

Louisiana State Office

Transforming Senior Centers into 21st Century Wellness Centers

A project made possible by a grant from AARP Foundation and Caesar's Foundation

Authored by Kathryn Lawler

December 2011

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Transforming Senior Centers into 21st Century Wellness Centers

Challenge: Senior Centers across the country are confronting a changing population and diversifying customer base at the same time traditional funding for senior services struggles to meet growing and changing demands. As a result, centers are forced to examine how they remain relevant to a diverse group of people and provide the proven results and outcomes demanded by public and private investments.

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Executive Summary

The older adult population of today is significantly different than the older adult populations of yesterday and of tomorrow. Senior centers have long been important community resources for older adults and their families but to stay relevant, they must adjust to the changing needs of their customers.

In June 2011, AARP Louisiana convened a group of national and local experts in New Orleans to review the current state of senior centers, new models that have been tested and examine the needs of a specific center in New Orleans that suffered damage during the storms of 2005. From this discussion a framework for how senior centers can re-position themselves to better meet consumers' needs emerged and proposed policy changes to facilitate these changes on a wide scale were identified.

The framework is rooted in empowerment, based on the idea that centers, cannot do to older adults, but work best when they facilitate older adults doing for themselves. Centers can start by identifying which of the emerging models best meet their own community's needs, then align programs and services to address a comprehensive definition of wellness and deliver measurable outcomes. They then must build broad based community partnerships to support these efforts and develop a governance model that can evolve with the center's needs.

Recommended policy changes focus on incentivizing innovation and integrating Older Americans Act programs with other national initiatives including Livable Communities work and healthcare reform. Senior centers are already in the communities touching the lives that many different federal programs want to touch. It is time to connect these local, neighborhood based resources to national and state goals aimed at improving quality of life, promoting wellness and reducing chronic disease. Instead of being a barrier which innovators are good at working around, policies and regulations should support and where possible, replicate the good work creative centers are doing across the country.

Senior centers have been and will continue to be valuable community assets providing significant benefit to older adults and their families. But in a rapidly changing environment where the needs and demands of their traditional customers and funding sources are shifting, the thousands of centers across the country have to evaluate what they have been doing and where they need to go in the future. The large number of older adults and the strong emphasis both locally and nationally on living healthier, longer lives provide significant opportunities for centers to serve older adults and their families in ways that were not possible in the past. Change will have to be significant enough to make a difference for this large demographic group. National policy if turned in this direction, can match the scale of change with the scale of the demand.

Introduction

Much like the experience of growing older, senior centers have undergone significant evolution in the 20th century. Starting as small social clubs, they grew exponentially with the passage of the Older Americans Act in 1965 and the formal support this law provides. Originally in church basements and other peripheral spaces, senior centers began to claim their own distinct buildings and their own separate identities in the 1970's and 1980's. During these same two decades, the nursing home industry grew at an unprecedented rate creating institutional care for older adults at a scale never seen before in the United States. The growing number of senior centers and the expanding aging network was increasingly called on to provide the alternative to institutional care, supporting those older adults who wanted to remain in the community. In many communities senior centers were integral to these efforts to support aging in community and it was working. In the early and mid 1970's some of the first research studies documented the impact of senior centers on the health and wellbeing of participants. Now there are thousands of senior centers providing a wide variety of services to millions of older adults living in the community each year. While there is no one set model for a senior center, since their earliest inception and their proliferation in communities across the country, they have served as a "community focal point, where older adults come together for services and activities that reflect their experience and skills, respond to their diverse needs and interests, enhance their dignity, support their independence and encourage their involvement in and with the center and the community." (National Council on Aging)

Throughout the last four decades senior centers have re-calibrated their programs, buildings, staff and funding to meet the changing needs of older adults. But like most of the aging and supportive services network, senior centers are confronting a series of significant and unprecedented shifts in both their customer base and funding sources. There are clearly a number of pioneering initiatives that have spearheaded innovations in senior center programming, structure and design. But there remain fundamental questions about purpose, role, customer base and long term financial sustainability. The federal policies that brought about the growth of senior centers in the second half of the 21st Century have not kept pace with the changing needs and desires of older people and like the senior centers themselves, need to be modernized to better meet needs and achieve objectives.

Recognizing this larger context and realizing both the local and national needs, AARP Louisiana convened a group of national experts¹ with knowledge and experience in pioneering innovative models, evidence-based health programming, state and federal policy, supportive housing, Medicaid and Medicare, senior center development, livable communities and public health. They worked together over three days in June 2011 to understand the local and national context in which senior centers currently operate and how it will change in the future.

The work group was also asked to examine the specific needs of a local senior center in New Orleans. The Hollygrove neighborhood of New Orleans was severely flooded following the storms of Hurricane Katrina. Along with hundreds of homes, the senior center which had existed on Hamilton Street for over 25 years, took on seven feet of water and suffered irreparable damage. The Hollygrove community has joined with the political leadership in New Orleans to not simply rebuild the senior center as it was, but to re-consider the purpose, role, structure and long term sustainability of the center. The neighborhood has changed, funding has shifted and in a post-Katrina world the community as a whole has made extensive efforts to embrace a comprehensive agenda of livability, health and wellness for people of all ages and abilities.

While it was a tragic storm and tremendous loss of property that forced the Hollygrove community to reconsider the future of its senior center, in many ways it is no different from communities across the country. In most places it is not a cataclysmic flood that is forcing a center to both physically and programmatically rebuild, but it is the huge demographic wave that is bringing a different population with a different set of demands. Senior centers will either adjust to meet these new needs or become irrelevant as some in this new generation of seniors find other places to connect, engage and stay healthy while others grow increasingly isolated and suffer the effects of depression, loneliness and inactivity that senior centers were originally established to address.

Early efforts to remake senior centers to fit the changing population's desires indicate that viable centers of the 21st century should be integrated into the heart and soul of a community. Community cannot be defined as just a community of older adults, but what people most want is to be part of a full community that includes people of all ages and abilities. Vibrant, active and inclusive centers are in fact,

¹ To see the complete list of experts who served on the workgroup and learn about their backgrounds, please see Appendix A.

places people want to be. They are the gathering spot, the focal point and a critical element to a successful, lively and livable community that facilitates a high quality of life for residents of all ages.

This more expansive vision of a senior center raises critical questions including, should senior centers even be senior centers? and do they have to be physical centers with walls? or can the services and programs that draw people together and offer advice and support when needed be delivered through a network or a virtual center with no walls? These issues and many more were considered by the work group that convened in New Orleans in June 2011. What emerged is a set of recommendations on how to sustain centers in this new environment including the policy changes needed to modernize existing entities into 21st Century Wellness Centers.

The Challenge and the Opportunity for Hollygrove and Beyond

Changing Customer Base

Like the rest of the country, much had already begun to change about the older adult population in Louisiana before the storms of 2005. Senior centers and senior services across the US are experiencing dramatic changes in their customer base as unprecedented numbers of people become older adults and unprecedented numbers of older adults live well into their 80's, 90's and 100's. In 2005, the last year the Hollygrove center was open, the first babyboomers were just about to turn 60 and become formally eligible for Older Americans Act services. Now babyboomers have begun turning 65 and enrolling in Medicare. The boomers' entry into "older age" begins a 20 year increase in the number of older adults in the U.S., a major driver of the growth of the older adult population. A second and equally powerful force is changing the nature of what it means to be an older American-- advances in medicine, healthcare and the success of programs like the Hollygrove Center have made it possible for older adults to live much longer than ever before. In 2005, the Hollygrove center was well aware of this growing change. Hollygrove participants, much like participants in senior centers across the country, had aged in place. The center's activities were increasingly tailored to an older, frailer population, leaving unmet needs in the younger-older adult population.

Today, serving people in their 60's, 70's and 80's means that a center must serve people raised in the 1930's, 40's, 50's and 60's—a forty year span filled with some of the biggest changes our nation has ever undergone. The musical tastes, political and social mores of individuals born and raised in these different decades can be extremely diverse. Some were born when Social Security was created and others worry Social Security will not be there for them. Some were born years before computers were invented and others were among the first computer programmers. The variety of needs, experiences and expectations is vast—creating synergies and potential tensions for a senior center to manage.

"Younger-older" adults across the country, and Hollygrove is no exception, increasingly need and want to continue working. They bring considerably higher education levels and professional backgrounds into their retirement. More and more of them have a desire to be meaningfully involved in part time work or volunteer opportunities that use their extensive backgrounds and skills. At the same time higher percentages are caring for grandchildren and great-grandchildren. On any given day then, they must

keep up with the latest changes in the local school system, after-care programs or bus routes while navigating the most recent revisions to their Medicare benefits and pension plans, all while maintaining their own physical and mental health.

As the customer base of senior centers changes, the range of potential services expands with it. For example, a center could be open 18-20 hours a day so that working older adults can come early in the morning to exercise before work, then by 9am the center could be filled with both frailer older adults engaged in programs to maintain balance, enhance cognitive abilities and manage chronic disease and younger retirees ready to learn new languages, acquire new artistic skills, organize volunteer activities or donate their professional skills to a local nonprofit. By early evening, the working populations might return seeking social opportunities, help and advice as they care for young children or older relatives or the latest spin and aerobics classes. All the while each of these subgroups of older adults might need assistance with home modifications and/or repairs, medication management or insurance counseling, financial counseling and fraud protection, healthy cooking classes and discounted tickets to local cultural events.

Senior centers of the 21st Century will have to be many things to many people in order to remain relevant to both the frailest and most active older adults. But there is no question that despite the many decades that separate them, all generations of older adults still need opportunities to socialize, to volunteer, to improve their health and wellness, to find resources and connect with the larger community.

Changing Funding Environment

At the same time senior centers are experiencing changes in their customer base, traditional funding sources—Older Americans Act and local government support-- are shrinking. Older Americans Act dollars have remained virtually stagnant for several years and while the upcoming re-authorization may increase the total dollar amount available, there is no indication that funding will be increased on a scale that matches the growing demands. Local governments in the current climate face unprecedented pressures on their budgets and as a result have been reducing services and supports over several years. Even without the recent economic downturn, local government revenues are not likely to keep pace with the increased demands.

While traditional funding sources are less and less likely to keep up with demand, the funding environment is also being reshaped by the new and dramatic changes in healthcare. Growing healthcare costs have forced individual companies, private insurers and Medicare, to place a growing emphasis on wellness, preventive health and chronic disease management. While there is still tremendous uncertainty about how the different provisions of the 2010 Affordable Care Act will be implemented, increasing emphasis on reducing costs by keeping people healthier, longer, presents real opportunities for community based senior centers that interface with individuals every day.

In this shifting environment, it's clear that a diverse set of funding sources is essential to long term survival and sustainability. Many senior centers have begun to explore and access different funding opportunities including endowments, membership fees, fee for service programs, corporate sponsorships, facility rentals, foundation support and other entrepreneurial activities. These early innovators have demonstrated that a diverse set of funding sources provides long term sustainability and programmatic flexibility to meet changing needs. But different funding sources also come with different demands. Foundations and healthcare providers want to see demonstrable results from their investments. Corporate sponsors may want access to potential markets in exchange for their support. Fee paying members may demand a different quality of service and/or choice. Senior centers positioning for these funds must also integrate these funders demands into their programming, staffing and organizational structure.

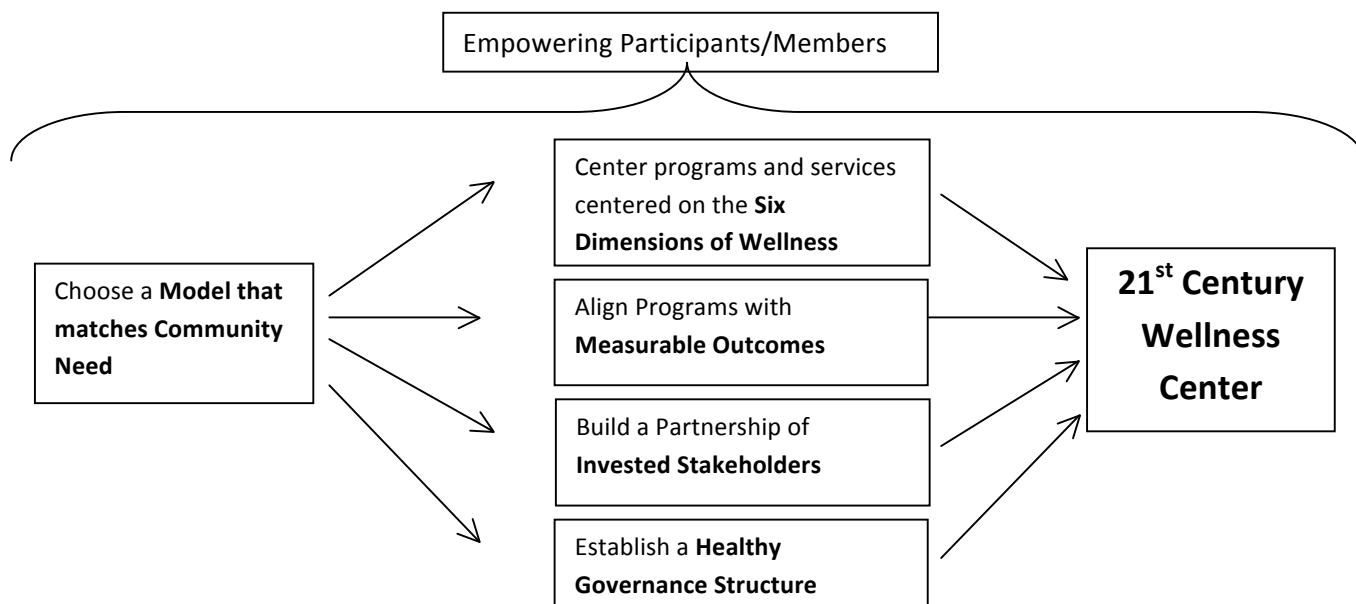
Evolving to Meet Future Needs

There are as many senior centers in the United States as there are Starbucks coffee shops (11,000)². But unlike Starbucks where part of the attraction is that anyone can get the same coffee at any store, anywhere, senior centers are local creations, adapted to distinct local needs. Efforts to evolve a single center like the Hollygrove/Carrollton Multipurpose Center must both tailor programs to specific community needs and complement the strengths and the gaps in the local network, yet integrate into their structure, programs and services, the best thinking and research from across the nation.

The New Orleans workgroup began to build a framework for 21st Century Wellness Centers. The framework outlines some of the important steps communities should take when examining the mission, purpose, customer base and funding structure of a community senior center. Several new models are already breaking down and reworking many of the defining characteristics of traditional senior centers. These models have demonstrated that senior centers do not need to be exclusively available to seniors nor does an effective senior center need to be a physical building with walls. But they have also demonstrated that a successful center, no matter what it is called does not do to its members/participants. Rather an effective center is designed to empower participants to learn, to improve their health, to make friends, to travel, to engage. A center facilitates self-empowerment, choices, individual and cooperative decisionmaking but a center can only be what participants want it to be. As a result, the framework that evolved from the New Orleans working group lays out a series of steps and choices for centers to determine where they want to go, but keeps empowerment as the primary object. The framework encourages communities to start by examining different models and:

- 1) Consider what model aligns with the community needs and the mission and vision of the center.
- 2) Commit to building its programs on the six dimensions of wellness and
- 3) Align programs with evidence-based models to create meaningful and measurable results for all generations of older adults.
- 4) Build broad partnerships made up of invested stakeholders willing to commit resources and expertise and
- 5) Create a governance structure with institutionalized ways to diversify and refresh leadership to ensure the center's long term success.

² Starbucks Company Profile, www.starbucks.com and National Institute on Senior Centers at www.ncoa.org



The next sections elaborate each of these elements of the framework.

Different Models for Different Communities³

A recent survey by the New Models Task Force of the National Institute of Senior Centers identified innovative and emerging senior center models from across the US. The analysis in this study⁴ defines what makes a center innovative:

- breadth of the innovation
- stakeholder involvement extent and type of resources
- impact on participation
- potential for replication
- long term feasibility

The study also cataloged six different types of new models. They include:

1. Multi-generational community centers
2. Wellness
3. Lifelong learning
4. Continuum of care/transitions
5. Entrepreneurial center

³ Senior Centers across the country have begun to explore how they can better serve their current and future customers within a changing funding environment. Some early research has begun to catalog this work and identifying key trends and growing opportunities. The National Institute of Senior Centers has taken a lead role. Participants in the June 2011 meeting in New Orleans, Louisiana reviewed some of this literature prior to the workshop and highlights are noted in the discussion below.

⁴ Pardasani, Manoj and Thompson, Peter "Senior Centers: Innovative and Emerging Models" Journal of Applied Gerontology, August 2010

6. The Café program

Each of these models have different missions, target different populations, focus on different activities and achieving different outcomes.

The Community Center and Wellness Center models are focused around state of the art fitness facilities. The Community Center is open to people of all ages, while the Wellness Center's activities and anticipated health outcomes are targeted to older adults. Lifelong Learning models focus on intellectual and creative activities for older adults. The Continuum of Care model focuses on providing health and wellness activities throughout the aging life span, tailoring activities and opportunities to older adults at all levels of fitness, ability and frailty. The Entrepreneurial Center model has civic engagement, volunteerism, opportunities to bring forward and generate income from the skills and talents of older adults. Lastly the Café model provides a restaurant open to people of all ages, but hosts activities and programs to enhance the physical and mental well being of older adults.

Combating social isolation and addressing comprehensive needs of older people were the primary objectives of the earliest senior centers⁵ and it is clear that as these new models emerge and evolve, they remain the core focus of all these new iterations. All of the models enhance social interaction and connectedness among a wide range of older adults. All serve as a resource center on a wide variety of issues older adults and their families encounter as they age and all provide basic health prevention services to the participants. The study noted that almost all of the programs and centers identified as emerging models are moving away from the term senior center as they believe it inhibits their ability to attract the broad range of older adults needed to maintain vitality and diversity.

The thought leaders who gathered in New Orleans in June 2011 also looked in depth at two models—the **Mather Lifeways Café Plus** model and the **Village Model**. They are both worth detailing further here.

The Mather Lifeways Café Plus model⁶ has been piloted now in many parts of the country. The appeal of the corner café, coffee shop or diner is universal. It cuts across

⁵ Anderson, Keith et. al. "Lexington Senior Citizens Center: Meeting the Challenges of the 21st Century" The University of Kentucky, Graduate School for Gerontology, May 2003 downloaded August 2011 at: http://www.indiana.edu/~leisure/module2/unit3_LA2/readings/Senior%20Centers%20-%2021st%20century.pdf

⁶ For more information please see, www.matherlifeways.com

racial, gender, age and socioeconomic lines. It's a place where everyone comes together, whether to do lunch, hang out grab a quick bite, chat with staff, visit neighbors, attend events, meet, greet, grow, learn, ask for advice or give it. The term "Café Plus" says it all. Inside the bright colorful, trendy, spaces customers catch up on email, learn new technologies, music, organize travel and theater outings, explore painting, exercise, get help solving problems, and celebrate the holidays. The Café Plus model is structured to defy stereotypes, reflect the way people want to live and empower people to learn, grow and continue living their lives. The Café program lures people in with the food and from there, the model flexes so that the possibilities are endless.

The Village Model⁷ is an organic model being shaped and re-shaped on the ground by committed volunteers and neighbors who believe that by supporting one another they can enhance quality of life and make it possible to live in the community as long as one desires. Villages are usually formed in areas with higher than average concentrations of older adults. They are membership-driven, grass-roots organizations, run by volunteers and paid staff. Villages coordinate access to affordable services including transportation, inspiring health and wellness programs, home repairs, social and educational activities and trips. They also offer access to vetted- discounted providers of a range of services including transportation, home repair, in home support services and landscaping. Villages complement the work of other important programs including NORCs and the programs of the Area Agencies on Aging.

Commitment to Six Dimensions of Wellness⁸

The workgroup determined that 21st Century Wellness Centers need to orient their programs, services and most importantly, intended outcomes around the six dimensions of wellness:

Dimension of Wellness	Definition
Emotional	Degree to which one feels positive and enthusiastic about one's self and life.
Spiritual	The development of a deep appreciation for the depth and expanse of life and natural forces that exist in the universe
Intellectual	Expanding one's own knowledge and skills while discovering the potential for sharing one's gifts with others
Social	Emphasizes the interdependence of human beings and encourages contribution to one's community and the environment
Physical	Achieved through good nutrition and regular physical activity
Occupational	Recognizes personal satisfaction and enrichment in one's life through work

The six dimensions address the variety of needs in the diverse older adult population. To evaluate their programs, senior centers should be able to ask and answer "What are we doing to promote wellness in

⁷ For more information please see www.vtvnetwork.org

⁸ Dr. Bill Hettler, National Wellness Institute

each of these areas?” Some programs or activities may touch multiple facets of wellness, others might be specifically targeted to address health needs in a particular community and many centers may find that they can best meet the needs of local residents through partnership with other organizations or institutions. To every extent possible however, and regardless of the provider, programs should be built on evidence-based models to ensure that measurable outcomes can be achieved in all areas of wellness.

Aligning Activities with Outcomes

Different models are right for different communities and clearly the specific priorities, needs and histories of local residents are an important part of shaping the decision to select one model over another. To be successful, centers must also complement what already exists in the community and they must be able to deliver clear and specific outcomes to the individuals, foundations, companies, governments and agencies that invest in their work.

The Blueprint for Aging, a comprehensive partnership in Washtenaw County, Michigan supported by the Robert Wood Johnson Foundation outlined how senior centers in that county could maintain their relevance, meet crucial community challenges and sustain funding. They believe that senior centers must be recognized as an important link in local aging in place strategies, hold a critical place in continuum of care efforts and maintain a strong corps of volunteers to continually identify and refresh priorities. Their work demonstrated how traditional and relatively new senior center activities can align with evidence-based research to ensure that the resources of centers are producing significant and measurable outcomes⁹. A brief summary is included in the following table.

⁹ “Senior Center Activities Promote Health and Well Being Outcomes for Individuals and Communities” Blueprint for Aging, Washtenaw County, Michigan; downloaded from www.blueprintforaging.org

Aligning Measurable Outcomes with Senior Center Activities

Health Outcome	Senior Center Activity	
Established Social Networks	<input type="checkbox"/> Welcoming atmosphere <input type="checkbox"/> Games, special events <input type="checkbox"/> Regular newsletter <input type="checkbox"/> Congregate meals	<input type="checkbox"/> Communication workshops <input type="checkbox"/> Coffee bar <input type="checkbox"/> Men's groups and activities
Reduced Isolation	<input type="checkbox"/> Existence of neighborhood senior center <input type="checkbox"/> Transportation to center and walkable environment surrounding the center <input type="checkbox"/> Congregate meals <input type="checkbox"/> Center outreach	<input type="checkbox"/> Travel and day trips among peer groups <input type="checkbox"/> Social events <input type="checkbox"/> Book clubs
Improved Strength and Balance	<input type="checkbox"/> Variety of exercise and activity classes of all levels	
Maintain Cognitive Health	<input type="checkbox"/> Lectures and classes (foreign language, computer literacy, current events, history, etc.)	
Positive Nutritional Status	<input type="checkbox"/> Meals and programming (classes on healthy cooking, gardening) <input type="checkbox"/> Community garden	
Health Promotion and Chronic Disease Management	<input type="checkbox"/> Health surveys, screening clinics <input type="checkbox"/> Immunization and other preventive measures <input type="checkbox"/> Evidence-based disease and disability prevention programs <input type="checkbox"/> Educational presentations and lectures	<input type="checkbox"/> Chronic disease management support groups <input type="checkbox"/> Targeted exercise groups <input type="checkbox"/> Community resource identification and access
Community Outcome	Senior Center Activities	
High Level of Community Involvement and Civic Engagement	<input type="checkbox"/> Established volunteer culture with organized structure to support existing and foster new volunteers: <input type="checkbox"/> Matching volunteers to opportunities	<input type="checkbox"/> Volunteer training <input type="checkbox"/> Volunteer recruitment and leadership opportunities at the center
Resource Center for Aging in Place	<input type="checkbox"/> Information and access services that connect older adults and their families to wide range of services including: home repair counseling, supportive services, Medicaid waivers, Benefits Check-Up, Medicare and other insurance counseling, retirement planning, second career coaching <input type="checkbox"/> Co-location for critical community services- from DMV, to post office, veterans affairs and social services <input type="checkbox"/> Transportation services for medical appointments, grocery store, religious services	

Each senior center, including Hollygrove, must respond to its own context, developing and tailoring its programs to the needs of a specific community with its own strengths and challenges. Identifying an emerging model that fits with community needs, answers the critical questions of who will the center serve and what will its focus be. Selecting and aligning programs with evidence-based research that can

produce proven, measurable results ensures that the center’s participants and investors receive the outcomes they desire and need.

Diverse and Invested Stakeholders

While almost all senior centers are structured around multi-faceted funding structures, the need to diversify sources of support continues to grow. Recognizing that it is unrealistic to discuss how senior centers might change without exploring where funding for those changes will come from, the New Orleans workgroup focused on how these stakeholders might be interested in becoming revenue partners, understanding that they would then need to have significant and measureable results often times demonstrating cost savings. Some examples include:

Potential Stakeholder/Investor	Results/Return on Investment
All payers of healthcare costs, especially those with direct incentives to reduce utilization including: <ul style="list-style-type: none"> ▪ Medicare Advantage¹⁰ ▪ Medicaid managed care ▪ Accountable Care Organizations 	Measuring that senior center participation or specific activities decrease utilization
Medical Homes	Growing use of medical homes creates a single coordinator of services to oversee total health of an individual and a potential interest in the preventive health activities of a 21 st Century Wellness Center
Hospitals	Provisions of the Affordable Care Act require nonprofit hospitals to complete Community Health Assessments and put plans in place to

¹⁰ Medicare provides health benefits to 45 million elderly and disabled Americans. Currently, most beneficiaries (78%) have their health bills paid directly by the traditional fee-for-service program. The remaining 22% are covered by Medicare Advantage (formerly called Medicare+Choice (M+C)). Medicare Advantage, also known as Medicare Part C, is a program that allows beneficiaries to enroll in private health plans to receive Medicare-covered benefits. Beneficiaries have the option of enrolling in a variety of private plans including health maintenance organizations (HMOs), preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service (PFFS) plans, and medical savings accounts (MSAs) coupled with high deductible insurance plans. In recent years, the number of Medicare Advantage plans and beneficiaries enrolled in these plans has increased rapidly. (<http://www.kff.org/medicare/choice.cfm>)

	improve overall community health; hospital readmission rates will also impact payments rates under the new law ¹¹ . The senior center that can facilitate an implementation strategy or impact readmission rates could be an important partner for these nonprofit hospitals.
Community (neighborhood, city, region)	Measurable increase in civic engagement of residents (young and old)
Universities	Senior centers can provide important opportunities for student training, student engagement and service in community; research opportunities; expanded education
Families/caregivers	Willing to pay for quality support services
Private Donors	Improvement in community wellbeing/health indicators
Local Businesses (pharmacies, banks, medical clinics etc.)	Relationships to build customer base
Cities	Quality senior centers are an asset to the neighborhood in which they are located; they can spur development, raise property values, enhance the quality of life of residents making the community a more attractive place to live.

Whether or not senior centers can deliver these kinds of results will determine with whom they can partner in the future. But with a growing interest in how preventive health can help reduce healthcare costs over the entirety of an older adult’s life, the role that senior centers can play in maintaining all the six dimensions of wellness becomes increasingly valuable to potential partners. This is particularly true now as a result of the Affordable Care Act. The Act places a renewed emphasis on community based health programs, wellness and preventive care. Some companies are already taking advantage of the new incentives and grants for work place wellness programs and enhancing existing or creating new wellness programs.¹² The need to reduce costs by keeping people healthier, longer means that programs, organizations or centers that can prove that they play a valuable and measurable role in maintaining or improving the health status of individuals have new opportunities to partner. Centers may find that they can work directly with Medicare, insurance programs, workplace wellness programs, or local governments looking to provide benefits to their employees. If centers can demonstrate positive

¹¹ Zuckerman, Stephen, “How Will Hospitals Be Affected by Healthcare Reform?” Urban Institute, July 2010; <http://www.rwjf.org/files/research/66028hospitals.pdf>

¹² “Wellness Programs Get a Boost in new Health Care Reform Law” <http://www.shrm.org/Publications/HRNews/Pages/WellnessReformBoast.aspx>

results, these different healthcare payers are poised to become much more significant partners and investors in 21st Century Wellness Centers.

Governance Structure

21st Century Wellness Centers are developing out of a recognition that current senior centers must evolve to meet changing needs. To be successful, however, this is not just a single evolution but a commitment to continual evolution. A thoughtful and intentional governance structure can ensure that a center is constantly surveying the community's needs and adjusting programs, services and where necessary the physical facility to stay relevant and have meaningful impact. The New Orleans workgroup concluded that a shared leadership structure that incorporated both the participants and the stakeholders and which had built in triggers to regularly refresh leadership was critical to the health of the center. Some guiding principles for creating a leadership team were generated by the group:

- Board membership that incorporates individuals from the community, stakeholder groups, funders and participants that reflect the wide range of ages of participants
- Mechanisms to regularly refresh leadership including term limits and specific demographic profile to reflect diversity of participants
- Invest in training leadership – help Board members develop/expand their skill set and leadership styles
- Multiple stakeholders with real ownership can create stability in the organization and throughout the community
- Leadership must have a shared mission and goals and use this to drive the Center
- Center needs functional shared leadership not the heroic leadership of one or two individuals; centers should not be too closely associated with any one older adult or any one group of older adults
- Leadership should have a variety of experiences and professional backgrounds

Moving to Scale: National Policy Change

Communities across the country are struggling to adapt and change their senior centers into a model that works for the 21st century senior, with 21st century needs. Innovative work is transforming centers across the country. There are networks which support the local implementation of specific models like the Mather Café Program and the Village Model. The National Institute on Senior Centers has for the last several decades been the center of research and support for thousands of existing centers. But to move this work to scale and help centers in communities large and small, urban and rural, serving frail and/or active older adults—the policy which has most significantly impacted the development and operations of senior centers must change.

The Older Americans Act of 1965 spurred the growth of senior centers across the country. Revisions in the mid-1970's highlighted the role of multi-purpose senior centers and began to create structure and consistent funding to specific programs in the centers. The Older Americans Act defines senior centers as “community facilities for the organization and provision of a broad spectrum of services, which shall include provision of health (including mental health), social, nutritional, and educational services and the provision of facilities for recreational activities for older individuals.” Many senior centers utilize funding from different titles of the Older Americans Act including funding for congregate meals, transportation, health and wellness, but these limited pools have been stretched thin to meet new needs and their regulations are often maneuvered around in pursuit of innovation rather than serving as the drivers of innovation. Regulations need to be updated and funding should be expanded if the Older Americans Act is going to once again drive change.

As the Older Americans Act undergoes the next cycle of re-authorization, there are both general policies and specific reforms that could facilitate wide spread change in senior center programs, facilities and the health of older adults both present and future. To spur evolution across the entire network of senior centers, national and local policies will have to reward the innovators and create incentives for other centers to adopt their practices.

General Policy Considerations:

Reward Outcomes, not “Widgets”: The Older Americans Act (OAA), in many of its different titles, measures units of services. This forces providers to measure the number of outputs they create and not necessarily the outcomes of their work. Funding should be made more flexible to allow local communities to use evidence-based programs to achieve outcomes. This is not only important to older adults but keeps aging as a substantial actor and influencer as healthcare continues to evolve in this country. As the senior centers or any providers using OAA funds seek additional support from foundations and other sponsors, these stakeholders and potential co-investors want to know that aging service providers are moving the needle not just counting widgets.

Incentivize the use of Evidence-Based Models: Over the last decade, demonstration funding from the Older Americans Act has supported the integration of evidence-based programs particularly related to chronic disease management and preventive medicine in a number of areas of the country. Evidence-based programming works and should form the cornerstone of programming both in and out of senior centers. Programs that use these models should receive additional funding and support to scale these efforts and reach larger populations.

Reward Innovative Partnerships: Older Americans Act funding should be targeted to programs, centers and initiatives that are supported by diverse, multi-sector partnerships with broad based support. Core Older Americans Act funding is delivered by formula, providing little incentive to change how things are done. An additional “innovation fund” could be developed to provide supplemental dollars to organizations, to agencies or even to entire states that take significant strides toward modernizing the way they do business. This would be particularly helpful to senior centers that are looking to adopt a new model of operations, new goals, mission and vision and new ways of delivering programs.

Specific Policy Changes¹³:

Provide Greater Flexibility in the Congregate Meal Program: the Congregate meal program provides funds to serve older adults a meal in a group setting. But the meals are highly regulated and do not provide the choices that older adults desire. While there is no doubt the meals need to provide healthy and nutritional supplement to older adults, the focus on the exact nutritional content of every meal is that many sites have lost the very important social aspect that was part of the original intention. Eating together should certainly be about older adults receiving essential nutrients and vitamins, but socializing and getting out of the house for something other than a doctor's appointment is also an essential part of maintaining health. Senior centers need to be able to offer the food and the choices that appeal to older adults and treat them as elders, not children at a school lunch counter. The funds should support restaurant style dining, salad and sushi bars or whatever reflects the preferences of the local community. There are still many different options that at minimum sites in every state should be given on a demonstration basis to explore how they can more creatively meet the needs of the young and the old, older adults.

Revolving Low to Zero-interest Loan Fund for Senior Center Rehab and Construction: Make funding available to local senior centers to serve as a zero to low interest loan fund that can specifically help senior centers modernize their facilities. This could be done by setting aside a pool of funds in the Administration on Aging budget, by allocating a subset of Community Development Block Grant Funds for senior center facility upgrades or allowing OAA funds to match CDBG funds, leveraging these additional resources for senior centers.

Increase Training Dollars

Real transformation in senior centers cannot come without either exposing existing staff to new ideas or bringing in new staff trained in new models. The Older Americans Act should flex existing funds or set aside new dollars to facilitate wide spread sharing of these new ideas and efforts that have already proven to work.

¹³ A number of these recommendations come from the Platform of the National Council on Aging detailed in "Older Americans Re-authorization Issue Brief" September 2011 <http://www.ncoa.org/assets/files/pdf/Older-Americans-Act-Reauthorization-Senior-Center-Issue-Brief-Sept-2011.pdf>

Senior Centers and Livable Communities

There is considerable work being done at the national level to bring together the Departments of Housing and Urban Development (HUD), Transportation (DOT) and the Federal Transit Authority (FTA) to create more livable and sustainable communities. The Department of Health and Human Services (HHS) has also joined in a separate partnership with HUD to explore the opportunities to use housing and community design to promote healthy lifestyles and disease prevention. The Administration on Aging (AoA) has not formally engaged the federal Sustainable Communities Partnership but doing so would provide a tremendous opportunity to integrate the needs of older adults into efforts across the country that are changing land use, transportation planning and the expansion of transit. Senior centers are well positioned to become focal points in these community efforts, bringing together residents of all ages to improve their quality of life now and develop plans and set policies that shape their future.

There are a number of ways to integrate older adults into this work:

- Administration on Aging should target its Community Innovations in Aging funds to livable communities work led by the aging network
- HUD/DOT/FTA should score proposals to the Sustainable Communities Programs higher if they include specific efforts to include older adults in their planning and programs
- AoA funds could be a permissible match for Sustainable Partnership grant programs providing greater incentive for local partners to include older adults
- Senior Centers should be included in any community assessments examining assets and opportunities
- AoA should fund the development of a livable communities model with a senior center serving as a community focal, bringing together different partners and stakeholders to pursue key issues of sustainability. This model or models would then serve as a template for communities across the country who understand the importance of helping older adults remain in the community but need examples of how to bring together the health, transportation and housing needs of older adults into local comprehensive efforts to improve the lives of all citizens. The model could explore new opportunities for multi-generational senior centers to be a significant part of broader livable community agendas.

Employ Centers in Medicare Reform

While much remains uncertain about the future of Medicare and Medicaid and even the final outcomes of the Affordable Care Act, most agree that as the nation's two largest payers of healthcare, Medicare and Medicaid are likely to undergo further change and reform. Increasingly both systems will attempt to reduce costs by improving health and the efficiency of care. Senior centers have traditionally remained

within the realm of the Older Americans Act network, but they have a significant amount to offer Medicare and other health care providers who need to reach those they cover on a regular basis but need informal, community based ways to do so. With several thousand senior centers located in communities across the nation, senior centers are well positioned to be an important provider of preventive care, increasing physical activity and chronic disease management. Senior centers may have to organize their programs and services differently and increase their data tracking and evaluation, but Medicare too should be looking to these valuable community resources that can make a real difference in short and long term health outcomes.

Conclusion

Senior centers were created when insightful professionals realized that as older adults were continuing to live longer than ever before, community supports had to change. Recognized as critical to successful aging, socialization and community engagement required places to gather and realize the benefits of a shared meal, conversation, stories and advice. Senior Centers have since grown to provide much more than that. But just like their inception, the future viability of senior centers lies with a new generation of insightful professionals who must work with the community to reshape the mission, vision, programs and even physical facilities to meet modern needs.

As a result, the coming decade could be the most exciting and dynamic in the history of American senior centers. They are being challenged to respond to changes in the population, changes in the funding environment and the opportunities and challenges of our changing healthcare system. There are a significant number of centers that have tried and successfully adopted new ways of working, new models of serving older adults and some to serve people of all ages. But for this visionary work to continue and for senior centers across the country to evolve at the pace and scale required, policy and funding must reflect the demands and desires of a 21st century older adult.

In its infancy, the Older Americans Act radically redefined what it meant to grow older in the community and since then has supported millions of older adults and their families. Each re-authorization of the Act is an opportunity to evaluate and adjust funding, regulations and policies to meet current and future needs. Expanding the flexibility of the current titles, creating supports for centers ready to modernize such as new models and funding, and aligning senior centers with national efforts on livability and healthcare reform can position senior centers to respond to changing demands and build a more sustainable future.

Senior centers across the country are vibrant community focal points because of the people who participate, the professionals who provide services and supports and the local stakeholders who offer their resources, volunteers and expertise. Supported by policy and funding changes, these individuals and organizations, like those that came before them, will imagine, transform and create senior centers for this new century.

21st Century Wellness Center Project Thought Leaders Bios

Joanne Binette **Senior Research Advisor, AARP**

Joanne Binette is a Senior Research Advisor with State Research in Research and Strategic Analysis. Joanne is on the State Strategy Team and serves as a research consultant to the states and as well as national partners. Joanne conducts primary and secondary research that helps the states get the information they need to plan state activities and advocate for AARP's issues. Joanne has been involved with the Hollygrove Project as an advisor since the program's inception in 2008.

Prior to coming to AARP, Joanne was a Program Evaluator for a substance abuse prevention program in the District of Columbia. She also spent some time as a Survey Statistician at the U.S. Census Bureau, specializing in data analysis on disability issues.

Joanne holds a Bachelor of Science in Human Resources and a Master of Public Administration, both from the University of Delaware in Newark. She also has extensive professional training in survey design, focus group moderation, statistical analysis, communications, and leadership.

Hugh Eley **Assistant Secretary, DHH**

Mr. Eley is Assistant Secretary of the Office of Aging and Adult Services, Dept. of Health and Hospitals. He was named to this position in 2006 and directed the creation and implementation of this new Office as a health reform initiative. The office brings together all of the long-term care programs that serve aging adults and people with adult-onset disabilities. These include Medicaid home and community-based long-term care programs, such as the Elderly and Disabled Adult Waiver, Adult Day Health Care Waiver, Long-Term Personal Care program and PACE.

Mr. Eley has been managing programs and services for the elderly and/or persons with disabilities for the past twenty years. From 1987 through 1996 he worked at the Governor's Office of Elderly Affairs. While there he served as State Long Term Care Ombudsman, as the first Director of the Elderly Protective Services program, and as Elder Rights Director. He has been at DHH since 1997. He served as Director of the Bureau of Protective Services and as a Medicaid Deputy Director prior to assuming his current position.

Mr. Eley holds a B.A. degree from the University of Louisiana at Monroe and a Masters of Public Administration from LSU. He is a member of the American Academy of Certified Public Managers, the Louisiana Developmental Disabilities Council, and the National Adult Protective Services Association. He is a former President of the Louisiana Society of Certified Public Managers and the Louisiana Aging Network Association. Over the years he has served on or led several task forces including the Committee on the Coordination of Police Services to Elderly Persons, the Governor's Task Force on Alzheimer's Disease, and the Elderly Health Care Council.

Catherine “Alicia” Georges
National Board of Directors, AARP

Alicia Georges, R.N., Ed.D., F.A.A.N., was elected to AARP's Board of Directors in 2010, where she serves on the AARP Board's Audit and Finance Committee as well as AARP's National Policy Council. Her career spans more than three decades as a nurse, educator and leader in efforts to eliminate health disparities and improve the health of minorities and the disadvantaged.

Dr. Georges is associate professor and chair of the department of nursing, Lehman College and the Graduate Center of the City University of New York (CUNY); she is an adjunct faculty member at Excelsior College. Dr. Georges is also a member of the Board of Directors for Family Care Services, Bronx, New York and is president of the National Black Nurses Foundation.

Dr. Georges received her doctorate from the University of Vermont, her MA in community health nursing, administration and supervision from NYU, and her nursing degree from Seton Hall University.

Dr. Georges was awarded a fellowship by the New York Academy of Medicine and has received numerous awards in her distinguished career in health and social public policy, including being named Nurse of Distinction, Region I, by the New York State Legislature and Outstanding Woman by New York Senator Larry Seabrook.

Susan Guidry
New Orleans City Council

Susan Guidry was elected District “A” Councilmember in March 2010.

Susan is a graduate of Archbishop Chapelle High School in Louisiana. She earned a BA in Secondary Education from the University of Southwestern Louisiana and a Juris Doctorate from Loyola Law School. Her professional career includes working as an attorney and community activist, as well as teaching English on the junior high and high school levels.

As an attorney, Susan fought for the rights of New Orleans entities after the flooding of Hurricane Katrina. She was a member of the litigation team that represented the Port of New Orleans and successfully settled the Port's suit against the insurers for Hurricane Katrina related damage to 22 miles of riverfront property.

Susan has an established track record as a citizen leader with an extensive record on crime reduction efforts at the community and neighborhood level. She served as the Chair of the Mid City Security District, on the board of the Bayou St. John Neighborhood Security Program, as Block Captain of the Mid-City Private Patrol and was the organizing member of the Mid-City Neighborhood Watch. Additionally, as President of the Parkview Neighborhood Association, Susan organized a Block Captain System for the Parkview neighborhood.

Councilmember's Key Staff for Thought Leaders Work Group

Kelly Butler

Director of Special Projects, Office of Councilmember Susan Guidry

Deborah Langhoff

Chief of Staff, Office of Councilmember Susan Guidry

Dr. Brenda Hatfield

State President, AARP Louisiana

Brenda was appointed as AARP Louisiana State President in April, 2011 after achieving a successful career of nearly 45 years in public service and corporate business and active involvement in the community. Brenda started her career as a Spanish teacher in New Orleans and Washington, D.C. She then held management positions in public library systems in Louisiana and Canada before accepting a position as Director of library media, instructional technology and communications for a large school district. Brenda transitioned into the corporate sector as a senior executive for Cox Communications where she served as the Director of Governmental Affairs and Local Programming in New Orleans.

Brenda was recruited to the City of New Orleans where she stepped into the role of Chief Administrative Officer, responsible for a \$467 million budget, two weeks before the nation's greatest natural disaster which destroyed the city's infrastructure and threatened to bankrupt it in 2005.

Brenda has been honored with numerous awards and recognition including the **2009 LSU Alumni Hall of Distinction, African American Success Story** from New Orleans Publishing Group, **New Orleans Public Schools Educational Administrator of the Year**, and Southern Woman Magazine's **Women of Influence Spirit Award**. Brenda earned a Ph.D. in Education from LSU, a Master of Library Science from the University of Toronto, and a Bachelor of Arts in Spanish and Social Studies Education from University of New Orleans. She is a Loyola University Fellow of the Institute of Politics.

Joseph Kimbrell

Chief Executive Officer, Louisiana Public Health Institute (LPHI)

Joe Kimbrell is a career public health leader who currently serves as the CEO of the Louisiana Public Health Institute (LPHI), an independent non-profit public health organization whose mission is to improve the health and quality of life in Louisiana. Joe also serves as the CEO and President of the National Network of Public Health Institute (NNPHI), which is dedicated to enhancing the capacity of the national public health system by providing a network for 35 non-governmental public health organizations and administrative and coordinating support for national public health programs.

Under Joe's leadership, LPHI has become a key public health stakeholder in post-Katrina Louisiana, partnering with state and federal government agencies, universities, state and national foundations and a variety of local partners in implementing population health initiatives. These efforts include statewide and regional media campaigns, surveys of the population and providers, and re-granting to enhance redevelopment and capacity of New Orleans area primary care, behavioral and school health clinics. In addition, NNPHI has experienced a similar growth in expanding its initial membership of 15 to 35 public health institutes and affiliate organizations that spans across the nation and its scope of work to support national programs and collaborative projects.

In addition to serving in leadership roles in the development and growth of LPHI and NNPHI, Joe has actively advocated for the sustainability of the public health leadership development system through his work with the South Central Public Health Institute and as Executive Director of the Public Health Leadership Society, administratively housed at NNPHI.

Prior to his career dedication to establishing the public health institute model, Joe served as the Deputy of the Louisiana Office of Public Health. Joe has a BA and a Masters in History from the Notre Dame Seminary, and a MSW from Tulane University.

Jill Jackson Ledford

Aging Services Director, Coastal Regional Commission

Jill Jackson Ledford has extensive experience in senior center operations, senior services and evidence-based health promotion for older adults. Currently she is involved in projects that are expanding evidence-based interventions for caregivers, developing livable communities and developing business and marketing plans for area agencies on aging.

Previously she served as Vice President, Health Promotions with the National Council on Aging where she oversaw the operations of the Center for Healthy Aging. Prior to joining NCOA, she led senior programs at Roper St. Francis Healthcare in Charleston, S.C. for 11 years, most recently serving as Executive Director, Lowcountry Senior Center, where she designed, helped to fund, and then managed this state-of-the-art senior center.

In addition, she directed local senior service agencies in South Carolina and Arkansas providing over ten different services for older adults. Her varied background includes experience in the home health, nursing home, disabilities, substance abuse treatment and training fields. She completed her Masters in Social Work at the University of South Carolina and is also a Master Trainer for the Stanford University Patient Chronic Disease Self Management Program.

She has extensive experience in evidence-based prevention programming, including program implementation and evaluation, as well as in training and technical assistance beyond her own organization. She has provided leadership to various projects and initiatives at the local, state and national levels, fostering collaboration and partnerships among diverse organizations.

Kathryn Lawler

External Affairs, Atlanta Regional Commission

Kathryn Lawler is the external affairs manager for the Atlanta Regional Commission, the Metropolitan Planning Organization and Area Agency on Aging for the greater Atlanta area. She provides support to the different divisions of the agency including transportation, land use, environment, workforce, local government support and aging. Her primary responsibility is to form strategic partnerships with federal, state and local governments, public and private organizations to transform the region into a more livable community for people of all ages and abilities.

Prior to this role, she was a consultant working with local governments, foundations and community based coalitions, interested in effectively organizing to better prepare for the rapidly growing older adult population. Her work specialized in the development of cross disciplinary partnerships, bringing together aging, planning, architecture, public and mental health professionals, hospitals, elected officials and local residents.

From 2002 to 2006, Kathryn was Director of Aging Atlanta, a 50 organization partnership focused on preparing the metro region for the rapid growth in the older adult population. From 2001 to 2002 she was a fellow at Harvard University's Joint Center on Housing Studies. Her research focused on the development of health and housing policy to facilitate aging in the community and modernize long term care systems.

Kathryn received a bachelor's degree from the University of Notre Dame and a master's degree from Harvard University.

Nancy McPherson

Senior State Director, AARP Louisiana

Nancy McPherson currently serves as the Senior State Director for AARP Louisiana where she leads a team of staff and volunteers in advancing reforms in livable communities, healthcare, and financial security at the local, state, and national levels on behalf of the 50+ population and AARP's almost 500,000 Louisiana members. For the last three years, AARP's work in Louisiana has included a partnership with Hollygrove, a New Orleans neighborhood, where residents, community leaders, and AARP staff are working together to develop a livable community with support from the AARP and Caesar's Foundations.

Prior to her work with AARP, Nancy spent nearly 20 years as a police executive and senior leader in the Portland, Seattle, and San Diego Police Departments and consultant for police departments across the U.S., Canada, the Netherlands, and Albania where her work focused on helping police leaders and police officers increase their effectiveness in reducing crime and improving police-community relations.

Among her numerous assignments, she was the sole outside police consultant to the LAPD following the Rodney King incident, and appointed by the federal court as a Special Master overseeing police reform in the Cincinnati Police Department from 2003-2007 following 2001 race riots in Cincinnati.

McPherson has a MPA from Old Dominion University and a BA in Political Science from San Diego State University. She is also a certified HR professional (SPHR).

Dr. Martha Pelaez
Health Foundation of South Florida

Dr. Martha Peláez is currently the director of the Healthy Aging Initiative of the Health Foundation of South Florida. Between her current position and her long-term tenure at the Pan American Health Organization/World Health Organization (PAHO/WHO), she served as an international consultant on aging and health as well as the executive director of the Latin American Academy of Medicine of Aging (ALMA). Further, Dr. Peláez is a founding member of ALMA. She received her doctoral degree from Tulane University and her master's degree from Boston University.

Dr. Peláez was the PAHO/WHO regional advisor on Aging and Health for more than 10 years. In this position, her work focused on the development of primary health care services in 28 countries in Latin America and the Caribbean adapted to the health needs of older adults: health promotion, preventive medicine and community-based rehabilitation programs. She coordinated with the WHO Global Program on Aging and Health in Geneva and with the United Nations Program on Aging on international projects and in resource mobilization to implement of the International Plan on Aging.

Prior to PAHO/WHO, Dr. Peláez was the director of education and training in the Center on Aging at Florida International University. Among many accomplishments, she developed the Center on Aging's international program, largely focused on health and aging issues in Latin American and the Caribbean through collaboration with universities in developing curriculum in gerontology and geriatrics.

Dr. Peláez has written numerous publications on health and aging, including the book *The State of Aging and Health in Latin America and the Caribbean*. She has served on the boards of various organizations focused on health and aging, such as the National Council on Aging.

Dr. Peláez joined the board of the Pan American Health and Education Foundation in 2008.

Susan Poor, MPH
NCB Capital Impact

In her role as Senior Policy Advisor with NCB Capital Impact, Susan Poor provides consulting and technical assistance services to organizations working to improve the continuum of long term supports and services (LTSS) at the local, state, and federal levels. Ms. Poor's focus is policy and best practices research, program planning and implementation, project management, and guidance of the collaborative stakeholder process in the development of new initiatives and interventions. Her areas of expertise include LTSS, home and community-based services and policy, long term care systems integration, aging in community innovations, Medicaid/Medicare managed care, family caregiving, care management and coordination, chronic disease management, hospital to home transitional care, advance care planning for end-of-life care, nonprofit management, and health insurance reform. Clients have included communities, states, and the federal government, funders, nonprofit organizations, policy institutes, trade associations, and academic institutions.

Ms. Poor is a Co-Chair of the San Francisco Long Term Care Coordinating Council, a Founder and Board Member of San Francisco Village, a member of the Leadership Council for the Consumer Consortium on Assisted Living, West Coast Director of Outreach and Volunteers for Share The Care, an alternate member of the San Francisco Health Care Reform Task Force, and a member of the San Francisco Network for End-of-Life Care.

Alisha Sanders
Senior Policy Research Associate, LeadingAge

Alisha Sanders, M.P.Aff., is a senior policy research associate at the Center for Applied Research (formerly the Future of Aging Services), an independent applied research center within the LeadingAge (formerly the American Association of Homes and Services for the Aging). Her work focuses on the Center's efforts to document and evaluate models and strategies to link low-income senior housing with health-related and supportive services to help residents meet their needs and successfully age in place. She has conducted multiple projects in area, which have included policy workshops, qualitative case studies, the development of training and education programs and materials, and program evaluations.

Alisha staffs LeadingAge's Affordable Housing with Services Steering Committee, a group of housing and service experts identifying new policy, funding and regulatory strategies for expanding affordable housing with services opportunities for low-income seniors. Prior to joining the Institute, she was the Associate Director of Public Policy for Aging Services of California (formally the California Association of Homes and Services for the Aging) where she advocated for improved affordable housing opportunities for California's lower-income seniors and provided technical assistance to CAHSA's housing members. Alisha has also worked on a number of other affordable housing related issues, including homelessness, inclusionary zoning, and predatory lending. Alisha holds a Master in Public Affairs from the LBJ School at the University of Texas and a Bachelor of Arts in Sociology from Rice University.

Betsie Sassen
Assistant Vice-President, Community Initiatives, Mather LifeWays

Betsie Sassen currently serves as Assistant Vice-President, Community Initiatives for Mather LifeWays in Evanston, Illinois.

As Assistant Vice-President, she oversees the operations of three Mather's—More Than a Café locations located on northwest and southeast sides of Chicago. In addition to overseeing café operations in the Chicagoland area, Ms. Sassen also consults with other organizations nationally and internationally interested in replicating the Café Plus model.

Prior to joining Mather LifeWays, Ms. Sassen's professional experience over the past eighteen years includes intensive care, managing an adult day care program, supervising a long-term care facility, and managing a large hospital senior membership and community health program. Ms. Sassen has her Bachelor's Degree in Nursing from Michigan State University (1992) and a Master's Degree in Nursing: Health Systems Management from Loyola University Chicago (2006). Additionally, she completed the Leadership AAHSA (American Association for Homes and Services for the Aged) program in 2009. She is a published author with articles in *Computer, Informatics, and Nursing, Marketing Health Services, Nursing Homes/Long Term Care Management, and Generations*. She has been interviewed and quoted in various publications including *The New York Times, The Washington Post, and The Chicago Tribune*.

Robin Wagner

Deputy Assistant Secretary, Office of Aging and Adult Services, LA Department of Health and Hospitals

Robin has worked in the area of gerontology and disability services since 1990 when she obtained her MSW with certification in Gerontology from Tulane School of Social Work. She has served as clinical faculty in gerontology at LSU Medical School and was Assistant Professor at Tulane School of Social Work where she researched and taught in the areas of aging and adult development, policy, and community practice.

Prior to her current position as Deputy Assistant Secretary for the Office of Aging and Adult Services, Robin worked in the DHH Office of the Secretary and for the Governor's Office of Disability Affairs on two major federal Systems Change/Transformation grants designed to shift Louisiana's system of long term care for older adults and people with disabilities away from reliance on institutions towards use of diverse and innovative home and community-based services.

Post Katrina, she was the DHH lead in developing Louisiana's Permanent Supportive Housing program for older adults and people with disabilities, a program which is now providing mainstream affordable housing with supportive services to over 2,000 households in south Louisiana.

She is currently responsible for implementation of the Office of Aging's new Community Choices waiver program which is to be implemented October 1st and which will provide a much broader array of community-based services than current Medicaid programs serving older adults in Louisiana.

Patrick Willard

Senior Legislative Representative, AARP

Patrick Willard is Senior Legislative Representative, with the State Health and Family team in AARP Government Affairs. He joined AARP in 2007 bringing a wide range of experience in federal, state, and local policy and communications.

As Advocacy Director for AARP in Tennessee, he co-chaired the Nashville Livability Project to set goals to make Music City a livable community for all ages. He also planned AARP's successful strategy for the "No Place Like Home" campaign to support Tennessee's transformation of its long-term care services aimed at increasing access and funding for long-term services and supports. The campaign resulted in the unanimous adoption of the Long-Term Care Community Choices Act of 2008.

Patrick served as Counselor to the Mayor in the Metropolitan Government of Nashville and Davidson County for seven years before joining AARP's Tennessee office. He began his career as a reporter for newspapers in Tennessee and New York. He later served as a congressional press secretary and legislative aide, state legislative

chief of staff, and director of the Tennessee House of Representatives Research Division. He holds a bachelor's degree from Vanderbilt University and a master's in journalism from Columbia University.

Walter Woods

Vice President, Impact Programs—Isolation, AARP Foundation

Email: wwoods@aarp.org; Phone: 202-434-2065

Walter Woods has over 20 years of social development and marketing experience. Currently, he works for the AARP Foundation as their Vice President, Impact Programs – Isolation where his primary responsibility is for the overarching strategic direction and day-to-day operation of the Foundation's emerging Isolation Impact Programs.

Prior to joining the AARP Foundation Mr. Woods served as Consultant to The World Bank Group where his community outreach work focused on nonprofit capacity building and bridging the support services communications gap. He was the Senior VP for Marketing and Development for the Boys & Girls Clubs of Greater Washington, and the Managing Director-Commercial Markets for AGA where he was responsible for developing and implementing non-dues revenue activities that targeted national commercial end users from five industry sectors.

Walter has a MBA from Northwestern University – Kellogg Graduate School of Management, Evanston, IL; a BBA cum laude from Howard University and awards and recognition from various organizations.

APPENDIX B

Hollygrove: a Brief History

The Hollygrove neighborhood has changed in significant ways over the last 100 years. The neighborhood itself was developed from the McCarty Plantation. About 50% of the neighborhood was built between 1900 and 1950 and by 1965 there was almost no vacant land left. Hollygrove has always been a working class neighborhood. Before the 1970's it was a mixed community, as both blacks and whites called Hollygrove home. Although it was mixed, it was not necessarily integrated. Specific sections tended to be either all white or all black. Many current residents can still recall which streets acted as the dividing line between the black and white communities. In general, whites lived closer to Claiborne Avenue and blacks lived closer to what is now Airline Highway. Parks were segregated through the 1960's. Some homes even had covenants on their title restricting sale to any person of color. Almost all the white families left Hollygrove in the 1970's during "white-flight". Though many continued to own their homes and rent to other families. In the two and a half decades before Hurricane Katrina, almost all Hollygrove residents were African-American.

When the neighborhood was in the peak of its physical development, Dr. Paul T. Robinson built the Robinson Infirmary and Clinic in 1949. It was the first privately funded health clinic in New Orleans built by and for African Americans. In 1954 the Clinic became the Robinson Guest House that many Hollygrove residents believe was a place where leaders of the Southern Christian Leadership Conference stayed while organizing the Civil Rights movement. In 1964 the building was transformed again into the Estelle Hubbard Memorial Home for the Incurables, a long term care facility operated by Xavier University. In 1980 the Home was renovated again into the Carrollton Hollygrove Multi-Purpose Center. Lifelong Hollygrove resident Emelda Washington organized the community to not only provide community space for friends and neighbors to socialize, share meals and do a range of activities together, the Hollygrove Center was among the first in the state to also provide licensed adult day care services for frailer adults needing significant attention and assistance throughout the day. Many current residents had older family members who attended the adult day center at the Multipurpose Facility allowing them to keep their older family members at home while continuing to work. Former Center Director, Howard Rogers, recounts the many people who came to the center throughout the years including senators, mayors, governors, legislators and Civil Rights leaders. The Center was a model across the city, because not only for the services it delivered, but because of the deep sense of

community ownership and the strong involvement of older adults in the development and execution of all its programs.

All services ceased at the Center when it took on between 6 and 7 feet of water in the flooding that followed Hurricane Katrina in August 2005. Since then the residents of the neighborhood organized to stop demolition of the Center until the community could be confident funds would be available to rebuild a Center in its place. Now in 2011, 1.8 million in FEMA funds has been designated to rebuild the Carrollton Hollygrove Center, but the neighborhood and many of the former participants from the Center have claimed the opportunity of rebuilding as a chance to bring back not only the support and services that made it possible for so many older adults to live in the community, but to create a 21st Century Wellness Center that provides opportunities for all residents to enhance their health and wellbeing.

Next Considerations for the Hollygrove Senior Center:

- I. Determine whether the center will be multi-generational or serve only older adults
- II. Examine which model of senior center best aligns with the community's future vision and desires
 - a. Local needs and preference survey will be very important tool
 - b. Identify gaps in the current service system supporting older adults in the community and determine which could be filled by the senior center
 - c. Refine target population, asking: Who will be served? Income? family size? family status?
- III. Evaluate what programs and services require physical space and which could be delivered virtually, offsite or by partner organizations?
- IV. Design and build **flexible** space that can evolve over time, because the only thing that is certain is that the center will need to evolve
- V. Determine what will be measured
- VI. Build a governance structure and institutionalize ways to refresh leadership
- VII. Provide staff with ability to mold programs over time, serve multiple age groups
- VIII. Develop partnership to provide long term and flexible funding

Accreditation to Ensure Quality

The National Institute of Senior Centers has been using a self assessment and national accreditation process. Over 200 senior centers have used this process to identify their strengths and weaknesses and measure their work against national standards. The assessment and standards require senior centers to:

- Have a well articulated mission and purpose¹⁴
- Participate in cooperative community planning, establish service delivery agreements with other community agencies and serve as a focal point in the community.
- create effective relationships among participants, staff and the governing structure
- have clear administrative and human resources policies and procedures that contribute to the effective management of its operation.
- Provide a broad range of group and individual activities and services that respond to the needs and interested of older adults, families and caregivers
- Maintain appropriate and adequate arrangements to evaluate and report on its operation and program
- Practice sound fiscal planning and management, financial record keeping and reporting
- Maintain complete records and circulate reports to inform its governing structure, participants, staff, funders, public officials and the general public
- Make use of facilities that promote effective program operation and provide for the health, safety and comfort of participants

These national accreditation standards raise the critical components of a well functioning senior center: mission, focal point for community members and programs, symbiotic and shared leadership among staff, board and participants, relationship building among participants, policies and procedures that ensure fiscal soundness, staff management, adequate reporting to funders and others, facilities that match the program needs, variety of programs that meet varied needs, regular and effective evaluation of programs and outcomes.

Acknowledging the strong foundation the accreditation process sets, the group of experts that convened in New Orleans focused on the nature of the programs that senior centers of the future should support and supply.

¹⁴ National Institute of Senior Centers, www.ncoa.org