Evaluation of Senior Community Centers in Rural and Urban Pennsylvania

By:

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EXECUTIVE SUMMARY

This research examined senior community centers in Pennsylvania to analyze challenges and opportunities that these centers face in providing services to a growing senior population. Specifically, the research: created an inventory of Pennsylvania's rural and urban senior community center (SCC) locations, including the types of services provided and activities available; analyzed SCC attendance and program participation, accessibility/access issues, means of transportation to/from the center, and relevant demographic characteristics; identified innovative and successful models that SCCs are using to provide services to older adults in rural and urban Pennsylvania, including those focusing on transportation, nutrition, social activities, and other issues; and formulated policy considerations regarding the development, growth, and maintenance of SCCs in Pennsylvania.

The research results indicate that 122,181 individuals age 55 years and older, or 3 percent of the projected over-55 population in Pennsylvania, participated in SCC programming in 2017. Participants accessed a wide variety of programs, including congregate meals, health and wellness programs, which are focused on maximizing mobility and physical well-being, group and recreational programs, which are often suggested by the participants at each center, and, at a few centers, personal care services. In general, participants are independent and active individuals who go to SCCs for the activities they like. Participants are savvy consumers who make their wishes known about the need for new and engaging programs, and who are highly engaged in center leadership and volunteer roles.

To assess the strengths and weaknesses of current SCCs, the researchers surveyed SCCs and also conducted five focus groups. Additionally, SCC participants who completed the online survey were also asked to identify innovative programming within their centers, which helped to produce consistent results across centers regardless of their urban or rural location.

The research found that innovative programming occurs regardless of the center's location, size, or participant characteristics. Innovation was noted when centers thought outside of the physical facility, or a "center-without-walls" approach, and were responsive to the needs and wants of their constituents. There is no one model, or one-size-fits-all description, of innovation.

Lack of flexibility was identified as the biggest impediment to SCC operations and growth. The areas most impacted by inflexibility were SCC funding, transportation, meals, staffing, and Pennsylvania Department of Aging reporting requirements.

The research found that centers lack the ability to share program ideas and find information across centers, whether regionally or across the state. By assisting centers in this area, the state will not only encourage and support innovation in SCC programming, but also provide a vehicle for consistent sharing of information that is currently lacking.

Finally, the research also identified important policy considerations for the Pennsylvania Department of Aging that could help enhance and further support SCCs. These include improved transportation service provision, revitalization of congregate meal offerings, funding, program flexibility, staffing, the sharing of information across programs on a regional and state level, and a centralized marketing initiative to promote Senior Community Centers across the state.

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INTRODUCTION

Senior Community Centers (SCCs), first recognized by the Older Americans Act as a community focal point, have become one of the most widely used services among America's older adults (NCOA, 2017). The mission of Pennsylvania's SCCs, as defined by the Pennsylvania State Plan on Aging 2016-2019, is to promote socialization, engagement, and a positive quality of life (PA.gov, 2019). According to the Pennsylvania Department of Aging (pa.gov, 2019), in addition to providing a nutritious meal, centers offer social activities, a range of informative programs, creative arts, exercise, volunteer opportunities, community services, and other special events, which are unique to individual centers.

SCCs serve people who are 55 years old and older, and they do not have means testing or income requirements for participation. SCCs across the state do not charge fees for attendance or for activities funded through the Area Agency on Aging (AAA); however, they may ask for contributions for some activities, and some centers have a membership fee that is used for fee-for-service activities, such as bus trips. Participants may come whenever they want, and no minimum attendance is required (pa.gov, 2019). Although SCCs provide services that connect participants to their community in a variety of ways, services within the centers are targeted to all seniors and not just those that face isolation, malnutrition or other specific needs.

There are SCCs in all 67 Pennsylvania counties, and many counties have multiple centers. SCCs are a vital link in the distribution of aging services, as they promote socialization, engagement, and a positive quality of life. Nearly 93,000 individuals participate in SCC programming annually, with an aggregate of more than 3.8 million annual visits. Over the past 3 years, the Pennsylvania Department of Aging has awarded over $6 million in state lottery-funded grants to SCCs to update facilities or to implement innovative programs so that these vital resources can remain a focal point in the community. To preserve the viability of these resources, the department recognizes that it must not only promote existing services and enhance the quality of services, but also improve cultural competence to draw a larger, more diverse population and be fully inclusive (pa.gov, 2019). Although most seniors participate in an SCC in their home county, there are no restrictions as to where a senior may attend a center.

Operational funding for SCCs is primary based on block grants and is managed by the local AAA for Senior Centers. As noted by Mr. Robert Cherry, Aging Services Specialist, Division of Older Americans Services Act, Pennsylvania Department of Aging (PDA):

> Senior centers are not funded with a specific allocation. The amount of funding an AAA applies to the senior program is determined locally. The vast majority of funding an AAA receives is in the form of a block grant. This gives the AAA the latitude to meet the unique needs of its constituency within the framework established by PDA. The amount each AAA receives in the block grant is

> determined through the application of an intrastate funding formula that weights several factors and applies that to census data (*Personal Communication*, June 12, 2019).

Funding for SCCs in Pennsylvania comes from the state lottery, which supports all aging services. The average annual cost to operate an SCC in Pennsylvania ranges from $16,798 to about $4 million, with a mean of about $578,838 and a median of about $299,866.

SCCs also provide evidenced-based health and wellness programming, and they receive some of their funding based on the provision of these programs. According to Ms. Katrina Kyle, Health and Wellness Program Specialist, Education and Outreach Office, PDA:

> If a senior community center's local Area Agency on Aging is providing the funding through the federal Older American's Act Title IIID funding, then the limitations are set by their local AAA. For those Title IIID funds, AAAs submit a Health and Wellness Annual Plan for each fiscal year on what evidence-based programs they will use those funds and in accordance with the Administration for Community Living's allowable use of funds. This is detailed out in the 'Aging Program Directive 16-04-01 Older Americans Act Title IIID Funding for Evidence-Based Programs and Health and Wellness Program' which is posted on PDA's website. AAAs may choose the same programs year after year or chose to add or delete programs. To track these programs when they are conducted, information about the evidence-based programs are to be entered in the AAA's SAMS data system, which is also stipulated in APD 16-04-01. SCCs can choose whatever programs they wish as long as they are not using funding that have local, state, or federal obligations (*Personal Communication*, June 18, 2019).

Nationwide, 11,400 SCCs serve more than 1 million older adults every day. The National Center for Health Statistics estimated that 15 percent of all Americans aged 65 and over (roughly 4 million individuals) had attended an SCC in the past year (NCOA, 2017). As the nation prepares itself for an increased need for geriatric health services in the coming decade, SCCs can play a vital role. As the baby boomers age en masse and begin to use aging services, the need for community services will only continue to grow.

In Pennsylvania, population projections show that, in rural counties, senior citizens will increase from 17 percent of the total population in 2010 to a projected 25 percent in 2040 (The Center for Rural Pennsylvania, 2014).

According to the 2016-2020 Pennsylvania State Plan on Aging, SCCs "are a vital linkage in the distribution of aging services, promoting socialization, engagement, and a positive quality of life" (pa.gov, p. 12). SCCs have been an integral part of the continuum of long-term care and provide for significant social and community-based services for the elderly population (Pardasani, 2010). The aging population is defined as all individuals aged 55 years or more.

The question remains about how best to serve this increasing population with limited lottery dollars and continuing state budget funding issues. In addition, this new generation of elderly is predicted to be different in many respects from the elderly who have been traditionally served by the aging system, and they are entering the system at a later time in their lives compared to past generations (MaloneBeach and Langeland, 2011, p 125). MaloneBeach et al. (2011) note that the baby boom generation of emerging seniors, in general, have higher educational levels and incomes, and just as they "shook up" the conceptualization of adolescence, they are predicted to also alter the conceptualization of aging.

Pardasani (2010) noted that while the population of elderly continues to increase, it has not translated into "an increased SCC participation" (p. 49). This is a disturbing trend as SCCs have been the hub of social and health support for many elders. Elders who are isolated tend to be in poorer physical and mental health than their counterparts who remain active in family or community activities. Fulbright (2010) found a significant difference in the rates (88 percent vs. 29.1 percent) of reported depressive symptoms in study participants who made friends at an SCC to those that did not have friends (p. 385). Newall and Menec (2015) reviewed the efficacy of the Senior Center Without Walls (SCWOW) concept for home-bound seniors. This concept targets isolated seniors with a phone-in "senior center" approach to reducing isolation. Positive effects of this program included connecting to the larger community, affecting mental well-being and helping to reduce isolation (Newall et al., 2015).

Historically, the traditional role of SCCs has been as a place to socialize and get a nutritious meal. While this mission may sound mundane, SCCs have also provided a vital link to socialization and health care services for many elderly. Numerous studies have noted the health benefits of socialization (Ashida and Heaney, 2008; Pardasani, 2010). These studies demonstrate that psychological and social well-being is positively connected to social supports that seniors can access through participation in an SCC. The importance and role of SCCs cannot be disputed but how best to serve the new population of elderly, the baby boom generation, is just being explored.

Participation in an SCC is influenced by a variety of factors including physical health, psychological well-being, access, and social networks. Ashida and Heaney (2008) found, "The more socially connected older adults perceive themselves to be, the less likely they are to intend to participate in SCC activities" (p.53). This study examined social network characteristics associated with older adults' intentions to participate and actual participation in social activities at a new senior center. Study participants were drawn from an urban, low-income neighborhood. Face-to-face interviews ($N = 126$) were conducted prior to the opening of a senior center in the participants' community. Measures included social network characteristics, social support, social connectedness, and demographic characteristics. Actual participation was assessed approximately 14 months after the senior center's opening. The study found that seniors who see themselves as having social connections, such as family and friends, may not necessarily see the need

to participate in an SCC. Pardasani (2010) noted the most common rationale for participation was the "benefits of socialization" (p. 59). The most common reasons for non-participation were "lack of interest, lack of need, transportation, lack of programs or services needed, and language/ cultural barriers" (Pardasani, 2010, pp. 59-60). The implications of these findings on attracting new, younger, more mobile and more socially connected seniors to SCCs is not known. This must be explored if SCCs want to remain a vital link in the social service delivery chain for all seniors, not just those limited by health, socio-economic status, and mobility, who are the traditional SCC participant.

As the baby boom generation retires en masse, the focus of and services provided by SCCs will need to evolve. As noted by MaloneBeach and Langeland (2011), it may not be that baby boomers are rejecting SCCs but rather they are healthier and have more options, therefore delaying the need for SCCs. Additionally, today's seniors also have strong ties to family and community. The need for volunteerism is evident in this new group of seniors, as is the desire to stay close to family of all ages. Thus, the segregation of children in day care and seniors in SCCs may need to be reconsidered (MaloneBeach and Langeland, 2011). Indeed, the concept of community centers that do not discriminate or make older adults suddenly separate from the community in which they have been a part for many years, may be a more attractive alternative. Some have suggested that SCCs will be transformed by market forces into clubs or country-club-style endeavors (Hostetler, 2011).

Louisiana is taking a different approach to SCCs by focusing more on "wellness centers" (Lawler, 2011). Due to the realization that SCCs must evolve while traditional sources of funding are shrinking, a commission was formed in the state to look at current models of care, with the goal of recommending changes to revise or update the concept of SCCs. The result was a model or models of varying levels of specialized programs for the elderly while maintaining a community focus. The levels or models of care are Community Center, Wellness Center, Lifelong Learning, Continuum of Care, Entrepreneurial Center and Café (Lawler, 2011)

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, and 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 (Lawler, p. 10, 2011).

This reorganization of the models and new conceptualization of SCCs is supported by Knickman and Snell (2002). The idea that society can continue to support the long-term-care needs of a growing elderly population is not viable (Knickman and Snell, 2002). To help reduce the cost of long-term care, accessibility to preventative services needs to be more readily available so seniors can access care sooner.

How seniors themselves view the benefits of participation in an SCC is also a vital link in the continued vitality and use of SCCs. Fitzpatrick, McCabe, Gitelson and Andereck (2005) discuss the relationship between social benefits and social reward as one possible underlying factor associated with SCC participation. Working for pay in some capacity at the SCC (such as assisting the director or leading groups), eating lunch at the center, and living close to the SCC were all associated with the perceived social benefit of the SCC (Fitzpatrick et al., 2005). While these concepts are important, the literature does not address how consumer "buy-in" or "perceived ownership" of the SCC, or the role these concepts might play in to energizing seniors to actively participate in their local center. Clearly the need to examine factors that support best practice models is needed as SCCs attempt to adapt to the challenge of attracting baby boomers to their centers.

A major issue that is relative to baby boomers is how they perceive themselves in relation to aging. Markwood (2013) notes, "Although most SCCs' core components continue to have great value, without a major makeover in physical space, programming, and marketing, it is not surprising that aging baby boomers reject the idea that they are aging" (p.75). Current SCC users tend to be female, have lower socio-economic status, and have significant health issues (Ashida and Heaney, 2008; Fitzpatrick, McCabe, Gitelson and Andereck, 2005; New York City Department of Aging, 2011). Attracting a more diverse, financially secure, better educated, and healthier population is the challenge over the next decade for SCCs. The New York City Department of Aging outlines the core services that "innovative centers" must have while allowing flexibility based on unique features of specific geographic areas (2011). It states that the core services must include the following: "Offer nutritional support (meals), provide a link to public services and benefits, provide a rich variety of linkages to community resources, promote health and healthy behaviors, and provide opportunities for social engagement" (New York Department of Aging, 2011, pp. 51-52). Eaton and Salari (2005) also emphasized the need for physical spaces that are conducive to the lifelong-learning concept that baby boom seniors embrace. "If the learning needs of baby boom consumers are not met, they will seek out other community-based alternatives" (p.478).

Baby boomers see themselves as active and community focused. They expect activities to be outward focused and engaging (Milner, 2007).

Evidence-based programming, as mandated by the federal government through the Older American's Act (OAA) for recreational activities and as monitored for compliancy by PDA in Pennsylvania through

the SCC system of providers, can be both a benefit as it provides demonstrably beneficial health and wellness programs but may also limit programs offered by SCCs.

> As noted in an Aging Program Directive APD#:16-04-01 (Issuance Date:09/29/16), the Pennsylvania Department of Aging (PDA) receives federal funding through the Older American's Act (OAA) Reauthorization 2016 Title IIID to provide disease prevention and health promotion services through the Health and Wellness Program. Under Title IIID of the OAA, funding has been provided since 1987 to states and territories based on their share of the population aged 60 and over for programs that support healthy lifestyles and promote healthy behaviors. Evidence-based disease prevention and health promotion programs reduce the need for more costly medical interventions. …The mission of PDA's Health and Wellness Program is to promote healthier lifestyles among older Pennsylvanians so that there is a measurable improvement in their quality of life and a subsequent reduction in overall healthcare costs. The OAA 2016 reauthorization stipulates that disease prevention and health promotion services are to be "evidence-based health promotion programs, including programs related to the prevention and mitigation of the effects of chronic disease (including osteoporosis, hypertension, obesity, diabetes, and cardiovascular disease), alcohol and substance abuse reduction, smoking cessation, weight loss and control, stress management, falls prevention, physical activity, and improved nutrition (OAA 2016 Reauthorized Section 102, Subsection 14 D, p 3).

Funding for SCCs is directly tied to the provision of evidence-based health and wellness programs. SCCs choose to provide specific evidenced-based programming that is suitable for their center. These programs can benefit the center and its participants if well enrolled and used. However, since some funding for centers is tied to participation in these programs, they must remain an attractive program offering to all center participants to help maintain the center's viability. Baby boomers have options when it comes to programs, especially health and fitness. How they see themselves fitting into current programming at the SCCs will determine how much they participate and how often they attend those programs.

The new baby boomer conceptualization of self presents challenging times for SCCs as they continue to evolve in a climate of decreasing funds. With ever increasing costs and decreasing budgets this can be an insurmountable challenge to some SCCs and their management. A study of California SCCs commissioned in 2010 found that 43 percent of all SCCs in the state were not keeping pace with expenses, and 25 percent were in danger of closing (California Commission on Aging, 2010). The National Planning Care Counsel (2017) estimated that the funding levels for aging services must be increased at least 20 times the per-person amount from 2003 levels. The challenges are many for SCCs to remain a vital link in the aging services chain. Attracting a new generation of seniors, decreased funding,

transportation issues, and providing an ever-increasing list of services are some of the issues facing todays SCCs.

Pennsylvania has an important role to play in helping SCCs evolve from the 20th to 21st century, and in creating a new concept of senior centers. Indeed, in the current 2016-2020 Pennsylvania State Plan on Aging (pa.gov), the first goal and objective relate directly to the provision of SCCs in the state:

> "GOAL 1: PROMOTE EXISTING SERVICES. OBJECTIVE 1.1 *Increase the knowledge and awareness of services supporting older Pennsylvanians among potential consumers, service providers, partners, and the public (p. 22).*

As the primary and most often sole funder of senior care services within the state, PDA remains the largest stakeholder in the successful provision of senior center services. The department is seen not only as the funder from which SCCs receive their monies, but also as a leader in SCC development and growth. PDA's role will not diminish through the next century but will most likely increase as the elderly population within the state increases. As noted by PDA personnel, SCCs are the gateway to other community and home-based elder care services:

> …senior centers are often the place where participants can learn about what services are offered by the AAA, and whether they may be eligible for certain additional services. Senior center directors will often assist participants apply for other aging-related services that they know may be available to the participant *(Robert Cherry, Personal Communication,* June 12, 2019).

Thus, to reach the goal and objective stated above, it is paramount that SCCs continuing their role in assisting seniors as they enter the aging system.

GOALS AND OBJECTIVES

This study was designed to meet five goals. The first goal, creating an inventory of Pennsylvania's rural and urban SCC locations, included the creation of an inventory of the types of services provided and the activities available.

The second goal was to analyze SCC attendance, including evaluation of accessibility/access issues that impact attendance, means of transportation to/from SCC programs, and relevant demographic characteristics.

The third goal was to analyze the challenges and opportunities that SCCs face in providing services to a growing elderly population in rural and urban Pennsylvania. To meet this goal, the research team collected both quantitative and qualitative data regarding challenges and opportunities, including waiting list data. In addition, Census data were used to calculate current numbers of eligible SCC participants by age (individuals over age 55 years) and to project potential users in the next 2-5 years to compare current availability with projected demand.

The fourth goal, identifying innovative and successful models SCCs are using to provide services in rural and urban communities, was conducted to help formulate program recommendations for PDA.

And the final goal was to formulate policy recommendations regarding the development, growth and maintenance of SCCs in Pennsylvania. Policy recommendations were based on the strengths and weaknesses identified by the study.

METHODOLOGY

The study used a two-prong approach for collecting both quantitative and qualitative data. Quantitative data regarding SCC participation, service availability, and use was collected through an online survey. The research also used focus groups to collect qualitative data about the strengths, weaknesses, and innovations of SCCs. The research team met with representatives of PDA to discuss outcomes in which it was interested in pursuing. At that time, a dataset was provided to the researchers that included contact information for all SCC programs in operation effective as of July 1, 2017. Unfortunately, much of the contact information was inaccurate and the research team spent several months locating accurate contact information for the SCCs in Pennsylvania. A revised listing of centers was finalized in January 2018, with email contact information for all but two centers.

While the SCC contact list was being corrected, the research team developed an online survey to compile the total numbers of unduplicated SCC users during the timeframe of reference, to analyze individual center capacity, client use rates, range of services offered, activities available, and relevant demographic characteristics (including LGBTQ participation – PDA requested). The survey also facilitated a preliminary identification of challenges and opportunities being experienced by SCC providers. This data provided the basis for focus group discussions that were scheduled during the next phase of the study.

The survey questions were developed in response to program data provided by PDA that outlined the types of evidence-based programs that were approved for Pennsylvanian SCCs to offer. Given the researchers' professional expertise in the aging field, additional questions were asked to solicit information regarding the availability and use of non-evidence-based programs that are offered by SCCs. The full survey was piloted with an SCC director to ensure that the questions were clear and complete, and the survey was granted content validity by that director.

The researchers contacted 520 SCCs via email to participate in the research. The two (2) centers that did not have email access received a hard copy of the research package. The research package included a memo explaining the goals of the project and the parameters for participation, along with an informed consent form for return, and a link to the study data collection survey. Despite best efforts to secure the largest sample possible, 25 centers had to be removed from the study population because correct contact

information could not be provided. This reduced the study population to 495. Data were collected using Survey Monkey, an online survey program. Involvement in this study was entirely voluntary and potential participants were advised that the Office of Research Protection of Pennsylvania State University had approved the study.

In keeping with established research protocols for maximizing study participation, three follow-up email contacts were completed to encourage all SCC directors to participate in the proposed study. Two student research assistants were recruited to work with the research team on the data collection and analysis process. A follow-up phone call was made to any center whose email was undeliverable to obtain correct contact information. Additionally, letters were mailed to centers who neither responded by email or phone to ensure that every center had equal opportunity to participate.

Survey data was analyzed using Excel and SPSS statistical software. Both aggregate and comparative data (rural centers versus urban centers) was evaluated.

For the focus groups, the researchers initially invited SCC staff and directors, and consumers (through the providers) to attend one of four focus groups on Penn State campuses in Scranton, Philadelphia, Fayette, and Dubois to discuss the preliminary findings, correct any misinformation, offer additional clarification to responses, and to respond to the trends that were identified. The focus group locations were selected to provide attendance opportunities across regions and across rural and urban locations. After receiving a poor response to attend the focus groups at Fayette and Dubois, the format was modified. Two face-to-face groups were held at the Scranton and Philadelphia campuses because enough responses to participate were received. The focus groups at Fayette and Dubois were conducted via video conference. In addition, to provide the most opportunity for SCC staff and/or participants to attend a focus group, a fifth video conference session was added that was open to any SCC across the state. Since a video conference can be accessed by most anyone with a computer and internet access or via phone, the researchers felt this provided the best opportunity for participation. Participants self-selected the focus group they would attend, either the in-person or video conferencing format.

Each of the 495 SCCs received an email and letter that fully outlined the purpose of the study and the focus group. Additionally, registration procedures were also provided to the participants through a letter sent to all SCCs.

All focus group sessions were led by the researchers. The discussions were audio recorded and transcribed. The student researchers transcribed the discussions after training by the principle researchers. The researchers worked with the Center for Rural Pennsylvania on finalizing the focus group script (format/questions). Questions covered all aspects of center operation, from activities to funding, with emphasis on the identification of innovative programming.

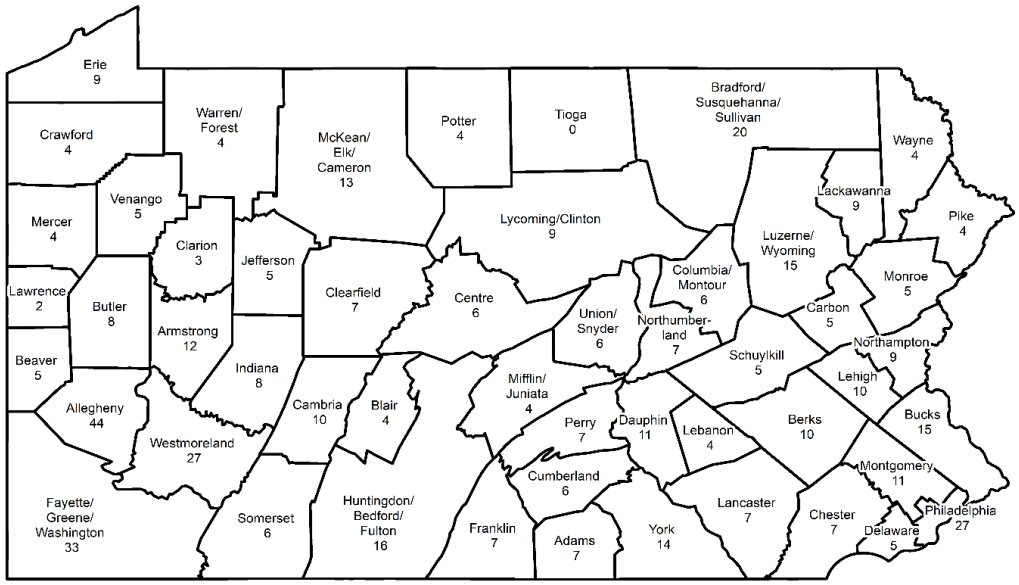
During the meeting with PDA representatives mentioned previously, it was noted that in general, PDA felt uninformed about the size of the population of SCC participants throughout the state - currently and moving into the future. In keeping with PDA recommendation, all those 55 years old and older were included in the potential population of SCC participation. With no documented population size, it is extremely difficult for PDA to plan for SCC services that would meet current and future needs. For this reason, the research team was asked to identify current SSC users, estimate potential users for each county, and calculate projections of potential users for each county within 2-5 years. Using 2016 Census data, the researchers calculated the total number of potential participants in 2017 for each county. Based on population estimates for the following 2-5 years, potential participant projections were calculated for each county. Projections assumed that participation rates for the timeframe under investigation would remain constant for the next 2-5 years. These figures were then used in conjunction with program capacity and use data to calculate gaps and overages in SCC services.

RESULTS

Inventory of Current Senior Community Center Providers in Pennsylvania

In 2018, PDA provided the research team with a list of 520 SCCs in operation across Pennsylvania. Twenty-five SCCs could not be reached by email, telephone or mail, leaving the research team to believe that those centers had ceased operation. The breakdown of operating SCCs by county is summarized in Figure 1.

Figure 1: Senior Community Centers Distribution in Pennsylvania – 2017



Total Rural County Centers = 265 Total Urban County Centers = 230

Nearly 54 percent of SCCs are in rural Pennsylvania counties, and 46 percent are in urban counties.

Data Collected from Senior Community Center Provider Survey

Of total study population to 495, 99 SCCs completed the electronic survey, representing a 20 percent response rate and a margin of error of +/- 9 percent. About 47 percent of respondents were located in rural counties, and about 53 percent were located in urban counties.

Data about SCC operations in 2017 was collected in several different areas, including the following: center administration and operations; participant characteristics; participant recruitment practices; participant involvement in center life; and programs/services provided with use rates.

Center Administration and Operations

Participating SCCs operate on a Monday-Friday schedule, typically between the hours of 9 a.m. and 3 p.m. PDA does not mandate hours of operation but there was no variation in schedule among participating centers. The mean full-time staff at participating centers was 1.0, with a range of 1-4 full-time staff. A strong reliance on volunteers was noted.

About 52 percent of center directors had information about the center's budget. Total budgets reported by respondents for 2017 ranged from about $16,798 to $4 million, with a mean of $578,838 and median of $299,866. Total budgets for 2018 ranged from about $77,060 to $4 million, with a mean of $519,575 and a median of $292,155.

Participant Characteristics

While the research team attempted to collect participant age and gender data from the respondents, center directors reported that such information was not routinely collected. The researchers attempted to estimate participant totals for the under 55-59 and over 60 age groups using PDA provided data, but due to the amount of missing data, they could not provide reliable estimates.

In 2017, 16.2 percent of centers provided services to participants who self-identified as LGBTQ, while 52.5 percent of centers reported they were unsure of client status. The mean percentage of LGBTQ participants was 2.6 percent of the total client population.

Participant Recruitment Practices

Ninety-two SCCs reported engaging in participant recruitment (92.9 percent), and using a variety of strategies (See Table 1).

Table 1: Participant Recruitment Strategies

Recruitment Strategy	% of Recruiting Centers that Use this Strategy (n = 92)
Recruit using referrals by others	93.5%
Recruiting using flyers	83.7%
Recruiting using Facebook	70.7%
Recruit using advertisements in media outlets	69.6%
Recruit using the Center webpage	66.3%
Recruit using Instagram	9.8%
Recruit using Twitter	7.6%

Centers also rated the effectiveness of their recruiting strategies, identifying those they found to be most successful.

Table 2: Effectiveness of Recruiting Approaches

Recruitment Approach	Rating of Most Effective Approaches (n = 92)
Word of mouth	62.0%
Media advertising	16,3%
Referrals by professionals	14.1%
Facebook advertising	9,8%
Flyers and menus	7.6%
Center Newsletter	7.6%
Center website	5.0%
Door-to-door canvas	1.1%
Center location in a mall	1.1%

For the seven centers that did not engage in recruitment activities, two of the reasons were lack of funding to carry out recruitment activities (28.6 percent) and a lack of staff (14.3 percent).

Programs/Services Provided with Usage Rates

The researchers used four categories of programs/services in the study including: congregate meal programs; health and wellness programs; group programs; and recreational programs. The types of programs/services in each of the four categories occupied one of two potential types: evidence-based programs that centers are directed to offer by PDA, and non-evidence-based programs that emerge from center participant interests and requests.

Table 3: Inventory of current senior community services provided in 2017 (n = 99)

Service/Program Category	Specific Service/Program Offered	% of Sample SCCs Offering Program/Service in 2017
Congregate Meal Programs (n = 99)		**82.8%**
Health and Wellness – Evidence Based Programs (n = 99)		**79.8%**
	Chronic Pain Management Program (n=24)	30.4%
	Wellness Initiative for Senior Evaluation (WISE) Program (n = 6)	7.6%
	Positive Self-Management for HIV (n = 1)	1.3%
	Home Meds Program (n=3)	3.8%
	GeriFit Program (n = 12)	15.2%
	Diabetes Self-Management Program (n = 31)	39.2%
	Tai Chi for Arthritis (n = 19)	24.1%
	Enhance Fitness Program (n = 12)	15.2%
	Stay Active and Independent for Life (SAIL) (n = 5)	6.3%
	Tai Ji Quan Moving for Better Balance Program (n=2)	2.5%
	Arthritis Foundation Exercise Program (n = 13)	16.%
	Matter of Balance Program (n = 22)	27,8%
	Walk with Ease Program (n = 19)	24.1%
	Exercise Program (n = 32)	40.5%
Health and Wellness – Non-Evidence Based Program (n = 99)		**29.1%**
	Silver Sneakers (n = 2)	8.7%
	Parkinson's Disease Introduction Class (n=1)	4.3%
	Exercise classes – assorted (n = 3)	13.0%
	Chair Yoga (n = 2)	8.7%
	Monthly health lecture/Wellness education (n 3)	13.0%
	Alzheimer's Support Group (n = 1)	4.3%
	Pickleball (n = 1)	4.3%
	Aqua exercise (n = 1)	4.3%
Health and Wellness – Non-Evidence Based Personal Care Services (n=3)		**13.0%**
	Incontinence Care (n = 2)	8.7%
	Depression/Mental Health Services (n = 2)	8.7%
	Medication Management (n = 1)	4.3%
	Substance Abuse Services (n = 3)	13.0%
	Transportation Services (n = 3)	13.0%
Group Services (n = 99)		**33.3%**
	Healthy Age Program (n = 7)	21.2%
	Chronic Conditions Educational Program (n = 10)	33.3%
Recreation Services (n = 99)		**24.2%**
	Choir	4.2%
	Bingo	12.5%
	Music/Singing	12.5%
	Cards	45.8%
	Computer lab/IPAD classes	15.7%

	Bus trips	16.7%
	Exercise class	20.8%
	Speakers	12.5%
	Knitting	11.1%
	Life skills	11.1%
	Emergency procedures training	11.1%
	Growing Stronger program	11.1%
	TIPS program	11.1%
	Tax preparation	22.2%
	Games	8.3%
	Entertainment	12.5%
	Fund raising events	4.2%
	Dances	8.3%
	Karaoke	8.3%
	Holiday/cultural celebrations	12.5%
	Billiards	4.2%
	Theater	4.2%
	Crafts	25.0%
	Book club	8.3%
	Painting	8.3%
	Discussion group	4.2%
	Qi gong	4.2%
	Meditation	4.2%
	Picnics	4.2%
	Boat rides	4.2%
	Dinners	4.2%
	Wii	4.2%
	Shuffleboard	4.2%
	Walking	4.2%
	Yiddish Club	4.2%

As evidenced by the programs/services offered by the participating centers, clients moderately avail the evidence-based health and wellness programs that are offered, especially physical activity programs aimed at maximizing ambulation and movement. As interest in the evidence-based programs has waned, new non-evidence-based health and wellness programs have emerged in response to participant demand. Given the positive well-being noted by participants in 2017, only three centers offered personal care services, including incontinence care, depression/mental health services, medication management, substance abuse services, and transportation services. It is difficult to ascertain whether the lack of interest in accessing personal care services has driven the offering of services or if the overwhelming view of center directors that the provision of personal care services is not within their mandate has caused a lack of attendance by those needing personal care services. At any rate, among the center directors surveyed, only 1.0 percent indicated that the absence of personal care services limited participant recruitment.

A diverse variety of group and recreational services are offered at the centers. Development of these services is participant-driven, and center staff are highly interested in offering group and recreational services that meet the emerging needs of participants.

Participant Involvement in Center Life

Leadership roles within the SCCs studied included opportunities for participants to serve as members of three planning, decision making, operational, and evaluative bodies: the center board of directors, the center advisory board, and/or the center council. These different types of boards and councils provide essentially the same function, which is to provide advice on the daily operations of the SCC. Organization for these boards is a function of the operational set up of the facility (i.e., whether it is a non-profit or for-profit center and whether it is free standing or part of a larger parent organization) (*Personal communication* Mary O'Donnell, Telespond Senior Services, May, 2018) Therefore, while most have only advisory responsibility, it is possible that in a for-profit, free-standing facility a Board of Directors may have fiduciary responsibility for the fiscal operation of that SCC. Most have advisory capacity on day-to-day center operations and programming.

The National Council on Aging (NCOA) has voluntary accrediting standards that SCCs may choose to apply for to promote themselves as an accredited program. To receive accreditation, SCC's must meet minimum requirements. Part of those requirements is the development of a center advisory board that would be responsible to oversee center operations. (NCOA, Standards and Accreditation, 2019).

Board of Directors

Two-thirds of the 99 respondents reported having an operational board of directors. Within these centers, the board of directors was responsible for a wide variety of center functions, including the following:

- Fiduciary responsibility, 98.1 percent
- Fundraising, 94.2 percent
- Organizational policy/procedure development, 44.0 percent
- Determining center activities and programs, 36.5 percent
- Recruitment of participants, 32.7 percent
- Governance, 16.0 percent
- Strategic planning, 8.0 percent
- Financial oversight, 8.0 percent
- Hiring and firing staff, 4.0 percent

Center participants were chosen for board of director membership participation in a variety of ways, including self-volunteer (40.4 percent), election by center participants (48.1 percent), appointment by the center director (5.8 percent) and nomination by the board of directions (63.5 percent).

Advisory Board

Thirty-nine percent of the respondents have an advisory board. Advisory boards range in size from three to 25 members, with mean size of 11.5 members. Responsibilities of the advisory board were many and diverse. Responsibilities included the following:

- Fiduciary responsibility, 30.8 percent
- Fundraising, 56.4 percent
- Recruitment of participants, 51.3 percent
- Determining center activities and programs, 53.8 percent
- Volunteering within the center, 18.2 percent
- Event planning, 9.1 percent
- Participant advocacy, 9.1 percent
- Liaison between center staff and participants, 9.1 percent
- Community collaboration/networking, 18.2 percent
- Building cleaning, 9.1 percent

On average, senior center participants accounted for 8.9 members (range = 0-25). This suggests that one-third of advisory board members were also senior center participants. Other stakeholders on the advisory boards included community members, aging professionals, AAA staff, center directors, center chaplains, past board members, and center staff.

As is the case with representation on the board of directors, center participants are selected for advisory board participation in a variety of ways, including self-volunteer (33.3 percent election by center participants (43.6 percent) nomination by the board of directors (23.1 percent); appointment by center director (30.8 percent); and nomination by an advisory council member (50.0 percent).

Center Council

Thirty-one percent of respondents reported having a center council. The main activities/services provided by the center councils included:

- Determining programs and activities, 80.6 percent
- Hiring/firing center staff, 6.5 percent
- Recruitment of new members, 67.7 percent
- Fund raising, 21.4 percent
- Program review/revision, 21.4 percent
- Volunteer recruitment, 7.1 percent
- Financial oversight, 14.3 percent

In addition to organizational oversight contributions, SCC participants volunteered significant time and energy in giving back to the community. Specifically, 71.7 percent of participants volunteered to run a center program, 67.7 percent assisted with new member recruitment, 44.4 percent assisted with program

and activity planning, 21.9 percent assisted with congregate meal preparation and serving, 18.8 percent were involved in fund raising, and 9.4 percent delivered home-bound meals in the community.

When center directors were asked to rate participant involvement at their centers, only 4.0 percent rated participants as "not involved." Participants are actively engaged in shaping the direction of services provided at their centers.

Total Number of Unduplicated Consumers Awaiting Senior Community Center Services

Due to the lack of documentation kept by centers, a total number of unduplicated consumers awaiting community center services could not be calculated. Qualitative reports suggest that the numbers of individuals on waiting lists is small and is primarily due to the offering of programs in cooperation with another organization.

Table 4: Percent of Centers with Program Waiting Lists, 2017

Program/Service with Waiting List for Services, 2017	% of Centers Where Waiting List was Reported (n = 99)
Congregate Meals	4.0%
Matter of Balance Program	4.5%
Aqua Exercise	3.1%
Parkinson's Disease Introduction Class	1.0%

County Estimates of Current Potential Consumers of Senior Community Centers

Data provided by PDA for 2017 indicate that 122,181 unduplicated individuals participated in senior center programming. This represents a 3.0 percent participation rate based on the projected total of 4,021,297 persons over age 55 in Pennsylvania as of 2016 (https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?fpt=table).

Due to the socialization model of SCC in Pennsylvania, age is the only criteria used to calculate eligibility for participation. County estimates of current potential consumers of SCCs are summarized in Table 5.

Table 5: Pennsylvania Population Estimates, 2017

County	**Total Persons 55 Years and Older**
Adams	33,135
Alleghany	406,325
Armstrong	24,928
Beaver	61,415
Bedford	17,962
Berks	122,946
Blair	43,793
Bucks	203,988
Butler	60,324

Cambria	51,447
Cameron	2,094
Carbon	22,906
Centre	36,820
Chester	148,291
Clarion	13,093
Clearfield	27,771
Clinton	12,504
Columbia	21,228
Crawford	29,966
Cumberland	75,703
Dauphin	83,019
Delaware	167,882
Elk	11,632
Erie	85,806
Fayette	48,651
Forest	2,660
Franklin	47,746
Fulton	4,963
Greene	12,707
Huntingdon	15,017
Indiana	28,152
Jefferson	15,681
Juniata	8,014
Lackawanna	72,367
Lancaster	156,569
Lawrence	32,422
Lebanon	44,394
Lehigh	106,435
Luzerne	109,301`
Lycoming	38,289
McKean	14,635
Mercer	40,187
Mifflin	15,787
Monroe	52,166
Montgomery	251,200
Montour	6,453
Northampton	95,941
Northumberland	33,263
Perry	15,040
Philadelphia	393,153
Pike	19,450
Potter	6,559
Schuylkill	51,239
Snyder	12,313
Somerset	27,738
Sullivan	2,932
Susquehanna	15,990
Tioga	14,828

Union	12,753
Venango	20,237
Warren	15,673
Washington	73,715
Wayne	20,218
Westmoreland	134,932
Wyoming	9,747
York	134,596
PENNSYLVANIA TOTAL	4,021,297

Source: American Community Survey 5-Year Estimates – 2017
https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?fpt=table

County Projections of Eligible Senior Community Center Participants within 5 years

Given the timing of the study period (2017), and the time frame of projected aging consumer data available, a 5-year projection was possible. For this reason, two county projections were developed (2020 and 2025) to facilitate informed planning moving forward. Using the 3.0 percent participation rate established for the 2017 study year, projections for 2020 indicated that total potential senior center participants across the state will total 120,638. This is fewer participants than those recorded in 2017 (122,181). Projections for 2025 indicated that total potential senior center participants will increase to 137,965. Centers will have 6 years to plan for the addition of 15,784 new clients across the state. With the current level of participation noted across the state, this goal is well within reach with proper planning and funding support. However, this calculation assumes that participation rates will remain constant over the next 5 years. If participation rates increase due to variables other than age, the gap between service availability and need may change. The full list of county projections is provided in Appendix 1.

Strengths and Weaknesses of Current Senior Community Centers

To assess the strengths and weaknesses of current SCCs, the researchers conducted five focus groups were conducted. Two of the focus groups were held at the following physical locations: September 28, 2018, Brandywine Pa. (18 stakeholders responded, 14 participated); and October 19, 2018, Scranton, Pa. (9 stakeholders responded, 9 participated). Three focus groups were held via video conferencing: September 7, 2018, Fayette, Pa. (3 stakeholders responded, 3 participated); October 5, 2018, DuBois Pa. (3 stakeholders responded, 2 participated); and October 26, 2018, Open Session (3 stakeholders responded, 2 participated). A total of 30 representatives from SCCs across the Commonwealth participated in the focus groups. A total of 25 SCCS were represented. There was about a 60/40 split of urban/rural SCCs represented.

The major areas of interest and concern reported by the focus group participants and identified by the researchers through the survey data analysis are identified below. It should be noted that there are

inherent limitations with focus group data. The participants represent a cross-section of SCCs but that does not necessarily follow that all SCCs will share the concerns or experiences presented below.

Innovative Programming from Focus Groups and Online Survey

The good news is that, as reported by the participants of the focus groups, SCCs across the state are providing innovative programming based on the needs of participants in their local area. The key to innovation is two-fold: listening to the needs of the local participants and thinking out of the box. Most centers have moved away in part from the traditional senior center activities such as cards and bingo. This is largely due to participant interests, changing participant demographics, and competition from other venues in the community such as the YMCA/YWCA, gyms, library programs, etc. SCCs noted they must provide a wider variety of educational and cultural activities to attract a younger population of seniors; activities that may or may not be offered currently at the SCC.

Although exercise remains a staple at most centers, the directors across all focus groups noted that participants do not want to participate in the evidence-based exercise programs as required by PDA. Focus group participants reported that the main areas of resistance were the length of time a senior must commit to the program and the amount of paperwork each participant must complete. SCCs noted that current seniors have many options for exercise programs and report preferring to go to a gym, where they are not required to complete a lengthy program assessment or participation paperwork.

To attract participants, centers have begun to rely on different, engaging activities, and, in many cases, programs provided off-site. Some of these include such varied activities as: live music and food; dental labs; hikes at local nature areas; kayaking; diabetic support groups; medical programs and check-ups; and language classes.

The focus groups reported that the most attended programming was trips. These not only include traditional bus trips to local and regional attractions, but also trips to other parts of the U.S. and abroad. This is reflective of the higher expectations of baby boomers for activities in their retirement years. The SCCs reported having travel clubs, which were important not only for the experience each individual trips provides but also to attract new members to the SCC.

The idea of activities outside of the senior center itself is reflected in comments from senior center directors that younger seniors want a "senior center without walls." In other words, they are more active and have other choices, so they want activities that bring them into the community. The SCCs discussed a "center without walls" approach. This means that many activities are not held within the SCCs itself, as they have been done traditionally, but in the community. It appears that younger seniors are more mobile, want to continue to engage with the larger community, and are not content to only participate in activities within the SCC.

To give respondents of the online survey an opportunity to discuss and report on innovative programming in their center, participants were asked, "What service innovations are you most proud of at your Center? What are you doing that is successful and that you think other Centers might like to implement? Thirty-five responses were consistent in terms of those found in the focus groups.

Respondents noted offering trips, lunch and learns sessions, a café during the summer months where breakfast and lunch are offered, tai chi, and yoga. Additionally, out-of-the-box thinking was reflected in such activities as "Catch Others Being Kind," where senior center participants look for random acts of kindness from their fellow participants, who are then celebrated at the end of the month. Centers also noted that wellness programs and those that focused on health were also popular with participants of their centers.

As noted in the focus groups, activities that are community-focused and support the center without walls concept are also popular. Additionally, activities that use the talents of the senior center participants to give back to their community appear to garner a good response, such as knitting shawls for those who have cancer. Art/painting classes were also reported as being very successful.

Interestingly, one center reported being "not sure" when asked about what it is most proud of providing. What is not known from this response is whether the respondent was not sure of the intent of the question or not sure if what his/her center offered was in effect "innovative." If the latter, this may reflect the lack of sharing of information among centers as discussed later in this report.

It appears from the research that today's seniors, for the most part, want a varied program from their SCC. Seniors appear to pick and choose activities based on interest, and they are not attending SCCs daily but when activities or trips are available that suit their individual needs and desires. SCCs therefore must determine what the seniors in their coverage area want and be innovative in their program offerings. A caveat here is that SCC offerings are significantly limited by funding and staffing.

Funding and Funding Issues

As discussed in the focus groups, all SCC directors noted that funding was an issue. SCCs who are affiliated or part of a larger parent organization stated that the larger, parent organization (such as a community service provider of other aging services) can support, at least in part, some of the operational expenses associated with running an SCC. Such areas as staffing (shared staff between programs, especially those in an administrative and not direct care capacity), and marketing were most noted. Free-standing centers are not affiliated with another organization, and shoulder all operational costs of the SCC. Therefore, these centers may have a greater financial burden as there is no alternate funding sources other than what that SCC generates.

Major issues with funding included cutbacks from sources such as United Way and limited funding from the local AAAs and PDA. Staffing issues also limit centers in their ability to spend the necessary time to search for alternate funding sources, such as grants. In addition, restrictions put on funding or fundraising within the centers (i.e., mandates to use the lowest bidder for meals even when the quality of meals provided is poor) negatively impact attendance and participant counts thus reducing reimbursement from AAAs. Additional sources of funding are local foundations. This is a sporadic and undependable source of funding from year to year, but it does allow the centers to pursue innovative activities and programming or to do physical upgrades.

Smaller, more rural centers also have fewer options than urban centers whose program are part of larger organizations that can offset some of the center's operational costs or that can subsidize marketing initiatives. Rural centers and those not affiliated with a parent organization have limited options to look for and secure alternative sources of funding. Most centers use fundraising activities. Here again, centers are limited in how much they can raise by the amount of staff time that can be devoted to this task

The one area that centers were most grateful was a PDA grant for SCC capital improvements. They found these grants to be a useful source of funding. According to Robert Cherry, with PDA, "Each year, the Department of Aging is allocated $2M to make grants to AAA-affiliated senior centers in Pennsylvania. When grant application season opens each year, any AAA-affiliated senior center may apply for funding from $5,000 to $150,000. Applications are evaluated by the Department and submitted to the Governor's office for final award (*Personal Communication*, June 17, 2019).

A portion of grant funding is used on capital improvements and renovations; however, there are restrictions on projects for which a center may apply. For example, many centers choose to upgrade technology, introduce new programming, and improve accessibility.

Transportation

As in real estate where location is one of the most important factors in selling a property, for senior services, it can be said that transportation is one of the most important factors of success. This holds true for SCCs across the state. As noted by the researchers in their previous research, *Home and Community Based Alternatives to Nursing Home Care in Rural Pennsylvania,* and *Adult Day Care in Rural Pennsylvania* (Melnick, and Shanks- McElroy, 2011; Melnick and Shanks-McElroy, 2003), transportation continues to be a major issue and stumbling block for provision of services. The issues raised in the previous studies noted above have not been resolved.

Shared Ride transportation services (in some counties called Coordinated Transportation) continues to be inflexible. The Pennsylvania Department of Transportation (PENNDOT) notes that Shared Ride:

… enables senior citizens 65 years of age and older to use shared-ride, demand-responsive (normally curb-to-curb) services and pay only a small portion of the regular shared-ride fare. Senior citizens or an approved third-party sponsor pay 15 percent of the fare, and the Lottery Fund pays the remaining 85 percent on local shared-ride transportation service. The shared-ride program discount is available in every county of the state during public transportation shared-ride service hours, which are determined locally. (To qualify for the reduced fare, seniors must be at least 65 years of age and be able to supply one of the eligible proofs of age to their local shared-ride provider. Prior-day advance registration is required, and service is available to anyone who either pays the fare or for whom a human service agency pays the fare (PA.gov, 2019.)

As noted in the other studies previously referenced, county transportation (Shared Ride) by and large will not cross county lines. This leaves little recourse for people who are closer to a center in another county. They can either choose to travel greater distances to a center in their home county or find alternate transportation. For many older, disabled seniors there are limited options. If they cannot drive and are limited to county transportation, they must endure very long rides that may be difficult because of their health status.

The limited hours of operation for Shared Ride transportation continues to be an issue as well. SCCs almost unanimously noted that the hours of operation do not allow participants to take full advantage of the SCC and all it has to offer. Inflexibility, in terms of pick up and drop off times, limits participants and their desire to stay later for afternoon programs.

Finally, participant age also becomes a problem when Shared Ride transportation services are required to travel to/from the SCC. Some centers noted that they have younger participants (60 to 64 years of age) who do not qualify for county transportation and who no longer drive. They are left trying to find alternative sources of transportation. For most of these participants, monetary resources are also reduced. For this reason, the option of taking a taxi or Uber/Lyft does not exist for these individuals.

Meals

Meals are not the draw for SCCs as they were in the past. While some centers report that meals are still important, most report that, unless they have a different caterer or cook the meals on site, the high-calorie, high-carbohydrate, congregate meals they typically get from Meals on Wheels are not attractive to younger seniors. Those participants do not come for, nor do they partake in, the meal, preferring to leave and go out for options in the community. Variety appears to be the biggest draw for those centers that can offer their own food choices. Not having a large noon meal but salad bars and sandwiches are the main draw for younger seniors.

Lower-income individuals, on the other hand, are more apt to come to the SCC because of the meal no matter the vendor or lack of meal choice. Although these individuals are certainly one target population of any SCC, they are not the only population of seniors that SCCs are trying to target. Centers want meal programs that are "user friendly." Since the needs of participants vary widely among centers, centers should have the option to choose how and who provides their meals.

PDA Reporting Requirements Co-pilot and SAMS

Center directors are appreciative of the help that comes from PDA. While they understand that reporting is necessary to obtain funds from PDA/AAA, there were varying thoughts on Co-pilot and Social Assistance Management Systems (SAMS) reporting. SAMS is a data entry management system mandated by the federal government. Co-pilot is "a web-based application which utilizes touchscreen technology in order to simplify the collecting and reporting of services consumed by senior citizens at Senior Community Centers" (Information Age Technologies, 2019). However, most of the issues with Co-pilot relate to the amount of paperwork participants must complete. Many forms are multiple pages (14- 17 pages in length). SCCs reported that participants balk at completing the paperwork and refuse to continue to participate.

Some center directors reported that Co-Pilot is underused by PDA in terms of not gathering information that reflects the centers total programming. The reporting hierarchy requires that Co-Pilot data are reported to local AAA coordinators. The AAA coordinators report only evidence-based participation data to PDA, which are just a subset of the total Co-Pilot data that is reported to them by the Centers. As a result, centers felt the information that was reported to PDA did not give an accurate description of their programs.

Marketing

Most participating SCCs did not have a marketing person on staff unless they were part of a larger organization. Marketing to most centers was community outreach and making connections with the community. Center directors did not report knowing of or working on a structured marketing plan. What most talked about was advertising rather than marketing to targeted subpopulations. However, some centers were trying to market to specific populations by using newsletters, blast emails, and social media.

Some participants also noted that restrictions set by the county in which they operate limit where they can advertise. Some SCCs noted that their county does not allow them to advertise or post on social media. The reasons for this restriction are not clear from the focus group data.

One of the best methods for attracting new participants is word of mouth, no matter the size of the program or whether they were part of a larger organization. Centers were almost unanimously in

agreement on this point. Good programing promotes attendance through word-of-mouth – happy participants tell others about the SCC.

An interesting idea from one participant suggested that a larger, statewide ad campaign to educate younger seniors about SCCs and how they have changed be initiated by PDA. She felt that the current public conceptualization of SCCs is outdated. In other words, this isn't your mother's SCC anymore.

Staffing

Staffing was an issue for most SCCs, with rural centers who were not part of a larger organization particularly impacted. SCC directors reported that most were the only paid staff within the center. The desire to have additional staff to assist with activities, marketing, trips, and other duties was widespread among the participants. Only those larger, more urban centers had more than one staff member to operate the center or had access to other resources, such as a marketing person from the larger organization. Centers universally reported the reliance on volunteers, most of whom were center participants, to operate the center. Most SCCs noted that, without the assistance of volunteers, they would not be able to operate their centers.

Sharing of Information

As reported by the participants, there is little to no sharing of information across centers. For all centers, again particularly in rural areas, the ability to share information or to gain insight to innovative programming is limited at best. Currently PDA does not offer support in this area so unless a center belongs to the Pennsylvania Association of Senior Centers (PASC) and staff attends the annual meeting, little information is shared across centers either locally, regionally or across the state. According to Bobbi Manges, PASC executive director, PASC currently has 195 members and membership costs $60 for a new member and $40 for a renewing member. (Personal communication, July 3, 2019). Approximately 39 percent of the total SCCs in Pennsylvania are PASC members.

The participants noted that having some venue, whether a newsletter or a webpage managed through PDA, where program information could be shared would be of great assistance. However, they also noted that, because of limited staff, the centers do not want the primary responsibility of compiling this information as they felt that this would be an additional burden for most SCCs to assume.

Summary

All focus groups strongly noted the aforementioned areas of strengths and weaknesses, innovative programming, funding and funding sources, transportation, meal delivery, PDA reporting requirements, marketing, staffing, and sharing of information. The underlying issue that relates to all of these areas is flexibility or the lack thereof. Flexibility is vitally important to SCCs to respond to the changing demographic of SCC users. SCC staff said they must have the ability to be as flexible as possible to meet the needs of their participants. Flexibility is critical in the following area:

- SCCs need flexibility to offer programs that are not part of the evidence-based programming as prescribed by PDA. While evidenced-based programs are, in their inception, excellent ideas, SCCs noted that they have become too cumbersome and participants refuse to participate in them. No matter how well a program works, if participants do not take advantage of them, they are not fulling their mission. SCCs want to offer and receive funding for alternative programming that their seniors request and will participate in.
- SCCs want to offer meals participants want to eat while still meeting nutritional guidelines. As with programing, if seniors will not eat the meals offered at the SCC then they are not providing any value to those participants. SCCs also noted that, for younger seniors, the meal at the SCC is much less of a draw than it has been for previous generations. With more options, in terms of financial flexibility and food choice offered by local restaurants, many seniors come to their local SCC for some programs but prefer to eat their meals off-site at a place of their choosing. SCCs need the flexibility to choose how to provide a meal (or not provide a meal) based on the needs of their individual participants.
- Shared-ride transportation remains an issue in providing access to services regardless of SCC location (i.e., rural or urban). Flexible transportation that meets the needs of the participants, in terms of pick-up and drop-off times, and takes participants to the center closest to them, even if it is across county lines, would assist centers in maximizing the use of their centers while reaching the senior population who do not have private transportation.
- Funding that is stable and reflects the need for growth in this important service, as well as the flexibility to spend funds with less restrictions, is vital to the well-being of SCCs. It is difficult to plan long-term, as must be done as baby boomers change the look and feel of SCCs, when long-range funding is uncertain. It is assumed that PDA will continue to fund SCCs; but, at what level and with what requirements are the questions that SCCs cannot know. SCCs need to be able to respond to the needs of their individual participants on the local level. Therefore, as much as possible, PDA should look to offer flexibility to the centers to accomplish this goal.

CONCLUSIONS

Summary and Analysis of Challenges and Opportunities in Providing Senior Community Center Services to Rural and Urban Areas

SCCs are a vital link between seniors and aging services. Centers report a wide, varying range of programs and activities. SCC directors demonstrated a high level of commitment to their participants, and their care for them was evident in the comments they made through the focus group data collection process.

There are many challenges moving forward for SCCs in Pennsylvania. One major area is staffing. SCC directors reported few paid staff within the centers, with most operating with one paid staff person. Staffing issues can impact centers in either a positive or negative way. With adequate staff, SCCs can perform vital duties such as developing programs and applying for grants. It also allows for some center staff to attend conferences run PASC. Currently, respondents to this research reported lack of staff as one barrier to attending PASC conferences, where innovative program ideas are shared. SCCs also reported having no other source for sharing ideas, and, in many instances, feel isolated from others in their service area and the state.

Centers reported that they rely heavily on volunteers rather than paid staff, with volunteers drawn primarily from center participants. This can be an opportunity as well as a challenge. If participants are actively engaged in the operation of the center, then they may take more ownership in terms of growth and development of the center. This idea can result in participant-generated programming that is responsive to the needs and wants of the people who use the center.

One challenge of relying too heavily on volunteers is that they are untrained. This may be an issue if they have to run programs independently. Also, as volunteers, they may not be consistent in attendance or as reliable as paid staff. And participant volunteers should not be over-burdened. The primary role of the SCC participant is to participate and have a social, recreational experience. Over reliance on participants may make them less likely to attend the center if they feel overburdened or used as unpaid staff. There also may be liability issues, depending on what the activity entails and directors need to be mindful of all these potential issues. Using volunteers also does not allow senior centers to move forward with planning, as volunteers may not be available from year-to-year as paid staff. Abilities or skill sets also will vary depending upon the volunteer. Therefore, it follows that the variety of skill sets brought into the program by volunteers may not be consistent or provide consistency in programming from one year to the next.

Funding for SCCs within the state needs to be reassessed since SCCs see it as a major challenge in several areas moving forward. Overall, most centers see their funding on the decline during the last few

years. They reported that less monies are available through their AAAs and are increasingly worried that funding will be further cut at the local and state levels.

Participants of the focus groups also reported that their funding is largely based on meals served and participation in evidenced-based programming. This presents significant challenges. For most centers, meal attendance has declined as more baby boomers with higher expectations and a desire for more options choose not to eat the meals served at the center. PDA should consider evaluating how the local AAAs fund programs and look more closely at models that move away from meals and evidenced-based programming as the sole criteria for funding. This study did not examine nor did it produce alternatives to this current method, but there may be more stable models that focus on a wider variety of activities, participation and alternative meal provision other than congregate meals.

In terms of evidence-based programming, SCC directors reported only providing these programs because of state mandates. This is because seniors do not want to participate in these programs because of extensive time commitments and paperwork. As previously discussed, the participant must complete weekly reports on their progress: reports that be multiple pages. This is a burden that most seniors do not want to contend with, and, as a result, they do not participate in the evidenced-based programs. While centers have a wide and varying program schedule, they are only reporting the PDA-approved, evidenced-based programs, which tend to have low attendance. Therefore, PDA is not receiving the true picture of what is happening within the centers, and funding may therefore be limited for centers currently and going forward. This finding is supported in the literature. Bobbitt and Schwingel (2017) also found a disconnect between evidenced-based programming as a national strategy and implementation on a local level in SCCs that needed to be more responsive to their clientele.

The opportunities in this area are many. Changing the current reporting and funding structure to allow for more flexibility in meal procurement and activities will not only allow for a clearer picture of current operations, but also allow centers to be responsive to the needs of their local participants, thus attracting more participants to their centers. If potential participants hear negative comments about the food served or the type of activities offered, they may be less likely to explore SCCs in their communities. Baby boomers have many more options then previous generations in terms of leisure activates and meal options. Staying on the current restrictive funding course in these areas will not allow for innovation or growth; it will only result in the decline of this vital first link in the aging services chain. PDA should devise and encourage SCCs to report all of their programming, as it is varied and responsive to the needs of the participants.

Shared-ride transportation continues to be a barrier to service delivery and presents the state with both a challenge to modernize the current delivery system and an opportunity to increase the systems' responsiveness to its consumers. Long-standing issues continue to plague service delivery:

- Not crossing county lines even when a center is in an adjacent community to the potential participant and is closer than taking that person to his/her home county SCC.
- Lack of flexibility in scheduling: transportation systems operate on a very limited time schedule that does not allow for SCC participants to arrive early or later it the afternoon, severely limiting participation in many activities. This limits the participants' opportunities for socialization and is an overall deterrent to attending the center. This is in direct opposition to the idea of SCCs as gateways to the aging service delivery system.
- The amount of time riders spend on vans is also a reoccurring issue. In many cases, riders may spend most of their day on the van instead of at the center. Ride times may be 1 hour or more in some cases.

The state needs to revise the transportation system to reflect the changing needs of consumers. Innovation is needed to bring this system into the 21st century.

A major barrier to innovative programming lies in the inability of centers to share information in a consistent way. Unless a center belongs to PASC and can afford to send a staff member to the annual conference, or has more than one staff member to operate the center, little to no sharing of innovative program ideas occurs. It is both a challenge and an opportunity for PDA to take the lead and find other ways for programs to share ideas, challenges and opportunities to replicate services and programs that are working.

SCC directors report local opportunities to share information as being the most beneficial. Development of regional as well as statewide venues to pass along ideas, to discuss issues and challenges, and to share opportunities would only enhance the development of SCC programming as it responds to the challenges of the baby boomer generation. SSC directors want opportunities to share information, but they need assistance from either the local AAA or PDA.

Finally, the state has an opportunity to educate the general public on the "new" SCC on a statewide level. Centers do not have the funds, time, or expertise to manage large scale marketing campaigns. However, PDA and other state entities, such as the Department of Health Services, have a unique opportunity and the necessary resources to develop public service campaigns that would showcase today's SCCs and all they offer. This would not only educate the public but would help maintain SCCs as gateways to the aging service delivery system. The current conceptualization of SCCs by those that would benefit most are outdated. SCC directors reported that this is a major barrier that they try to overcome at the local level. Seeing all of the activities that are offered would most certainly encourage exploration of local centers by potential participants.

Comparison of Current and Projected Demands for Senior Community Center Programs with Existing Service Capacity for Each County

Using the 3 percent participation rate established for the 2017 study year, projections for 2020 indicated that total potential senior center participants across the state will total more than 120,600. This is fewer participants than those recorded in 2017 (122,181). Projections for 2025 indicated that total potential senior center participants will increase to 137,965. Centers will have 6 years to plan for the addition of 15,784 new clients across the state. With the current level of participation noted across the state, this goal is well within reach with proper planning and funding support. However, this calculation assumes that participation rates will remain constant over the next 5 years. If participation rates increase due to variables other than age, the gap between service availability and need may change.

Identification of Counties Where the Demand for Senior Community Center Services Exceeds Capacity and/or is Expected to Exceed Service Capacity Within the Next 5 Years

Given the low waiting list demand for limited services, there is no sense that the demand for SCC services exceeds capacity at the present time. As new services and programs are introduced in response to community and participant demand, it is doubtful that service demand will exceed service capacity within the next 5 years. However, serious and significant strategic planning and resource allocation will be required to positively accommodate the additional 15,000+ participants who are projected to begin assessing services by 2025.

Identification of Models of Innovative and Successful Senior Community Center Programs and Practices in Pennsylvania

SCC program innovation was evident and commendable. Despite the limitations with staffing and funding, all of the centers that participated in this study demonstrated program innovation, which was directly related to flexibility and the ability to focus on the needs and wants of their constituents. What works or is innovative in an urban center may not be viable in more rural areas. Therefore, this study does not identify particular centers that are innovative but discusses innovation across centers.

Innovation is the ability to think outside of the center, both literally and figuratively. Most centers, while still providing traditional programming such as bingo card games and in-house entertainment, are moving away from sedentary activities to more engaging and active programming. Examples of these types of programs include local, day trips and long-distance travel. Excursions outside of the center are more popular with baby boomers. However, in some centers, these excursions also give participants access to venues, such as shopping centers, that may not be fulfilled by other services. One center noted

that weekly trips to grocery stores and other retail establishments is very popular with participants who no longer drive.

This "center without walls" concept may be the senior center of the future. These centers may have a physical location for meetings and some activities, but the primary focus is on activities outside of the physical center itself. A potential barrier is the transportation issue. Either the center must purchase its own van or bus or participants must find their own transportation to activities in the community.

Some centers find success with evening programs that are purely entrainment-based or educational. Socialization around evening activities that include dinner, drinks and dancing work exceptionally well in some centers, but, not others.

Educational programs on topics ranging from wellness issues, such as blood pressure control or the use of medical marijuana, also demonstrate the interactive nature of programming that attracts a younger generation of elders.

Although as previously noted, while congregate meals are not the attraction to senior center participants as they once were, younger seniors are attracted to programming that features cooking demonstrations by local chefs or cooking classes that focus on unique ethnic cuisine.

All of these examples share the same elements of innovation. In sum, innovation and success revolve around out-of-the-box thinking, flexibility, and the willingness to risk failure in order to try new ideas and be responsive to center participants. Additionally, active, community-focused programming may be innovative now but will most likely be a staple of senior center programming in the near future.

Rural and Urban Analysis of Challenges and Opportunities, Supply and Demand, and Innovative and Successful Program Models for Senior Community Center Service Delivery

From the data collected through the online survey and focus groups, the research found that urban and rural centers had some differences and many similarities. Differences between urban and rural centers included the size and number of participants served and whether the center was part of a larger organization with more resources, which urban centers but not rural reported to be the case in this study. Except for transportation issues, where urban centers had some additional transportation options than rural centers, there were no significant differences in the challenges and issues that SCCs face. Both rural and urban centers struggle equally with balancing PDA mandates for evidence-based programming when participants are more interested in creative, consumer-driven programs. In urban centers, where attendance is higher, funding the balance between evidence-based and non-evidence-based programming may be easier than lower attended rural centers. When such a balance cannot be maintained, the potential loss of participants is increased.

The researchers anticipated more delineation in the focus groups than occurred regarding issues facing urban and rural centers. The issues presented by both rural and urban SCCs, including meals, innovative programming, reporting issues, and marketing, were similar. Responses to the challenges varied, but the researchers found no significant distinctions.

POLICY CONSIDERATIONS

As noted, the lack of flexibility is the main deterrent to continued growth in SCCs. This study found no difference in the art of innovation in programming. Rural centers are just as innovative as urban centers, as both continue to respond to the needs of their constituents.

While each center is unique there are themes that are consistent across centers. Those themes are reflected in the recommendations below.

Transportation: Lack of Availability and Flexibility

As noted in prior research that reviewed Adult Day Care (Melnick et al, 2003) and Home and Community Based Alternatives to Nursing Home Care (Melnick, et al 2012), transportation remains one of the largest barriers to service provision. Almost all centers in this study reported using coordinated transportation services but several centers reported either having or contemplating the purchase of their own vehicle. The lack of flexibility in terms of pick-up and drop-off times limits participants, who rely on transportations services, in fully participating in center activities. As previously noted, the time that seniors spend on the vans is long, and for SCC participants this means that they arrive at the centers later and must leave, in many cases, soon after lunch. They therefore are not able to fully partake in all center activities. The continued issue of vans not crossing county lines when services are closer in an adjacent county has not abated. For many potential participants, this is a deterrent to coming to an SCC, and, therefore, works against the idea of SCCs providing gateway services to the aging population.

While no transportation system can be totally flexible and responsive to all the constituents it serves, the current transportation system is woefully inadequate to handle the increased demands that are coming, if they have not already arrived, as baby boomers enter the aging system in larger numbers. The researchers strongly recommend that PDA launch efforts, such as holding statewide hearings, to understand what is working and what needs to be revised in the transportation system across the state. Innovation in transportation may include adoption of an Uber or Lyft model that is able to respond to the needs of the state's seniors. The state might consider offering grants to counties that develop innovation in transportation, including extended hours, consortiums with sister counties, and shorter commute times.

Funding

SCC respondents said they appreciated PDA efforts to assist centers with grants for program development and capital improvements. SSCs asked that PDA reevaluate funding based on participation in evidenced-based programming and congregate meals. SCCs noted that these are two areas that deter seniors, particularly baby boomers, from participating in their centers.

If PDA values SCCs, then funding models must be revised to reflect the desire to keep SCCs as viable entries into aging services. The amount of available monies for aging services is limited and the demand across all aging services is high. By adequately funding this gateway service, seniors can remain in the community and have better physical and mental health. This will in turn help to reduce the draw on other costlier services.

The researchers recommend that PDA look to reward centers for innovation and support trial and error efforts in this regard, thereby moving away from funding models that no longer meet the needs or desires of SCC participants.

Revitalization of Congregate Meal Offerings

As noted throughout this research, the congregate meal system currently in place needs further review to ensure that it remains vital and provides SCC participants with nutritious low-cost meals they actually want to eat. While some centers did note that their participants came for the congregate meals, most centers reported that meal participation has declined as baby boomers become more prominent in their centers. Younger seniors want healthier, less carb-loaded meals and can choose not to eat at the centers. Thus, meals lose their ability to draw in and retain seniors in the centers. They can be a deterrent for participation especially keeping seniors for a full day of programming. Those centers that have had the ability to move away from these meals and either use catering services that offer choices or prepare the meals on site find that more of their participants use the center for meals. Seniors learn through health classes how to make healthier food choices and then they are served heavy, calorie-laden meals. This is counter intuitive, and this generation of seniors is savvy and can choose not to eat at the centers. Today's seniors want choices, and revisions to the congregate meal program is necessary as is more flexible funding of meals so that centers can choose a meal provider who can met the needs of their participants.

Program Flexibility

Evidenced-based practice is a gold standard to measure any organization's or program's efficacy. PDA should be commended for adopting this standard for the exercise programs it requires SCCs to provide. Indeed, it can be said that this was directed with the best of intentions. However, the evidenced-based exercise programs as used by SCCs at the direction of PDA are not working. It is simply that younger

seniors do not want to complete the extensive paperwork or commit to many weeks of one program. Centers offer the programs because they must, not because they are working.

While providing programming that is proven to be effective is the goal, the programs cannot be so prescriptive and intrusive that no one participates. Modernization, reduction of paperwork, and varied programming are needed.

Staffing Issues

Across programs a major barrier is staffing, specifically the lack of staff for most centers. Most centers reported having one full-time, paid employee or shared staff across multiple centers. Lack of additional staff impeded the center's ability to innovate as well as operate on a functional level. Centers should be commended for achieving all they are currently doing with such limited staff. With only one employee at most centers, vital activities to maintain and grow centers is limited. This impedes service delivery and growth. This issue stems from limited resources.

SCCs report the use of volunteers, mostly participant recruits. While this should be encouraged to promote center ownership by participants, volunteers can only do so much. Funding, as it relates to increasing staff, even a part-time position, would help SCCs move from being reactive to proactive in their development.

Sharing of Information Across Programs on a Regional and State Level

Center directors were enthusiastic about learning what other centers are doing across the state, particularly at a regional level. However, due to low staffing levels and funding issues, most could not participate in PASC. This is an impediment as PASC is a primary source to share information and gain insight into innovative programming. PDA should take an active role in assisting SCCs in this regard. Statewide meetings offered by PDA should not only contain information about reporting requirements but should also focus on sharing new program ideas. Senior center directors report that they do not have the time to organize a statewide or regional online platform or blog to share information, but they were enthusiastic about participating if it could be primarily directed and operated by PDA or another entity.

What SCC directors thought would be most useful is regional meetings. An unintended benefit of the focus groups was the sharing that occurred when directors had an opportunity to talk with each other. Indeed, the researchers frequently needed to redirect the conversation back to the research questions, but it was done with some regret as it was delightful to see the sharing occur. The researchers suggest that PDA help facilitate these connections and build a sharing network, perhaps by using local AAA office regional meetings.

Centralized Marketing to Promote Senior Community Centers Across the State

One of the most innovative ideas generated by the focus groups came from a participant who suggested PDA sponsor advertising across the state to educate today's seniors on what SCCs are and how they are different than the past - a "this is not your mother's senior center" campaign. One of the main barriers to marketing programs is the negative perception that many baby boomers have of SCCs. Educating the public would go a long way in helping centers attract baby boomers. Perhaps PDA can work with the appropriate state agencies to develop a public service campaign.

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APPENDIX -- Pennsylvania Population Projections by County, 2020 and 2025

Source: Pennsylvania State Data Center for the Center for Rural Pennsylvania

		July 2, 2020	3.0% estimate of SC Users	July 1, 2025	3.0% estimate of SC Users
			July 1, 2020		July 1, 2025
County	Age	Total		Total	
Adams County	55-59	7,741		7,118	
Adams County	60-64	7,447		7,516	
Adams County	65-69	6,632		7,079	
Adams County	70-74	5,452		6,048	
Adams County	75-79	3,872		4,775	
Adams County	80-84	2,523		3,117	
Adams County	85+	2,722		2,989	
Adams County	Total	36,389	1,092	38,642	1,159
Allegheny County	55-59	84,634		72,940	
Allegheny County	60-64	92,416		81,845	
Allegheny County	65-69	81,989		87,535	
Allegheny County	70-74	63,107		75,147	
Allegheny County	75-79	41,761		55,023	
Allegheny County	80-84	29,341		33,527	
Allegheny County	85+	38,981		38,868	
Allegheny County	Total	432,229	12,967	444,885	13,347
Armstrong County	55-59	5,181		4,378	
Armstrong County	60-64	5,704		5,055	
Armstrong County	65-69	4,927		5,542	
Armstrong County	70-74	4,095		4,555	
Armstrong County	75-79	2,684		3,484	
Armstrong County	80-84	1,850		2,101	
Armstrong County	85+	2,154		2,225	
Armstrong County	Total	26,595	798	27,340	820
Beaver County	55-59	13,065		10,638	
Beaver County	60-64	14,001		12,718	
Beaver County	65-69	12,087		13,333	
Beaver County	70-74	9,636		11,241	
Beaver County	75-79	6,413		8,243	
Beaver County	80-84	4,651		5,054	
Beaver County	85+	5,738		5,807	
Beaver County	Total	65,591	1,967	67,034	2,011

Bedford County	55-59	3,592		3,273	
Bedford County	60-64	4,022		3,648	
Bedford County	65-69	3,465		3,819	
Bedford County	70-74	2,752		3,185	
Bedford County	75-79	2,190		2,364	
Bedford County	80-84	1,539		1,732	
Bedford County	85+	1,551		1,730	
Bedford County	Total	19,111	573	19,751	592
Berks County	55-59	30,346		27,106	
Berks County	60-64	28,463		29,303	
Berks County	65-69	24,238		26,822	
Berks County	70-74	20,078		22,265	
Berks County	75-79	13,222		17,460	
Berks County	80-84	8,815		10,583	
Berks County	85+	10,779		11,101	
Berks County	Total	135,941	4,078	144,640	4,339
Blair County	55-59	8,695		7,741	
Blair County	60-64	9,152		8,377	
Blair County	65-69	8,519		8,744	
Blair County	70-74	7,538		8,331	
Blair County	75-79	5,130		6,594	
Blair County	80-84	3,406		4,132	
Blair County	85+	4,176		4,334	
Blair County	Total	46,616	1,398	48,253	1,447
Bradford County	55-59	4,807		3,936	
Bradford County	60-64	4,767		4,682	
Bradford County	65-69	4,261		4,532	
Bradford County	70-74	3,749		4,030	
Bradford County	75-79	2,817		3,296	
Bradford County	80-84	1,837		2,277	
Bradford County	85+	1,857		2,117	
Bradford County	Total	24,095	723	24,870	746
Bucks County	55-59	51,815		43,829	
Bucks County	60-64	50,560		49,669	
Bucks County	65-69	41,357		47,726	
Bucks County	70-74	32,507		37,924	
Bucks County	75-79	22,045		28,883	
Bucks County	80-84	14,192		18,021	
Bucks County	85+	16,500		17,788	

Bucks County	Total	228,976	6,869	243,840	7,315
Butler County	55-59	14,550		13,068	
Butler County	60-64	14,589		14,045	
Butler County	65-69	12,307		13,897	
Butler County	70-74	9,652		11,316	
Butler County	75-79	6,429		8,561	
Butler County	80-84	4,347		5,246	
Butler County	85+	5,150		5,490	
Butler County	Total	67,024	2,010	71,623	2,148
Cambria County	55-59	9,571		8,340	
Cambria County	60-64	10,839		9,235	
Cambria County	65-69	10,257		10,264	
Cambria County	70-74	8,105		9,385	
Cambria County	75-79	5,533		7,069	
Cambria County	80-84	3,890		4,443	
Cambria County	85+	5,170		5,171	
Cambria County	Total	53,365	1,601	53,907	1,617
Cameron County	55-59	360		242	
Cameron County	60-64	432		374	
Cameron County	65-69	437		411	
Cameron County	70-74	354		401	
Cameron County	75-79	248		308	
Cameron County	80-84	139		198	
Cameron County	85+	205		196	
Cameron County	Total	2,175	65	2,130	64
Carbon County	55-59	4,852		4,422	
Carbon County	60-64	5,039		4,796	
Carbon County	65-69	4,572		4,766	
Carbon County	70-74	3,684		4,197	
Carbon County	75-79	2,719		3,167	
Carbon County	80-84	1,738		2,153	
Carbon County	85+	1,932		2,057	
Carbon County	Total	24,536	736	25,558	766
Centre County	55-59	8,853		7,850	
Centre County	60-64	8,342		8,626	
Centre County	65-69	7,605		8,014	
Centre County	70-74	6,253		7,221	
Centre County	75-79	4,187		5,464	
Centre County	80-84	2,859		3,359	

Centre County	85+	2,996		3,321	
Centre County	Total	41,095	1,233	43,855	1,315
Chester County	55-59	40,077		36,001	
Chester County	60-64	38,060		38,695	
Chester County	65-69	30,499		35,342	
Chester County	70-74	23,414		27,786	
Chester County	75-79	15,994		20,611	
Chester County	80-84	9,897		12,944	
Chester County	85+	11,072		12,017	
Chester County	Total	169,013	5,070	183,396	5,501
Clarion County	55-59	2,678		2,448	
Clarion County	60-64	2,854		2,623	
Clarion County	65-69	2,600		2,746	
Clarion County	70-74	2,171		2,532	
Clarion County	75-79	1,601		1,902	
Clarion County	80-84	1,123		1,293	
Clarion County	85+	1,119		1,281	
Clarion County	Total	14,146	424	14,825	444
Clearfield County	55-59	6,173		5,517	
Clearfield County	60-64	6,094		5,939	
Clearfield County	65-69	5,263		5,763	
Clearfield County	70-74	4,379		4,778	
Clearfield County	75-79	3,199		3,846	
Clearfield County	80-84	2,294		2,588	
Clearfield County	85+	2,531		2,763	
Clearfield County	Total	29,933	898	31,194	935
Clinton County	55-59	2,434		2,086	
Clinton County	60-64	2,678		2,354	
Clinton County	65-69	2,461		2,697	
Clinton County	70-74	2,208		2,311	
Clinton County	75-79	1,449		1,916	
Clinton County	80-84	1,007		1,155	
Clinton County	85+	1,098		1,190	
Clinton County	Total	13,335	400	13,709	411
Columbia County	55-59	4,325		3,839	
Columbia County	60-64	4,452		4,071	
Columbia County	65-69	4,085		4,210	
Columbia County	70-74	3,491		3,725	
Columbia County	75-79	2,411		3,032	

Columbia County	80-84	1,661		1,931	
Columbia County	85+	1,922		2,033	
Columbia County	Total	22,347	670	22,841	685
Crawford County	55-59	6,002		5,356	
Crawford County	60-64	6,340		5,778	
Crawford County	65-69	5,975		6,032	
Crawford County	70-74	5,084		5,477	
Crawford County	75-79	3,626		4,447	
Crawford County	80-84	2,254		2,918	
Crawford County	85+	2,519		2,720	
Crawford County	Total	31,800	954	32,728	981
Cumberland County	55-59	17,100		15,369	
Cumberland County	60-64	16,626		16,503	
Cumberland County	65-69	14,944		15,770	
Cumberland County	70-74	12,852		13,963	
Cumberland County	75-79	8,667		11,339	
Cumberland County	80-84	5,692		7,036	
Cumberland County	85+	6,787		7,178	
Cumberland County	Total	82,668	2,480	87,158	2,614
Dauphin County	55-59	19,582		17,054	
Dauphin County	60-64	19,923		18,814	
Dauphin County	65-69	17,643		19,045	
Dauphin County	70-74	13,924		16,128	
Dauphin County	75-79	8,414		12,067	
Dauphin County	80-84	5,630		6,707	
Dauphin County	85+	6,402		6,809	
Dauphin County	Total	91,518	2,745	96,624	2,898
Elk County	55-59	2,576		2,375	
Elk County	60-64	2,728		2,498	
Elk County	65-69	2,197		2,590	
Elk County	70-74	1,693		1,905	
Elk County	75-79	1,149		1,468	
Elk County	80-84	965		917	
Elk County	85+	1,100		1,169	
Elk County	Total	12,408	372	12,922	387
Erie County	55-59	18,831		16,942	
Erie County	60-64	20,091		18,157	
Erie County	65-69	17,862		18,786	
Erie County	70-74	13,338		16,402	

Erie County	75-79	9,152		11,588	
Erie County	80-84	6,037		7,318	
Erie County	85+	7,270		7,549	
Erie County	Total	92,581	2,777	96,742	2,902
Fayette County	55-59	9,528		8,819	
Fayette County	60-64	10,379		9,132	
Fayette County	65-69	9,572		9,728	
Fayette County	70-74	8,142		9,295	
Fayette County	75-79	5,694		7,106	
Fayette County	80-84	3,660		4,572	
Fayette County	85+	4,456		4,628	
Fayette County	Total	51,431	1,543	53,280	1,598
Forest County	55-59	532		393	
Forest County	60-64	499		480	
Forest County	65-69	438		405	
Forest County	70-74	385		395	
Forest County	75-79	407		340	
Forest County	80-84	257		328	
Forest County	85+	199		259	
Forest County	Total	2,717	82	2,600	78
Franklin County	55-59	10,678		10,054	
Franklin County	60-64	10,309		10,419	
Franklin County	65-69	9,115		9,794	
Franklin County	70-74	7,647		8,333	
Franklin County	75-79	5,816		6,656	
Franklin County	80-84	3,803		4,662	
Franklin County	85+	4,251		4,566	
Franklin County	Total	51,619	1,548	54,484	1,634
Fulton County	55-59	1,057		1,016	
Fulton County	60-64	1,063		1,007	
Fulton County	65-69	902		1,025	
Fulton County	70-74	840		808	
Fulton County	75-79	634		703	
Fulton County	80-84	422		487	
Fulton County	85+	348		419	
Fulton County	Total	5,266	158	5,465	164
Huntingdon County	55-59	3,265		3,081	
Huntingdon County	60-64	3,209		3,131	
Huntingdon County	65-69	2,789		2,954	

Huntingdon County	70-74	2,623		2,658	
Huntingdon County	75-79	1,881		2,235	
Huntingdon County	80-84	1,167		1,475	
Huntingdon County	85+	1,177		1,300	
Huntingdon County	Total	16,111	483	16,834	505
Indiana County	55-59	5,574		4,931	
Indiana County	60-64	6,204		5,406	
Indiana County	65-69	5,705		5,900	
Indiana County	70-74	4,567		5,279	
Indiana County	75-79	3,211		3,997	
Indiana County	80-84	2,173		2,584	
Indiana County	85+	2,456		2,641	
Indiana County	Total	29,890	899	30,738	922
Jefferson County	55-59	3,358		2,731	
Jefferson County	60-64	3,537		3,211	
Jefferson County	65-69	2,932		3,371	
Jefferson County	70-74	2,395		2,673	
Jefferson County	75-79	1,696		2,063	
Jefferson County	80-84	1,291		1,346	
Jefferson County	85+	1,450		1,542	
Jefferson County	Total	16,659	500	16,937	508
Juniata County	55-59	1,808		1,613	
Juniata County	60-64	1,800		1,783	
Juniata County	65-69	1,621		1,828	
Juniata County	70-74	1,304		1,429	
Juniata County	75-79	877		1,130	
Juniata County	80-84	645		700	
Juniata County	85+	696		760	
Juniata County	Total	8,751	263	9,243	277
Lackawanna County	55-59	14,939		13,569	
Lackawanna County	60-64	15,539		14,576	
Lackawanna County	65-69	13,867		14,692	
Lackawanna County	70-74	11,649		12,640	
Lackawanna County	75-79	7,942		10,276	
Lackawanna County	80-84	5,595		6,444	
Lackawanna County	85+	7,332		7,455	
Lackawanna County	Total	76,863	2,306	79,652	2,389
Lancaster County	55-59	36,032		31,191	
Lancaster County	60-64	35,495		34,816	

Lancaster County	65-69	30,753		33,760	
Lancaster County	70-74	24,846		28,271	
Lancaster County	75-79	17,336		21,899	
Lancaster County	80-84	11,807		14,048	
Lancaster County	85+	14,612		15,172	
Lancaster County	Total	170,881	5,126	179,157	5,374
Lawrence County	55-59	6,237		5,420	
Lawrence County	60-64	7,029		6,074	
Lawrence County	65-69	6,506		6,811	
Lawrence County	70-74	5,034		5,838	
Lawrence County	75-79	3,360		4,367	
Lawrence County	80-84	2,465		2,686	
Lawrence County	85+	3,242		3,239	
Lawrence County	Total	33,873	1,017	34,435	1,033
Lebanon County	55-59	9,645		8,412	
Lebanon County	60-64	9,514		9,443	
Lebanon County	65-69	8,598		9,056	
Lebanon County	70-74	7,347		8,131	
Lebanon County	75-79	5,394		6,474	
Lebanon County	80-84	3,452		4,382	
Lebanon County	85+	4,215		4,411	
Lebanon County	Total	48,165	1,445	50,309	1,509
Lehigh County	55-59	25,368		23,122	
Lehigh County	60-64	24,978		24,513	
Lehigh County	65-69	21,213		24,044	
Lehigh County	70-74	17,151		19,415	
Lehigh County	75-79	11,369		15,086	
Lehigh County	80-84	7,559		9,203	
Lehigh County	85+	9,687		9,890	
Lehigh County	Total	117,325	3,520	125,273	3,758
Luzerne County	55-59	23,431		20,956	
Luzerne County	60-64	23,233		22,765	
Luzerne County	65-69	20,853		22,111	
Luzerne County	70-74	17,936		19,168	
Luzerne County	75-79	12,244		15,664	
Luzerne County	80-84	8,320		9,840	
Luzerne County	85+	10,869		10,954	
Luzerne County	Total	116,886	3,506	121,458	3,643
Lycoming County	55-59	8,094		6,868	

Lycoming County	60-64	8,670		7,844	
Lycoming County	65-69	7,599		8,155	
Lycoming County	70-74	6,030		7,011	
Lycoming County	75-79	4,221		5,260	
Lycoming County	80-84	2,827		3,391	
Lycoming County	85+	3,501		3,602	
Lycoming County	Total	40,942	1,228	42,131	1,263
McKean County	55-59	2,918		2,759	
McKean County	60-64	3,379		2,935	
McKean County	65-69	3,051		3,316	
McKean County	70-74	2,342		2,800	
McKean County	75-79	1,591		2,020	
McKean County	80-84	1,123		1,261	
McKean County	85+	1,292		1,358	
McKean County	Total	15,696	471	16,449	493
Mercer County	55-59	8,021		7,010	
Mercer County	60-64	8,535		7,667	
Mercer County	65-69	7,697		8,119	
Mercer County	70-74	6,091		6,916	
Mercer County	75-79	4,503		5,349	
Mercer County	80-84	3,171		3,640	
Mercer County	85+	4,083		4,155	
Mercer County	Total	42,101	1,263	42,856	1,285
Mifflin County	55-59	3,377		3,081	
Mifflin County	60-64	3,353		3,273	
Mifflin County	65-69	2,696		2,912	
Mifflin County	70-74	2,313		2,372	
Mifflin County	75-79	1,908		2,008	
Mifflin County	80-84	1,349		1,522	
Mifflin County	85+	1,495		1,611	
Mifflin County	Total	16,491	495	16,779	503
Monroe County	55-59	14,313		12,161	
Monroe County	60-64	13,600		13,721	
Monroe County	65-69	10,827		12,856	
Monroe County	70-74	8,496		9,929	
Monroe County	75-79	5,741		7,334	
Monroe County	80-84	3,606		4,558	
Monroe County	85+	3,277		3,866	
Monroe County	Total	59,860	1,796	64,425	1,932

Montgomery County	55-59	61,781		55,575	
Montgomery County	60-64	60,333		59,744	
Montgomery County	65-69	50,018		57,181	
Montgomery County	70-74	39,754		46,566	
Montgomery County	75-79	26,877		34,846	
Montgomery County	80-84	17,542		21,676	
Montgomery County	85+	22,547		22,914	
Montgomery County	Total	278,852	8,366	298,502	8,955
Montour County	55-59	6,806		1,087	
Montour County	60-64	1,447		1,351	
Montour County	65-69	1,193		1,324	
Montour County	70-74	962		1,066	
Montour County	75-79	654		822	
Montour County	80-84	495		514	
Montour County	85+	631		635	
Montour County	Total	6,806	204	6,799	204
Northampton County	55-59	22,398		20,336	
Northampton County	60-64	22,340		21,476	
Northampton County	65-69	18,901		21,415	
Northampton County	70-74	15,832		17,506	
Northampton County	75-79	10,472		13,794	
Northampton County	80-84	6,608		8,397	
Northampton County	85+	8,599		8,653	
Northampton County	Total	105,150	3,155	111,577	3,347
Northumberland Count	55-59	6,999		6,093	
Northumberland Count	60-64	7,096		6,807	
Northumberland Count	65-69	6,421		6,692	
Northumberland Count	70-74	5,323		5,900	
Northumberland Count	75-79	3,727		4,601	
Northumberland Count	80-84	2,651		2,962	
Northumberland Count	85+	3,122		3,252	
Northumberland Count	Total	35,339	1,060	36,307	1,089
Perry County	55-59	3,378		3,189	
Perry County	60-64	3,522		3,287	
Perry County	65-69	3,235		3,281	
Perry County	70-74	2,755		3,096	
Perry County	75-79	1,753		2,336	
Perry County	80-84	971		1,369	
Perry County	85+	947		1,058	
Perry County	Total	16,561	497	17,616	528

Philadelphia County	55-59	93,363		88,871	
Philadelphia County	60-64	93,663		90,001	
Philadelphia County	65-69	79,742		88,633	
Philadelphia County	70-74	63,138		72,837	
Philadelphia County	75-79	41,437		54,655	
Philadelphia County	80-84	28,078		33,027	
Philadelphia County	85+	32,224		34,050	
Philadelphia County	Total	431,645	12,949	462,074	13,862
Pike County	55-59	5,024		4,159	
Pike County	60-64	4,494		4,825	
Pike County	65-69	3,709		4,164	
Pike County	70-74	3,110		3,311	
Pike County	75-79	2,442		2,660	
Pike County	80-84	1,541		1,923	
Pike County	85+	1,280		1,566	
Pike County	Total	21,600	648	22,608	678
Potter County	55-59	1,314		1,033	
Potter County	60-64	1,229		1,220	
Potter County	65-69	1,201		1,190	
Potter County	70-74	1,118		1,095	
Potter County	75-79	865		1,034	
Potter County	80-84	631		735	
Potter County	85+	640		764	
Potter County	Total	6,998	210	7,071	212
Schuylkill County	55-59	10,629		10,171	
Schuylkill County	60-64	11,042		10,316	
Schuylkill County	65-69	9,915		10,523	
Schuylkill County	70-74	8,333		9,070	
Schuylkill County	75-79	5,632		7,221	
Schuylkill County	80-84	3,850		4,489	
Schuylkill County	85+	4,947		4,971	
Schuylkill County	Total	54,348	1,630	56,761	1,702
Snyder County	55-59	2,946		2,715	
Snyder County	60-64	2,741		2,785	
Snyder County	65-69	2,332		2,592	
Snyder County	70-74	1,985		2,152	
Snyder County	75-79	1,462		1,708	
Snyder County	80-84	969		1,157	
Snyder County	85+	1,017		1,110	

Snyder County	Total	13,452	404	14,219	426
Somerset County	55-59	5,482		4,714	
Somerset County	60-64	5,968		5,284	
Somerset County	65-69	5,348		5,590	
Somerset County	70-74	4,377		4,887	
Somerset County	75-79	3,058		3,808	
Somerset County	80-84	2,207		2,449	
Somerset County	85+	2,624		2,745	
Somerset County	Total	29,064	872	29,477	884
Sullivan County	55-59	524		364	
Sullivan County	60-64	572		511	
Sullivan County	65-69	499		527	
Sullivan County	70-74	494		469	
Sullivan County	75-79	395		456	
Sullivan County	80-84	289		336	
Sullivan County	85+	300		354	
Sullivan County	Total	3,073	92	3,017	90
Susquehanna County	55-59	3,386		2,709	
Susquehanna County	60-64	3,572		3,257	
Susquehanna County	65-69	3,067		3,446	
Susquehanna County	70-74	2,753		2,836	
Susquehanna County	75-79	1,981		2,329	
Susquehanna County	80-84	1,224		1,540	
Susquehanna County	85+	1,142		1,302	
Susquehanna County	Total	17,125	514	17,419	522
Tioga County	55-59	2,940		2,447	
Tioga County	60-64	3,238		2,976	
Tioga County	65-69	2,882		3,075	
Tioga County	70-74	2,429		2,682	
Tioga County	75-79	1,885		2,120	
Tioga County	80-84	1,269		1,514	
Tioga County	85+	1,232		1,421	
Tioga County	Total	15,875	476	16,235	487
Union County	55-59	2,899		2,605	
Union County	60-64	2,784		2,735	
Union County	65-69	2,294		2,570	
Union County	70-74	1,930		2,074	
Union County	75-79	1,474		1,720	
Union County	80-84	1,058		1,207	

Union County	85+	1,268		1,350	
Union County	Total	13,707	411	14,261	427
Venango County	55-59	4,023		3,322	
Venango County	60-64	4,625		3,967	
Venango County	65-69	4,073		4,271	
Venango County	70-74	3,085		3,719	
Venango County	75-79	2,298		2,734	
Venango County	80-84	1,579		1,876	
Venango County	85+	1,780		1,941	
Venango County	Total	21,463	644	21,830	654
Warren County	55-59	3,153		2,660	
Warren County	60-64	3,397		3,039	
Warren County	65-69	3,109		3,302	
Warren County	70-74	2,718		2,961	
Warren County	75-79	1,861		2,339	
Warren County	80-84	1,164		1,473	
Warren County	85+	1,314		1,389	
Warren County	Total	16,716	502	17,163	514
Washington County	55-59	15,446		13,340	
Washington County	60-64	16,586		15,067	
Washington County	65-69	14,772		15,761	
Washington County	70-74	12,117		13,623	
Washington County	75-79	7,944		10,564	
Washington County	80-84	5,575		6,379	
Washington County	85+	6,570		6,917	
Washington County	Total	79,010	2,370	81,651	2,449
Wayne County	55-59	4,123		3,503	
Wayne County	60-64	4,197		4,007	
Wayne County	65-69	3,906		4,108	
Wayne County	70-74	3,686		3,686	
Wayne County	75-79	2,709		3,148	
Wayne County	80-84	1,570		2,124	
Wayne County	85+	1,540		1,722	
Wayne County	Total	21,731	652	22,298	669
Westmoreland County	55-59	27,634		24,527	
Westmoreland County	60-64	29,757		26,670	
Westmoreland County	65-69	26,037		28,097	
Westmoreland County	70-74	21,815		23,903	
Westmoreland County	75-79	14,878		18,998	

Westmoreland County	80-84	10,171		11,925	
Westmoreland County	85+	12,606		12,950	
Westmoreland County	Total	142,898	4,287	147,070	4,412
Wyoming County	55-59	2,054		1,715	
Wyoming County	60-64	2,175		2,028	
Wyoming County	65-69	2,076		2,101	
Wyoming County	70-74	1,697		1,871	
Wyoming County	75-79	1,204		1,441	
Wyoming County	80-84	664		936	
Wyoming County	85+	652		727	
Wyoming County	Total	10,522	316	10,819	324
York County	55-59	33,902		30,830	
York County	60-64	32,380		32,955	
York County	65-69	27,540		30,589	
York County	70-74	22,203		25,172	
York County	75-79	14,912		19,354	
York County	80-84	9,504		11,942	
York County	85+	10,319		11,248	
York County	Total	150,760	4,522	162,090	4,862
			125,330		

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