both urban and rural participants identified socialization opportunities as a primary motivation for participation (Calsyn & Winter, 1999; Kirk & Alessi, 2002). Krout (1984) conducted a study comparing the utilization needs of the elderly in rural and urban centers. He concluded that the needs of the two groups were mostly the same. However, he identified transportation, access and geographical isolation as some of the hindrances to utilization in rural regions (p. 151). Only four other studies have addressed the relationship between proximity to senior center and utilization. Two of the studies found that participants and frequent users of senior center programs tended to live in close proximity to senior centers and were generally aware of the programs and services offered (DFTA, 2002; Leanse and Wagner, 1975; Tuckman, 1967).

*G] So who participates in Senior Centers?*

In a study (based on data collected in 1984) conducted by Sabin (1993), older, less educated and non-White seniors were found to participate in senior center activities more frequently than their counterparts.



This group of individuals frequent the social agency

model of senior centers in which a center provides supportive services to the elderly in need.

Socially active, ambulatory and middle-income elderly, however, were found to participate largely in senior centers that functioned as voluntary associations (p. 113). Though this study had several limitations, it can be concluded that the different types of senior center models and the diverse ranges of services and programs offered by them help to serve the needs of the diverse population. The data was drawn from a National Health Interview Survey in 1984 and several important variables that could affect participation, such as transportation, specific programs and services, and a needs assessment, were not included.

In a related study conducted by Krout in 1982, older individuals with a higher level of education and income were found to be less inclined to participate in senior center activities. In the study, two major reasons given for the lack of involvement were “being too busy” and “lack of interest” (p. 349). This study raised several important issues. If some older individuals chose not to participate, would it be feasible then to cater senior center programs to meet the needs of low-income, lesser-educated elderly. Would this create a cost-benefit for senior centers and allow better utilization of scarce resources? Krout (1982) hypothesized that the young-elderly were in a position to purchase services from a variety of sources and did not need the senior centers. The findings would help emphasize the current argument for means-testing and cost-

sharing of services among the elderly. A study conducted by Krout (1988a) for the AARP investigated variations and correlations of the frequency, degree of involvement, stability, duration and discontinuation of senior center use. Reasons given for participation centered on the theme of social interaction and companionship. Increase in participation was found to be linked to greater need for companionship and the quality of programs. Decreased involvement was found to be linked to health problems. Former users of senior centers also reported lower levels of life satisfaction and higher degree of isolation. Krout also conducted another study in 1988 that explored issues of participation and stability of senior center attendance. He found that frequency of attendance was directly linked to sex, income, marital status and contact with friends. Duration of attendance was dependent on health, age, and income levels. The most important finding was the importance of health to the degree and frequency of participation (p. 17).

Another longitudinal study conducted by John Krout in 1994 tracked the changes in senior center participant characteristics during the 1980s. In comparing his findings from 1982 to 1989, the author noted that participants in the later study were found to be older, had slightly higher income, and were less healthy (p. 55). This result lends credence to the belief among senior center administrators that their participants are “aging in place” and are not being replaced by their younger cohorts. Krout also hypothesized that the greater the size of the center, budget, and diversity of programs, the greater the diversity of participants. However, one of the major limitations of the study was that it was descriptive and thus the conclusions are somewhat tentative and over-generalized.

Calsyn and Winters (1999) found that senior center users tended to be older (ages 75 and older), rural-based, in relatively good health, and keenly aware of formal service systems within

their community. They found that race, income mental health status and loneliness did not correlate with senior center participation. A 2001 study of Canadian senior center participants reported that senior center participants were more likely to be rural-based, female, living alone and those



who had fewer limitations with their activities of daily living (Strain, 2001). A 2002 study conducted by the DFTA (New York City Department for the Aging) revealed that the average senior center participant is 77 years old, more likely to be female, born in the U.S., English speaking, and to have completed high school. In addition, a majority of the participants were relatively healthy, widowed, and lived alone, although they were socially active within their communities. The survey revealed that most senior center participants lived within walking distance from their senior center and identified socialization as a main criterion for participation. The most commonly utilized services for this urban elderly population were recreational, educational, intergenerational programs, nutrition, transportation and assistance with entitlements. The chief obstacles to participation were cited as bad weather and poor health (DFTA, 2002).

Another recent nationwide study conducted under the auspices of the National Institute of Senior Centers (NISC) investigated the patterns and impact of participation among the elderly in California, Florida, Iowa, Maine, New Hampshire, Texas and Tennessee. The author reported that over 75% of all members indicated that the center had helped them to remain independent and maintain their overall physical health. Socialization was once again cited as the primary reason for participation among the center users (Aday, 2003).

In the most recent studies, Turner (2004) and Pardasani (2004a) have also found that the majority of senior center participants tend to be female consumers older than 75 and that participation wanes as frailty increases. Both authors found that the most consistent attendees have low, fixed incomes and express the greatest need for the congregate meal programs. Turner (2004) also discovered a positive link between availability of transportation and senior center attendance. Both researchers found that participants listed the need for socialization and the type of programs offered as their primary reasons for attending senior centers.

#### *H] Senior Center Programs and Services*

Maxwell (1962) defined the term “program” as “the sum total of all that individuals and groups do in the center and in the name of the center” (p. 118). Leanse, Tiven and Robb (1977) wrote a guide on Senior Center Operation for the National Council on the Aging and define “program” as “a range of services and activities offered to older people who come to the center, plus services based in the center but reaching out to the community’s vulnerable, house-bound and isolated older members” (p. 127). The authors argue that for a senior center program to be effective, seniors must be involved in the development, implementation and evaluation of the program (p. 129). It is assumed that effective programs will enable the members to grow, feel empowered, and meet their needs. The authors also placed great emphasis on recognizing the diversity and differences among the aging populations that senior centers serve. They believe that centers should individualize programs to meet the specific needs, interests and abilities of participants, while recognizing and accommodating age and cultural variations (p. 129).

From their advent in 1943, senior center programs have evolved in their complexity and variety, reflecting their goal to reach out to the broadest cross-section of the aging population.

As the concept and design of senior centers has grown more complex (from a primary purpose of recreation or social service only to more comprehensive, inclusive models), communities have benefited from diverse programming and service choices. Currently, senior centers, recreational clubs, nutritional or meal sites, multipurpose senior centers and community centers co-exist and comprise the spectrum of the senior center universe. Studies conducted by researchers in the last three decades have shown a significant growth in the diversity of programs and services offered (Aday, 2003; Gavin & Meyers, 2003; Krout, 1985; Leanse & Wagener, 1975; Pardasani, 2004a; Skarupski & Pelkowski, 2003). A study commissioned by the National Council on Aging (1975) offered the following data on programs:

- 42% of the senior centers surveyed provided less than 3 services,
- 5% provided less than the three basic services (education, recreation and information referral),
- 31% reported 3 basic services plus volunteer opportunities, and
- 22% reported 3 basic services, plus volunteer opportunities and health services (Leanse and Wagener, 1975, p. 29).



Ten years later, Krout (1985) surveyed a random sample of 755 senior centers and classified the services they offered into 7 categories: access, health and nutrition, in-home support, income supplement, special services, information and assistance, personal counseling and mental health services. Four additional categories of programs (education, leadership opportunities, recreational and volunteer opportunities) were also identified. The mean number of services offered was 11.1 and the mean number of programs offered by the centers was 17.6. Twenty five percent of the centers polled offered between 15 to 17 programs or activities, while 43%

offer 10 to 14 programs. With respect to services, 17% provided 21 to 25 services, 22% provided 16 to 20 services, and only 12% provided 6 to 10 services (p. 467).

Gelfand, Bechil and Chester (1992) conducted a study of senior centers in Maryland to identify a minimum core of services and programs that need to be provided by senior centers. They identified crafts, exercise, information and referral, meals, opportunities for socializing, and transportation as essential to the programming core of any senior center (p. 159). A study conducted by the New York City Department for the Aging (2002) obtained similar results when they reported that lunch, educational programs, recreational activities, health education, fitness classes, information, and case assistance were the most commonly utilized services.

Another nationwide study conducted under the auspices of the National Institute of Senior Centers (NISC) investigated the patterns and impact of participation among older adults in California, Florida, Iowa, Maine, New Hampshire, Texas and Tennessee. The author reported that over 75% of all members indicated that the center had helped them to remain independent and maintain their overall physical health. Socialization was once again cited as the primary reason for participation among the center users (Aday, 2003). A recent survey of 220 senior centers in New York State revealed a diverse array of nearly 48 services and programs that could be broadly categorized as recreational, health, nutritional, volunteer or social services (Pardasani, 2004b). The number and type of programs offered depended on the type of senior center (senior club, nutrition site, recreational facility, adult care, senior centers, etc.) with multipurpose senior centers providing the greatest diversity and number of services (Pardasani, 2004b).

In recent years, there has been a greater emphasis on programs and services related to lifelong learning, technology support, primary health promotion, mental health services, elder abuse prevention, caregiver support and community ombudsman facilitation (Arnold, 2002;

Chaffin & Harlow, 2005; Eaton & Salari, 2005; Ellis, Johnson, Fischer & Hargrove, 2005; Lin & Knapp, 1984; Manigbas, 2002; Miller & Pratt, 2003; Phelan, *et al.*, 2002; Skarupski & Pelkowski, 2003). This expanding roster of services and programs reflects the goal of public funders (federal, state and local) to provide vital preventive services to older adults within their communities to deter or delay long term institutionalization, a significantly more expensive proposition.

### *I] Senior Center Budgets*

The proposed budget allocation for 2009 towards the Older Americans Act was \$1.731



billion, a 10% decrease from 2008. Of this total allocation, \$351,348,000 was budgeted for Supportive Services and Centers (Title III B covering senior centers) and an additional \$758,003,000 towards nutritional programs (congregate and home-delivered meals)

(Congressional Research Service, 2008). A report by the

Congressional Research Service (2008) posits that 9.5 million older adults received a form of service supported by the OAA. If we accept the recent census data of 33 million people over the age of 65, this allocation for community-based services (which include home-based services such as home-health care, health assessments, access and transportation services, as well as senior centers ) worked out to approximately \$10 per older adult person (US Bureau of Census, 2000). Even if we assumed that only 25% of the older adult population would be in need of senior center programs and services, the total expenditure per person works out to \$40 per year.

This per capita allocation is woefully inadequate and incapable of supporting senior centers at their current levels of functioning.

The average proportion of federal contributions to senior center budgets has fallen from 29% in 1982 to 19% in 1990 (Wacker, Roberto & Piper, 2003). At current funding levels, senior centers are not expected into survive to the next decade, if they continue to rely on public funding. It is projected that senior centers will have to increase their reliance on private sources of funding such as foundations, philanthropic organizations, individuals, and quite possibly, consumers in order to meet their fiscal needs (Aday, 2003; Krout 1998; Pardasani, 2004c).

## **Rationale for this study**

Change and innovation are concepts that are hard to translate into practice. While many senior centers across the country find their hands tied due to limited resources and manpower, other senior centers have responded comprehensively and urgently to the rapidly evolving older adult market. Senior centers are trying to adapt their service models to the changing needs and demographic profiles of the older adult population. In their effort to reach out to a broader cross-section of consumers, administrators and managers have undertaken unique, innovative and strategic measures to ensure the sustainability of senior centers nationwide.

The challenges for the senior centers can be summarized as follows:

- (i) Continue to serve the current participants effectively while trying to engage non participating older adults
- (ii) Attract baby-boomers and “younger” seniors
- (iii) Re-conceptualize participation in the new era of increased consumer choices
- (iv) Compete with other community options and alternatives available to senior centers

- (v) Re-invent the image of senior centers and re-position them as community focal points through marketing and outreach
- (vi) Develop strategic partnerships and collaborations with other service providers
- (vii) Re-design and re-building of modern facilities
- (viii) Attract potential funders – individual and foundations – to expand and innovate

(Krout, 1998, Pardasani, 2004c, Turner, 2004, Young, 2006).



Ryzin (2005) surveyed senior center administrators across the United States and reported the following trends:

- (i) Upgrading or re-building of facilities
- (ii) New programming choices that reflect the needs and interests of the non traditional seniors
- (iii) Charging participants for specific services and programs
- (iv) Expanded health and fitness programs, including new fitness centers, evidence-based health education, and programs that match the abilities of the diverse membership
- (v) Expanded inter-generational programming opportunities
- (vi) Innovative partnerships with businesses to expand outreach

Senior centers in many communities are being re-conceptualized as inter-generation community centers, with expanded programs and services for all members of the community to be provided under one roof. The bedrock of these centers is the state-of-the-art health and fitness facilities, as well as opportunities for inter-generational programs, volunteering and civic

engagement. The movement to remake the image of senior centers is reflected in the nationwide, spirited debate over the use of the term “senior centers” (Ryzin, 2005). While some administrators recommend the use of another name to better describe senior centers, opponents argue that moving away from the term may denote shame in who we are (Young, 2006).

Senior center administrators are making a concerted effort to engage with community members, agencies and businesses to ensure greater visibility and name recognition. Many administrators have created or joined regional, state-wide or national coalitions in order to engage in legislative advocacy for the continued support and recognition for senior centers.

Programmatically, there has been a concerted effort on part of many senior centers to assess the leisure patterns and service needs of older adults in the communities they serve. This data is being utilized to create new recreational programs with an increased emphasis on lifelong learning, performing arts, cultural enrichment, health education and financial planning. Where possible, even traditional congregate meal programs are being scrapped in exchange for café-style establishments that promote greater choices (Pardasani, 2004c, Ryzin, 2005, Young, 2006).

In conclusion, innovation and change are permeating through the senior center world. However, constraints of resources, manpower and expertise may inhibit their potential success. Many administrators and managers have asked for successful examples of innovation and would like specific information on the design and implementation of new models of service. There have been very few attempts to catalog and document the various changes that have occurred in our field in the last decade. It is with this deficit in mind that the New Models Taskforce set out to gather data on new models of senior centers.

## **Methodology**

### *a. Questionnaire*

An initial 14-item questionnaire was developed by the Taskforce. This questionnaire asked respondents to provide information on the size and budget of their senior center, as well as to describe an innovative project that they had undertaken. Additional questions attempted to assess the reaction to the innovation from staff and participants, the resources utilized for the project and the outcomes of its implementation. This questionnaire was made available online to potential respondents (*Appendix A*).

A second questionnaire comprising 10-items was developed as a follow-up to the first questionnaire. Respondents with the most significant innovations (based on the criteria listed below) were short-listed. Members of the Taskforce then conducted phone interviews with the selected



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respondents. The second questionnaire was utilized for this follow-up interview. The questionnaire allowed for more in-depth assessment of the innovative project or model, including addressing issues such as feasibility, replication and cooperation from the Board of Directors and/or funders (*Appendix B*).

### *b. Sampling*

The first questionnaire was posted online at a website provided by Indiana University Northwest. An introductory letter (*Appendix C*) was drafted by the Taskforce. This letter explained the purpose of the study and directed potential respondents to the website. The letter

was sent out as an email to all members of the National Institute of Senior Centers (NISC). Additionally, NISC members were asked to forward this email to their colleagues and partners within the senior center field. The email was also sent to the coordinators of various State Associations of Senior Centers and State Departments on Aging. Follow up calls and emails were made to virtually all of the state associations and aging departments to encourage dissemination of the survey. This type of sampling could be best described as a purposive, non random type of convenience sampling. Since it is difficult to assess how many senior center administrators received this invitation, an accurate response rate could not be calculated for this study.

The second questionnaire was administered in-person by members of the Taskforce. Selected respondents, who had also given permission to be contacted, provided follow-up data on their innovative projects or models. Approximately, forty respondents were contacted via this method.

*c. Data Collection Process*

The initial data was collected by an online questionnaire and then transferred to an Excel file. This allowed the authors to conduct an initial data analysis of the sample and categorize the type of innovations. The initial criteria used to assess whether a project or model was innovative were:

- Approach or Style of Innovation
- Degree of Innovation
- Significant Impact of Innovation
- Sustainability of Innovation

- Replicability of Innovation
- Measurement Methodology

After a careful review of all submissions by the taskforce members, 35 senior centers were short-listed for further study. The short-listed respondents were then contacted via telephone by members of the Taskforce to conduct follow-up interviews. This data was tabulated in an Excel file and the emerging models or trends were summarized. Specific characteristics of the various categories of models were highlighted and resulting definitions of each model were developed.

*d. Sample*

A total of 147 senior center administrators and managers responded to this survey. The sample was quite diverse with respect to size of budgets, and the number of staff and participants. Annual budgets ranged from \$13,000 to \$10 million. The average senior center budget for this sample was \$325,000. The number of participants served ranged from 50 to 10,000, with the majority of the respondents reporting a few hundred participants (150-800). The number of staff ranged from 1 to 130, with the majority of senior centers reporting very small staff loads (1-5). The following is a breakdown of the number of respondents by state (in descending order of responses)-

Minnesota	22
Michigan	13
California	12
Massachusetts	11
Florida	9
Pennsylvania	9
Kansas	7
Georgia	4

Utah	4
Tennessee	4
West Virginia	4
North Carolina	4
Connecticut	4
New Hampshire	3
South Carolina	3
Texas	3
Maryland	3
Ohio	3
Arkansas	2
Indiana	2
New York	2
Arizona	2
Delaware	2
Illinois	2
South Dakota	2
Kentucky	2
Rhode Island	1
Nevada	1
Washington	1
Virginia	1
Oregon	1
Colorado	1
Vermont	1
Maine	1
Iowa	1



## **Findings**

Based upon the initial and follow-up interviews with survey respondents, some broad patterns of models emerged. The Taskforce identified eight, specific, emerging models of senior centers. The defining characteristics of each model were delineated and highlighted.

***Note:** The Taskforce does not make any claims that these are the only emerging models available in the United States. Due to the limited number of respondents and the sampling method, the sample may not be representative of the senior center field across the nation. The members of the Taskforce also believe that there are several overlapping characteristics between*

*the models and that they are not mutually exclusive. In fact, many senior centers represent more than one model or exhibit the characteristics of several models. To facilitate this process, we have attempted to define senior centers by their most significant characteristics. It is our hope that these models provide guidance and a framework for other senior centers as they embark on their individual process of innovation.*

The following are the eight models of emerging senior centers as highlighted by our nationwide study:

- Centers of Excellence
- Community Center
- Wellness Center
- Lifelong Learning/Arts
- Continuum of Care/Transitions
- The Next Chapter
- Entrepreneurial Model
- Café Model

We will now provide the defining characteristics of each model, and discuss their impact on the older adults and communities served by them, as well as provide examples from field:

## **I. CENTERS OF EXCELLENCE MODEL**

The defining characteristics of such senior centers are their drive to:



- Meet the highest standards of excellence, primarily as identified by NISC accreditation
- Apply for state association of senior centers' accreditation
- Operate as nonprofit centers that meet state nonprofit standards
- Apply for recognition from nonprofit and governmental centers, eg., the Malcolm Baldrige National Quality Award
- Hire and support directors with higher education and/or management certificates
- Promote continuous improvement, adaptability, and strategic management

### **Example #1: Fergus Falls Senior Citizens Program, Inc., Fergus Falls, MN**

The Fergus Fall Senior Citizens Program, Inc. ([www.ffsenior.org](http://www.ffsenior.org)) has received:

- A Certificate of Excellence in Nonprofit Leadership & Management
- NISC Accreditation and Re-Accreditation
- MN Nonprofit Excellence Award
- Certified Senior Advisor® designation
- Recognition that it meets the Charities Review Council Standards
- Recognition as a Community Leader beyond a Senior Center

### **Example #2: Sartory Senior Center, Coral Springs, FL**

The Sartory Senior Center ([www.coral Springs.org/seniorprograms](http://www.coral Springs.org/seniorprograms)) has:

- Been funded by the City government (Parks & Recreation)
- Led community in a statewide initiative to create “Communities for a Lifetime”
- Created a broad coalition by involving all members of the community in planning and development
- Stopped migration of older adults from rural areas to urban areas to access services
- Demonstrated leadership and civic-mindedness, as a result of which they are viewed as an integral focal point in their community.

### **Impact of the Centers of Excellence Model:**

- Provides planning, evaluation roadmap, risk management for communities they serve
- Increased credibility, accountability, quality assurance, consistency
- Inspiration and increased morale among staff and participants
- Increased Public Relations: recognition, prestige, image, professionalism, press
- Increased Funding
- Builds/increases strategic partnerships, enhances programming
- Stakeholder involvement, development, educates, increases participation
- Senior centers seen as integral and viable models within communities

## II. COMMUNITY CENTER MODEL

The defining characteristics of such senior centers are:

- Diverse and comprehensive programming
- Programming to be offered at multiple sites through partnerships, e.g. 'Centers Beyond Walls'
- Provide inclusive programming and activities for all ages and abilities
- A state-of-the-art health and fitness center
- Programs that encompass health, recreational, educational, cultural, nutritional and social service needs
- Consistent and intensive program evaluation and needs assessments
- Use of alternative names instead of 'Senior Center'



### **Example #1: Fort Collins Senior Center, Fort Collins, CO**

The Fort Collins Senior Center ([www.ci.fort-collins.co.us/recreation/seniorcenter](http://www.ci.fort-collins.co.us/recreation/seniorcenter)) is:

- A program that was created by a public process of advocacy, a needs assessment and voting on a funding stream
- City-funded
- A center that hosts 30-60 events per day, reports 1,000 visits per day, and provides off-site events
- A center that operates 7 days a week, 6 a.m. to 9 or 10 p.m.,
- Partnered with community agencies and organizations (e.g. medical, schools, businesses)
- A Center that has received national/international recognition

### **Example #2: Manzano Mesa Multi-generational Center, Albuquerque, NM**

The Manzano Mesa Multi-Generational Center ([www.cabq.gov/seniors/centers/manzano-mesa-multigenerational-center/](http://www.cabq.gov/seniors/centers/manzano-mesa-multigenerational-center/)):

- Operates a 37,000 sq. ft. multi-generational facility
- Provides programs for consumers - youth through seniors
- Operates extended hours from early morning to late evenings- senior use high from morning to early afternoons, community use high in the evenings
- Worked collaboratively with community to create niche programming for seniors
- Established a large number of strategic partnerships
- Receives city and federal funding

**Other examples of the community center model, including examples of alternative names:**

- Avenidas, ‘New Roads for Older Adults’  
[www.avenidas.org](http://www.avenidas.org)
- 55 Kip Center, ‘Building Bridges to Successful Aging’ [www.55kipcenter.org](http://www.55kipcenter.org)
- Mill Park Center, ‘A Community Center for Active Adults’  
[www.seniorcenterservices.com](http://www.seniorcenterservices.com)
- Vesper Hall, ‘We Add Quality to Life’  
[www.bluespringsgov.com/vesper](http://www.bluespringsgov.com/vesper)
- Evergreen Commons, ‘Helping Adults get the Most out of Life’  
[www.evergreencommons.org](http://www.evergreencommons.org)
- PEAK Center, ‘People Experiencing Activity, Arts and Knowledge’  
[www.peakcenter.org](http://www.peakcenter.org)
- Goodrich-Gannet Neighborhood Center  
[www.ggnc.org](http://www.ggnc.org)
- Fairhill Center for Aging  
[www.fairhillcenter.org](http://www.fairhillcenter.org)

**Impact of the Community Center Model:**

- It’s the “IN” thing to do- intergenerational program opportunities, integrated leisure activities, inclusive vs. exclusive
- Gives taxpayers and other stakeholders the most bang for their buck
- Best utilization of facility throughout the day
- Serves large segment of population, including seniors who may not go to a ‘senior center’
- Cost sharing results in cost savings
- Quality facilities promote quality programs
- Appealing to Boomers who resist ‘senior centers’

### III. WELLNESS CENTER MODEL

The defining characteristics of such senior centers are:

- Use of evidence-based health promotion models
- Consistent use of evaluation tools
- Significant collaborations
- A state-of-the-art health and fitness center
- Steady participation in health-related research protocols
- Use of innovative technology and current knowledge to promote health
- Coordination with healthcare professionals, universities, research institutions and pharmaceutical companies



#### **Example #1: Baltimore County Senior Centers, Baltimore, MD**

The Baltimore County Senior Centers ([www.baltimorecountymd.gov/Agencies/aging/centers/](http://www.baltimorecountymd.gov/Agencies/aging/centers/)):

- Have built a state-of-the-art fitness center and offer various health-promotion programs to attract adults 55-70
- Have established strategic partnerships with Towson University (provides assistance with research and staffing) and Erickson Communities Continuing Care.
- Received expanded funding from diverse sources- University (research, staffing), Center Council (equipment), Department of Aging (programs)
- Have found that participation among younger and older seniors has increased tremendously.

#### **Example #2: OPC Center, Rochester, MI**

The OPC Center ([www.opcseniorcenter.org](http://www.opcseniorcenter.org)):

- Is funded through a combination of a mill levy (1/3), fund raising and grants (1/3), service fees and charges (1/3)
- Serves three communities
- Operates a state-of-the-art fitness facility- lap & therapeutic pools, gyms, deck, garden, café
- Has more than doubled visits per day first year (700)
- Partners with university and hospital
- Operates 13 mini-buses

### **Example #3: Center in the Park, Philadelphia, PA**

The Center in the Park ([www.centerinthepark.org](http://www.centerinthepark.org)):

- Offers evidence-based health promotion programs such as In Touch, Beat the Blues, Harvest Health, Healthy Steps
- Partners with Thomas Jefferson University's Center for Applied Research on Aging and Health
- Is working on sustainability business plan for Harvest Health, a chronic disease self-management program and receives consultation fees



### **Other examples of the Wellness Center Model:**

- Lowcountry Senior Center, Evidence-Based Wellness Programs  
[www.ropersaintfrancis.com/seniorcenter](http://www.ropersaintfrancis.com/seniorcenter)
- North Shore (IL) Senior Center, Large Fitness Center  
[www.nssc.org](http://www.nssc.org)
- North Shore (WA) Senior Center, New Fitness Center  
[www.northshoreseniorcenter.org](http://www.northshoreseniorcenter.org)
- Monroe Center for Healthy Aging, Healthy Aging Alliance  
[www.monroectr.org](http://www.monroectr.org)
- Elsie Stuhr Senior Center, ICAA Senior Fitness Test  
[www.thprd.org/facilities/estuhr.cfm](http://www.thprd.org/facilities/estuhr.cfm)
- Rogers Adult Wellness Center  
[www.rogersarkansas.com/wellnesscenter/](http://www.rogersarkansas.com/wellnesscenter/)

### **Impact of the Wellness Centers Model:**

- Better outcome measurement through evidence-based programs
- Enhanced physical and mental health of participants (that can be documented)
- Ability to measurably promote independent lifestyles of seniors
- Increased strategic partnerships with professional organizations
- Raised the level of professionalism and image of senior centers as health-focused institutions
- Attracts younger seniors and non traditional participants

## IV. CENTERS FOR LIFELONG LEARNING AND THE ARTS MODEL

The defining characteristics of such senior centers are:

- Programs and activities offered at multiple sites
- Focus on intellectual stimulation, personal growth, and enhanced quality of life
- Culturally and linguistically diverse
- Highly skilled, competent and experienced cadre of staff and volunteers
- Programs that are inclusive, comprehensive and innovative
- Celebrating the exploration of our creative selves



### **Example #1: The New Center for Learning, Five Towns Senior Center, Woodmere, NY**

The New Center for Learning (email: [seniorwoodmere@aol.com](mailto:seniorwoodmere@aol.com)):

- Receives funding from the National Council of Jewish Women, School District, City, County, and State
- Provides programs for intellectual, social, cultural enrichment
- The organization is self-sustaining through fees
- Partners with school district to provide advertising and classrooms for its programs
- Offers 3-session classes to connect with new seniors
- Rigorous selection of instructors to maintain high and consistent quality of programming

### **Other examples of and resources for the Lifelong Learning and the Arts Model:**

- Center for the Arts, Nashville, TN  
[www.seniorarts.org/](http://www.seniorarts.org/)
- Whitney Senior Center  
[www.ci.stcloud.mn.us/CommSvcs/Whitney](http://www.ci.stcloud.mn.us/CommSvcs/Whitney)
- North Carolina Center for Creative Aging, Asheville, NC  
[www.cca-nc.org/](http://www.cca-nc.org/)
- Center for Creative Aging  
[www.creativeaging.org](http://www.creativeaging.org)

### **Impact of the Lifelong Learning and Arts Model:**

- Enhances partners' programming and facility use by offering senior programs
- More (and new) seniors access services because of off-site location
- Stimulating brain-fitness program helps keep minds alert
- Increases partnership opportunities with other agencies (libraries, arts organizations)

## V. CONTINUUM OF CARE or THE TRANSITIONS MODEL

The defining characteristics of such senior centers are:

- Senior centers play a vital role as the focal points of coordination of information, access and service delivery to the aging population.
- Comprehensive services and programs that meet the changing needs of consumers as they “age-in-community”.
- State-of-the art services that are characterized by incremental, as well as structured plans that allows for greater dependence on resources and focus as participant’s age.
- Services/Programs grounded in evidence-based theory and practice.
- Inter-disciplinary, comprehensive collaboration with healthcare institutions, healthcare providers, AAA’s, State Offices of Aging and Mental Health, researchers, educational institutions and community-based service providers to create a unique system of care.



### **Example #1: Avenidas, Palo Alto, CA**

Avenidas Village ([www.avenidas.org](http://www.avenidas.org)) offers:

- Home-based membership services
- One-call resource with concierge level service- health and wellness, daily living, arts and culture, community connections
- Access and discounts with pre-screened vendors
- Medical transportation
- Daily telephone check-in
- Free emergency preparedness review
- Member-only forum, activities, directory
- Volunteer opportunities

### **Example #2: Ann Arundel County Maryland, Senior Center Plus Program**

The Senior Center ([www.aacc.edu/seniors/centers.cfm](http://www.aacc.edu/seniors/centers.cfm)) offers:

- Respite Care for homebound seniors
- Integrated programming for frail and healthy/active seniors
- Transportation services
- Services staffed by Geriatric Nursing aides, Coordinator, and P/T Social Worker

### **Example #3: St. Joseph’s McAuley Center and Express Care Clinic Hot Springs, Arkansas**

The Senior Center ([www.saintjosephs.com/services/occupational/](http://www.saintjosephs.com/services/occupational/)) offers:

- Clinical and Social Continuum of Care Model of Care

- Healthcare Clinic within a Senior Center – provides rent to the Senior Center
- Critical healthcare services in a rural setting
- Services to all community members
- Community healthcare staffed by LPN, NPs and Physician's Assistant

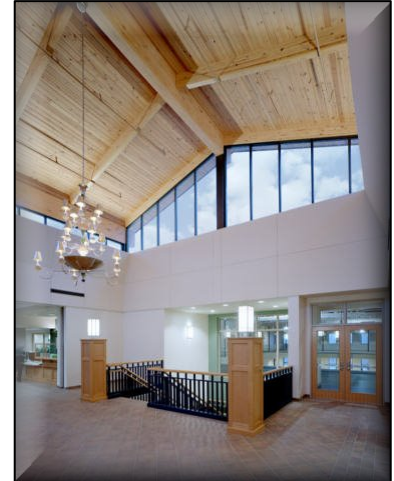
**Impact of the Continuum of Care/Transitions Model:**

- Serves as a conduit to incremental care for community-based seniors
- Promotes independent living
- Introduces community members and seniors to the Senior Center
- Creates a foundation for a Continuum of Care (very preliminary)
- Increases viability of the role and impact of senior centers (even as members age)

## VI. THE NEXT CHAPTER MODEL

The defining characteristics of such senior centers are:

- Life planning programs to explore future possibilities and goals as people age
- Engagement through paid work and volunteer service to help find meaning and purpose
- Recognition that seniors prefer to use their skills and experience in flexible work or service opportunities
- Continued learning for new direction, enrichment and retooling
- Peer and community connections of all ages



**Example #1: Newark Senior Center, Newark, Delaware ([www.newarkseniorcenter.com](http://www.newarkseniorcenter.com))**

**The Newark Senior Center:**

- Provides project consultancy services (for a fee) for nonprofits
- Participates in NCOA Wisdom Works, an evidence-based health promotion program
- Recruits and trains self-directed volunteer teams to enhance civic engagement
- Developed a volunteer database to match senior volunteers with area nonprofits
- Provides trainings (for a fee) in Nonprofit 101, Self-Directed Teams, How to be a Good Consultant, How to be an Effective Board Member
- Developed a marketing plan, wrote rental contracts, re-wrote a volunteer manual, developed a disaster recovery plan, and assisted a senior center with the NISC accreditation process

**Example #2: Senior Center Services of Bartholomew County, Columbus, IN:**

**([www.seniorcenterservices.com](http://www.seniorcenterservices.com))**

- Senior Products- a hobby venture became subcontracted manufacturing operation
- Developed a business plan and now the operation generates employment and income
- Program is self-supporting with potential to generate real income
- Offers temporary employment service
- Established a partnership with a staffing company for employment services
- Established partnerships w/area employers to increase opportunities

**Other examples of The Next Chapter model:**

- Fergus Falls Senior Center (MN) senior employment program [www.ffsenior.org](http://www.ffsenior.org)
- Coming Of Age (PA) Philadelphia. “Inspiring Opportunities for adults over 50” [www.comingofage.org](http://www.comingofage.org)
- Senior Center, Inc (VA) The Next Chapter [www.seniorcenterinc.org/next](http://www.seniorcenterinc.org/next)
- NorthShore Senior Center (IL) Life Options. [www.nssc.org](http://www.nssc.org)
- Mesa (AZ) Life Options [www.mc.maricopa.edu/community/communityed/crs\\_mlo.htm](http://www.mc.maricopa.edu/community/communityed/crs_mlo.htm)

### **Impact of the Next Chapter Model:**

- Seniors feel a sense of purpose, productivity, vitality
- Seniors feel physical and mental health is better
- Seniors enjoy making new friends, camaraderie of professional work environment
- Vital community resource of seniors wisdom and experience is mobilized
- Better senior buy-in to projects when choosing their own to work on
- Volunteer services at low-cost to nonprofits
- Income generation through product development, trainings and consultancy
- Promoting the senior center as vital, vibrant focal point for seniors of all ages and abilities



## VII. ENTREPRENEURIAL MODEL

The defining characteristics of such senior centers are:

- Focus on philanthropic funding rather than public funding
- Generating earned income
- Positioning in the marketplace as a focal point
- Use of successful business models from the for-profit and non-profit world
- Use of strategic management tools for continuous improvement
- Use of technology to enhance effectiveness and efficiency
- Contemporary, 'hip' facilities that are new or remodeled
- Very consumer driven -open non-traditional hours to attract diverse consumers



### **Example #1: Lou Walker Senior Center, Lithonia, GA**

The Lou Walker Senior Center ([www.co.dekalb.ga.us/humanserv/lou.htm](http://www.co.dekalb.ga.us/humanserv/lou.htm)):

- Received HUD 'pre-award' CBDG funding for a 40,000 sq. ft. facility opened in 2006
- Created a facility with a contemporary design- glass, steel, stone, digital screens
- Designed a comprehensive facility to meet changing needs of the present and future
- Ensured a non-institutional look for facility -not a traditional nursing home design
- Established 'Corridors of Life', a transitional program to ensure a continuum of care- seniors receive progressive level of services as they age (independence to long term care)
- Created Citizen Planning Committees that are vital to facility development and community patronage

### **Example #2: Lowcountry Senior Center, Charleston SC**

The Lowcountry Senior Center ([www.ropersaintfrancis.com/seniorcenter](http://www.ropersaintfrancis.com/seniorcenter)):

- Offers health promotion programs such as health fairs for all community members
- Collaborated with Roper St. Francis-Community Health Care and City of Charleston to design and implement community health fairs
- Used these health fairs as opportunities for positioning, branding, and marketing

### **Example #3: Senior Center, Inc., Charlottesville, VA**

The Senior Center, Inc. ([www.seniorcenterinc.org](http://www.seniorcenterinc.org)):

- Receives no government funding
- Raises 50% of its budget through philanthropy: (individual, foundations, corporate)
- Raises 50% of its budget through earned income- member and program dues/fees, newsletter ads, facility rental
- Strategic marketing focus on position in community through innovative ad campaigns

#### **Example #4: Medford Senior Center, Medford, OR**

The Medford Senior Center:

- Is a nonprofit center
- Built new facility with HUD grant and private donations
- Receives 94% of total funding from donations, meal program fees, thrift store, fund raising, bingo, travel club commissions
- Receives only 6% funding of total funding from city and county grants

#### **Other examples of the Entrepreneurial Model:**

- Iowa City (IA) and Madison (WI) produce their own TV shows.  
<http://www.ci.madison.wi.us/senior/facilities.html>  
<http://icsctv.uiowa.edu/>
- Evergreen Commons (MI) private fitness club subsidiary. [www.evergreencommons.com](http://www.evergreencommons.com)
- Sunshine Center (FL) on-site pharmacy [www.stpete.org/seniors](http://www.stpete.org/seniors)

#### **Impact of the Entrepreneurial Model:**

- Increased control over funding
- Greater independence through self-sufficiency
- Independence allows for rapid adaptability in a rapidly changing environment
- Increased financial security
- Increased program stability and sustainability
- Increased sense of ownership

## VIII. CAFÉ MODEL

The defining characteristics of such senior centers are:

- Retail approach to programs
- The café is the centerpiece
- Programs that are offered in addition to café at various sites
- Smaller, neighborhood-based focus
- Cafes are open to all community members – allows for introduction of new participants to other programs and services



### **Example #1: Mather LifeWays, Chicago, IL**

The Mather LifeWays Model ([www.matherlifeways.com](http://www.matherlifeways.com)):

- Provides award-winning concept and design
- Provides opportunity for a neighborhood-based, retail orientation
- Addresses needs of lower- and working-middle class consumers
- Provides an *experience* open to entire community
- Provides a warm, inviting, “ageless” environment
- Offers programs geared for age 55+
- Allows for a consumer driven menu and services
- Requires licensure and fees associated with development

### **Example #2: Borchardt Cyber Café, St. Barnabas Senior Center (SBSC) Los Angeles** ([www.sbssla.org/CyberCafe.html](http://www.sbssla.org/CyberCafe.html))

The Borchardt Cybe Café:

- Provides a popular location (café) for community members to gather and socialize
- Promotes a lifestyle of learning, using computers to reach broader goals of healthy living
- Creates a supportive social environment, where learning is experiential and community is as important as content
- Respects diverse adult learning styles by teaching students what they wish to learn, and encouraging them to explore creative possibilities
- Makes technology dynamic, by making it available in its infinite variety, *e.g.*, webcams, games, shopping, downloading music, information seeking, blogging, digital photography, film making

### **Impact of the Café Model**

- Attracts younger seniors (60% are 69 or younger at Mather’s)
- Rigorous training provides extraordinary customer experience and employment
- Engages participants to improve quality of life, promotes personal enrichment
- Provides/promotes good nutrition
- Social connections stave off cognitive decline
- Promotes partnerships with agencies focused on independent lifestyles and connecting older adults to resources

## **Other Findings of the Study**

In addition to the various models that were proposed by this study, several innovative projects and programs were reported by the respondents. Here is a summary of some of the innovative ideas that have been divided into categories by type of innovation:

### **i. Facility Design**

- Designing a large senior center within a long-term care facility
- Creating large, modern fitness centers with state-of-the art equipment
- Creating an outdoor space for programming and to rent out for a fee
- Creating a gallery space to display member art, as well as to rent out for a fee

### **i. Multi-generational Programming**

- Hosting Inter-generational “National Issues” Forums
- Adopt-a-class program (with local schools)
- Student Pen Pal program
- Local High School students meet their community service requirements by volunteering with the senior center
- Inter-generational Community Gardening Project
- “Bird-Houses in Public Parks” Project
- Inter-generational Spring Ball
- Multi-generational Holiday Parties and Carnivals

### **ii. Civic Engagement and Volunteering**

- Chore Corps – senior volunteers assisting the homebound elderly
- Golden Angel Tree Program – gift service for homebound, low- income elderly
- Multi-cultural Community Volunteer Training Program
- Highway Maintenance
- Senior Volunteer Corps
- Senior Grievance Committee

### **iii. Utilization and incorporation of new technology**

- Online TV Program in association with University of Iowa
- “My Senior Center” software to streamline data collection and analysis
- Automation of program reservations and meal orders to track member preferences
- Using “Skype” to connect seniors around the world

### **iv. Attracting boomers**

- Partner with local hospital and pharmacies for health promotion
- Fitness Centers and Computer Classes
- Creating an “Active Wellness Center”
- Visual Arts Programs
- Hosting Bridge Tournaments
- Cultural Programming (Opera, Theater, Writing, Pastels Paintings)



- Offering college courses in collaboration with a Community College
- “Outrageous Adventures” that promotes outdoor activities such as hiking, skiing,
- After-hours and late evening programs
- Women’s Texas Hold-em Leagues
- Cultural Exchange Travel Program
- Art Classes through local Museum
- Senior Golf League
- Senior Dating Service
- Foreign Language courses
- Ballroom Dance classes

**v. Innovative Marketing**

- March for Meals Expo, Hawaiian Picnic and Autumn Dance to attract seniors
- News articles covering various stories about programs and participants
- Participation in community events
- Offering the facility for community events
- Partner with citizen coalitions
- Partner with social service agencies

**vi. Fund Development**

- Creating a contribution pool among current members
- Offering fee-based programming
- Operating fitness centers
- Creating products for sale
- “Tree of Life” sculpture
- Thrift Store
- Offering group discounts on purchase of theater tickets



**vii. Collaborations and Partnerships**

- Developed a joint program with the local YMCA
- Collaboration with Association for the Blind for free vision screenings
- Collaboration with pharmacy for free medication education and screenings
- Collaboration with local businesses for conference sponsorship
- Collaboration with local universities and colleges to offer lifelong learning programs
- Collaboration with cultural institutions (museums, art institutes, theaters, etc.)

**viii. Programs**

- Holiday Meals for Homebound Elders
- Cultural Trips (museums, theater, etc.)
- Computer Classes
- Wine Tasting and Cooking Classes
- Unique Walking and Hiking Programs
- Music Bands
- Fee-based lunches

- Health Promotion and Education Programs
- Senior Job Fair
- Temporary Employment Service Corps
- Chronic Disease Self Management Programs
- Emergency Preparedness Training
- Family Caregiver Support and Respite Programs
- Men's Program Planning Group
- Indoor Golf Simulator

**ix. Pursuing Recognition of Excellence**

- NISC Accreditation
- NISC Membership
- Non Profit Standards of Excellence
- Accounting Standards Excellence
- Health Promotion Standards of Excellence
- Business Bureau Certification
- Community, Regional, State and National Recognition



## **Implications of this Study**

The purpose of this study was to document current practices in the senior center field. Our goal was to collect data on innovative strategies and emerging models and disseminate that information to practitioners in our field. We found many inspiring stories of change, growth and innovation across the nation. Our comprehensive analysis of the various submissions yielded some common themes that unify forward-thinking senior center directors and administrators. These are:

(i) **Collaboration**: The ability to form strategic partnerships with universities, colleges, high schools, social service agencies, businesses, hospitals, healthcare providers and other entities are integral to the sustainability of senior centers. If senior centers want to be viewed as community focal points, they must position themselves as a viable and legitimate community agency. Engaging in collaborative efforts will enable senior centers to expand their reach and enhance their influence in the community-level, decision-making process. Furthermore, community collaborations allow senior centers to offer a broader cross-section of services and programs to their target population – community-dwelling older adults.



(ii) **Responsiveness**: A common characteristic of innovative senior centers was their high level of responsiveness to their community needs. These senior centers engaged in comprehensive assessments of community resident profiles, needs, interests and resources. These strategic assessments, often conducted in coordination with other entities within the community, allowed the senior centers to engage a diverse group of older adults and offer meaningful

experiences to their consumers. Almost all senior centers who offered data-driven programming reported an increase in participation and revenue.

- (iii) Accountability: Most of the senior centers in our sample created structures for consistent feedback from their Board of Directors, staff, consumers and community members. This process allowed them to be responsive and accountable to their constituents. Accountability was also encapsulated in their efforts to streamline data collection and analysis as it related to service delivery. Program evaluation, a critical component of evidence-based programs, allowed senior centers to demonstrate their efficacy and impact on their communities. Some senior center administrators reported receiving recognition for their efforts to improve



standards of service and reporting. These accreditations, awards and certifications not only increased visibility and membership, but also attracted new sources of funding.

- (iv) Creativity: Given the limited resources, manpower and increased market competition, most administrators relied on their own creativity and that of their staff to envision and implement change. Ingenuity, resourcefulness and zeal are the hallmarks of our field. Most respondents utilized cutting-edge ideas and information from the aging service field and incorporated these into their own innovative designs. As clichéd as it sounds, thinking outside the box enabled administrators to expand and enhance their programming, fundraising, marketing and operations.

- (v) Passion: There is nothing more enabling and motivating than passion when we talk of change. Innovation and change are difficult, often frustrating, slow processes beset with

frequent missteps. It is during those difficult transitions that passion and drive help us push through. We found that all our respondents demonstrated a high level of confidence in the overall purpose and future of senior centers. These respondents were passionate about the impact that senior centers have on the lives of older adults and other members of the communities they serve. They strove to re-imagine, re-position, and re-purpose senior centers, thereby ensuring their continued significance, influence and viability for generations to come.



## **Conclusion**

For over six decades, the field of senior centers has benefitted millions of our family members, friends, and neighbors. The field has grown and, more importantly, adapted to the changing issues of aging in our communities. Founded as a grass-roots movement, senior centers remain effective and efficient in addressing local community issues and needs. The information gleaned from our research, including the following case studies, illustrates the creativity and vitality of senior center leaders and constituents. It is our hope that the New Models of Senior Centers research conducted from 2006-2009 will prompt more senior centers to dream of the possibilities, and work to make happen, an even brighter future for their own center and our field.

## **Dissemination**

Because NISC values the power of sharing information, the Taskforce dissemination was multifaceted. In addition to a seminar presentation at the 2008 ASA-NCOA conference in Washington D.C., these findings were presented at state conferences for senior centers in Pennsylvania, Texas, and West Virginia and Taskforce representatives remain available for future conference presentations. The power point presentation has been available on the NISC web site since April, 2008. A compact disk of this report is being distributed through the National Council on Aging (NCOA) and NISC networks.

