Evidence-Based Programs for Older Adults: A Disconnect Between U.S. National Strategy and Local Senior Center Implementation

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ABSTRACT

While U.S. national policies have been developed to support evidence-based (EB) lifestyle programs for older adults, there has been limited research to determine the extent to which these programs actually reach local communities. This study sought to identify factors that impact the implementation of EB physical activity, nutrition, and chronic disease management programs at regional (Area Agencies on Aging [AAAs]) and community levels (senior Centers [SCs]). Interviews were conducted with directors of four AAAs and 12 SCs to understand their perspectives on EB program implementation. Narratives revealed differences between AAAs and SCs regarding knowledge about EB programs and reasons to promote and adopt these programs. The only agreement occurred when discussing concerns about funding and program inflexibility. Substantial gaps exist between how EB lifestyle programs are promoted and implemented at the regional and community levels.

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Introduction

Increasing chronic diseases in an aging population has focused public policy initiatives on preventing disease, disability, and injury among older Americans through lifestyle interventions aimed at helping older adults learn about and practice healthy behaviors (The Healthy Aging Research Network Writing Group, 2006). For example, the Centers for Disease Control and Prevention (CDC), Administration on Aging (AoA), and National Council on Aging (NCOA) have emphasized the need for community-based health, prevention, and wellness programs that are grounded in research findings. These evidence-based (EB) programs have been proven to increase self-efficacy, decrease health service utilization, and enable participants to adopt healthy self-management behaviors such as increased physical
activity and better nutrition (AoA, 2012). Yet it is difficult to determine the extent to which EB approaches are being utilized (Brownson, Baker, Leet, Gillespie, & True, 2010).

Policies and strategies that promote, sometimes with funding, the use of community-based EB programs for older adults have been developed and implemented by a variety of national organizations. For example, in 2003, the AoA initiated the EB Prevention Program with the goal of increasing seniors’ access to EB interventions proven to be effective in reducing the risk of disease, disability, and injury. The intent of the program was to utilize the aging network as a way to put EB interventions into practice in community settings (Administration for Community Living, 2009). AoA is the lead organization for this program in conjunction with the CDC, the Agency for Healthcare Research and Quality, Centers for Medicare and Medicaid Services, and several other organizations. In addition, AoA has partnered with the NCOA to establish the Center for Healthy Aging. The AoA and NCOA have encouraged an EB framework to promote healthy aging. Their framework characterizes EB healthy aging as a process in which the planning, implementation, evaluation, and sustainability of programs, should be used in order to address health issues (Whitelaw, 2010).

The CDC also promoted the use of EB programs in several ways. In 2002, the CDC created the Aging States Project that provided funds to select states to explore partnerships with local public health departments. In 2004, the CDC added an additional focus on implementing EB wellness programs for older adults. More recently, the CDC has partnered with other organizations such as the AoA and NCOA to promote the use of EB programs throughout the aging network (CDC, 2011).

Despite the efforts to promote EB programs at the national level, surprisingly little is known about whether the programs are reaching the intended audiences. Unquestionably, a key challenge is the highly decentralized nature of service delivery to older persons across the United States (Blancato & Ponder, 2014; O’Shaughnessy, 2008). It is difficult to identify any dominant model of service delivery, and funding and staffing provided to local service providers varies considerably across the states. One of the primary reasons for this variability is the degree to which individual states have chosen to interpret key provisions of the Older Americans Act (OAA). The OAA was enacted in 1965 to give older Americans increased opportunities for participating in the benefits of American society (Pub.L. 89–73, 79 Stat. 218, July 14, 1965). The AoA was established under the direction of the Department of Health and Human Services to oversee efforts set out in the legislation designated by the OAA. The act also mandated that these units divide their states into planning and service areas and designate Area Agencies on Aging (AAAs) to administer programs for the elderly in those service areas. The AoA works directly with the State Departments on Aging to provide OAA funding to the AAAs.
within each state, which in turn, partner with local organizations as providers of service to older adults. A common community service organization that AAAs work with is the senior center. Senior centers (SCs) are community organizations that offer a wide variety of programs and services including meal and nutrition programs, health and fitness programs, and educational and arts programs (Markwood, 2013–14). However, due to decentralization, not all SCs receive funding from the OAA. While many receive federal, state, and/or local government funding—some of which may be distributed through their local AAA—others charge membership fees or specific program and event fees (NCOA, 2012). Because SCs are designated as points of service delivery for older adults by the OAA, are widely recognized as service providers to older adults, and are known to be providers of health, wellness, and fitness programming, they have been chosen as the community organization selected for this study.

While there has been more of a focus on dissemination and implementation of EB programs at the national level, there remains much inconsistency within the aging services network with respect to the implementation of EB programs at the local level (Noonan, Wilson, & Mercer, 2012). Pressman and Wildavsky (1973) were among the first to address implementation research as it relates to public policy. Their work focused on the gap between intent and what is put into action. Because of this gap between evidence and practice, many communities may not be benefitting from EB strategies that could help them meet their public health goals more efficiently and effectively (Noonan et al., 2012). The goal of this study was to increase our understanding of factors influencing the implementation of policies and practices related to EB lifestyle programs from the national to community level.

**Methods**

The study was guided by the diffusion of innovations theory, a framework that helps explain the factors that influence the implementation of innovations (Rogers, 2003). In this study, community-based EB lifestyle programs are the innovation and are defined as any one of the physical activity, nutrition, or chronic disease management programs approved by the AoA as a “highest-tier” program and/or listed on the NCOA Center for Healthy Aging website (NCOA, 2012). A mixed-method research design was employed. In-depth interviews were conducted with Directors of AAAs and SC leaders in the State of Illinois. Surveys were sent to SCs requesting information on center demographics and programming, with a particular focus on their use of EB programs. Rogers’ five stages of the diffusion of innovations theory, including knowledge, persuasion, decision, implementation, and confirmation, was adopted to guide the interviews and data analysis.
According to the Profile of Aging Americans, adults older than 65 represented 13% of the U.S. population in 2011. In addition, of the older adult population in the United States, 21% are a racial or ethnic minority, 28% live alone, and approximately 9% fall below the poverty level. The Census data for Illinois are broadly similar to that of the United States as a whole. The percentage of the population of older adults in Illinois was nearly 13% in 2010 and of those, 21% of adults older than 60 are from a minority background. Additionally, the Community Survey data in Illinois from 2005–2009 indicates that approximately 8% of older adults fall below the poverty level and 25% live alone.

The state of Illinois is divided into 13 AAAs. For this study, four AAAs that represent different geographic sections of the state were selected. These areas include a mix of urban and rural settings, an older adult racial/ethnic minority population between 5% and 12% and a poverty rate of around 6% to 9%. Senior centers in these AAAs range from small, rural centers that serve primarily as congregate meal sites to multipurpose SCs serving large metropolitan areas. In-depth interviews with the directors of the 4 AAAs were conducted. The guide developed for the interviews with the AAAs was designed using the diffusion of innovations theory and the stages of knowledge, persuasion, decision, implementation, and confirmation to guide the questions.

A survey to gather information about SCs was sent to 72 organizations within the four AAA areas. The survey collected information such as organizational characteristics, the demographics of older adults served, and programs offered. Of the mailed surveys, 11 were not viable because the SC was closing or surveys were returned as undeliverable. Of the remaining 61 surveys, 23 centers agreed to participate in the study and completed the survey. Returned surveys were sorted into the following two categories: (1) SCs offering EB nutrition, physical activity, and/or chronic disease management programs or a combination of EB and other exercise programs and (2) SCs offering non-EB programs. Figure 1 shows the type of wellness programs being offered by SCs.

From the 23 SCs that completed the survey, a subset of 12 SCs were selected for in-depth analysis and follow-up interviews. A maximum variation sampling procedure was used to select the subset of SCs in such a way as to include centers offering EB programming, as well as SCs not offering EB programming. In addition, different types of facilities were recruited to include some that serve low numbers of participants and offer only a few programs and others that serve large numbers of participants and offer many types of programs. The sample of SCs selected included those in rural and urban areas, centers that serve racial or ethnic minority populations, and those that serve areas of low socioeconomic status as well as those in more wealthy areas. Table 1 shows a nonparametric analysis using Mann-Whitney U test comparing the centers selected for interviews vs the non-selected
centers. Both groups were similar with respect to racial/ethnic composition (U = 42, p value = .151) and percentage of participants from a rural area (U = 58, p value = .651). However, when comparing the number of participants in the two groups, those centers selected for interviews had a significantly higher (U = 32, p value = .037) number of participants than those that were not selected for interviews.

A total of 12 interviews were conducted on site with the SC directors. Interviews lasted on average 1 hour. The interview guide was based on the five stages of diffusion of innovations theory guiding the study. The guide included questions about how SCs learn about EB programs (knowledge), what influences them to adopt (or not adopt) an EB program (persuasion), their intention to try the innovation (decision), how EB programs are implemented within their facility (implementation), and future plans for offering EB programs within their facilities (confirmation). The Institutional Review Board at the University of Illinois at Urbana-Champaign approved the study. All participants completed a statement of informed consent before data collection.

Table 1. Comparison of Center Surveys Selected and Non-selected for Interviews.

<table>
<thead>
<tr>
<th></th>
<th>All Surveys (n = 23)</th>
<th>Selected Surveys (n = 12)</th>
<th>Non-selected Surveys (n = 11)</th>
<th>Select vs. Non-select</th>
</tr>
</thead>
<tbody>
<tr>
<td>Old adults serveda</td>
<td>628.8 (855.2)</td>
<td>935.2 (1027.3)</td>
<td>294.5 (312.3)</td>
<td>32</td>
</tr>
<tr>
<td>Racial/ethnic minoritiesb</td>
<td>7.3 (10.7)</td>
<td>8.0 (9.0)</td>
<td>6.6 (11.8)</td>
<td>42</td>
</tr>
<tr>
<td>Rural areasb</td>
<td>36.8 (40.9)</td>
<td>25.6 (28.1)</td>
<td>49.1 (46.4)</td>
<td>58</td>
</tr>
</tbody>
</table>

Note. aMean (SD). bPercentage of population served.
Data analysis

All interviews were transcribed, checked for accuracy, and analyzed. Thematic analysis using both an inductive and deductive approach was used to code and theme the interviews (Braun & Clarke, 2006). Inductive analysis allowed patterns, themes, and categories to emerge from the data (Patton, 2002). Conversely, deductive analysis looked at data from the framework of diffusion of innovation theory (Patton, 2002). Each AAA interview was coded independently in an inductive manner by three researchers. Triangulation was used to establish agreement among the coders in order to establish the credibility of the emerging themes. Themes were only considered if an agreement was reached among the researchers. The subset of interviews from the SCs was also coded using inductive analysis in the same manner. Once the independent coding was complete, a codebook was created. Following this process, the researcher proceeded with coding all 12 interviews using NVivo 10 data analysis software (QSR International, 2012). The major themes that emerged from the data occurred in at least 11 of the 12 interviews and appeared anywhere from 40 to 64 times.

Results

Distinct differences were discovered between AAAs and SCs regarding knowledge about EB programs and reasons to adopt these programs. Driven by national policies, AAAs are knowledgeable and supportive of EB programs, while SCs are driven by clients and often expressed concerns about these programs. The only area of agreement was with respect to concerns about funding and program inflexibility. Of the four AAAs and 12 SCs that were interviewed, the themes were organized by the five stages of Rogers’ diffusion of innovations theory (Rogers, 2003):

Knowledge—AAAs Know About EB Programs; Senior Centers Do Not

All of the AAAs recognized the list of “highest-tier” EB programs approved by the AoA and NCOA. While the four AAAs had varying knowledge of the programs, each was most familiar with the following three: Chronic Disease Self-Management (CDSMP), Strong for Life, and Matter of Balance. All four expressed that they had spent time learning about programs in their areas through research and information they received from other organizations, which is reflected in the following quote:

We really did thorough research of what we could possibly afford and what we thought the interest in our area was. (AAA-3)

Of the SCs interviewed, 25% reported no knowledge of the EB programs approved by the AoA and NCOA, 42% were familiar with or had heard of
one of the programs, 25% had heard of only two of the programs, and 8% were familiar with three or more. Quotations indicating this limited knowledge are listed below:

We also hope to do the Strong for Life and CDSMP, those are coming down somewhere. I don’t think I am aware of many (policies about offering programs). (SC-5)

No, and nobody has contacted me to try to do anything like that. (SC-10)

These findings indicate there is a gap between the understanding of EB programs at the regional and community levels.

**Persuasion/decision—AAAs are driven by policy, senior centers by clients**

During the *persuasion* stage a favorable or unfavorable attitude about the program is formed, and during the *decision* stage, additional information about the innovation may be gathered and the innovation may be tried on a trial basis (Rogers, 2003). These stages were combined in this study because they were so closely linked during the interviews. Overall, the AAAs reported a favorable attitude toward EB programs. Their reasons for accepting the programs were mainly based on policy directives from the state and/or AoA that are related to the OAA. In addition, they recognized needs in their area and expressed a desire to meet those needs. This is reflected in the following quotations:

They said we had to do it . . . if you’re gonna spend [Title] IIID money it has to be evidence-based. (AAA-2)

Strategically we knew this was the direction that the Older Americans Act was going, and the Administration for Community Living was going. (AAA-1)

In reports on which EB programs were chosen and why, the most common reasons given were related to funding limitations and ease of use:

Strong for Life—the reason why we chose that is . . . it’s something we could implement everywhere. (AAA-2)

During the interviews with the SCs, they expressed the importance of client-driven programming, not always favorable for many EB programs. Some reasons for not offering EB programs are that SCs perceive a lack of interest among their older clients, changing participant demographics, and competition from other organizations now marketing to seniors. The directors of SCs made it clear that they chose programming mainly based on the preferences of their clients. In cases where the SC was using one of the EB programs, it was considered important that clients showed interest in the programming. This is supported by the following quote:
The exercise group already had their own thing. That didn’t go because they have to buy into it and they didn’t because they liked what they had. (SC-1)

These quotations underscore the fact that even when SCs attempted to offer EB programs, they remained unconvinced the programs were being perceived positively by their clients.

It became clear from the interviews that the centers are struggling to retain clients and have difficulties marketing their services to younger seniors. Offering EB programs, in many instances, did not match the SCs’ priorities for sustaining a successful, thriving organization. In many cases, the SC indicated that the EB programs with which they were familiar were more useful in long-term care and assisted living situations than in SC environments:

A lot of those programs are maybe more for an assisted living or nursing home and not for the clientele here. (SC-8)

This quote highlights that an unintended consequence of the policy to provide funding only to the highest-tier EB programs, is that it forces SCs to choose between offering alternative programming that may target the younger-old and receiving continued Title IIDD funding for their programs.

In addition to the pressure the SCs feel to retain clientele and target the young-old demographic, they discussed at length how they were also facing competition from a growing senior marketplace:

They are going to start offering all these wellness programs … and in 5 to 10 years the YMCAs, hospitals … will all have senior centers. (SC-2)

The concern SCs have about increased competition puts even more pressure on them to prioritize innovation in their programming.

**Implementation—AAAs and senior centers agree on implementation barriers: Funding and program inflexibility**

In response to the question of what would influence the center to offer more EB programs, both AAAs and SCs highlighted concerns about funding. Although the AAAs believe that funding through Title IIDD is valuable and could be an incentive, interviews with both AAAs and SC leaders revealed either that the funding was considered unreliable or that the funding that was available was not sufficient. The quotations below underscore this finding:

I couldn’t give them IIDD funding any longer unless they moved to evidence-based, and—they were just like, “we don’t need that funding.” … We could not convince them, for the little amount of money that we could give—that they should invest in the training. (AAA-3)
They’re not sure what’s happening with the budget. This is the first year that we did CDSMP and Strong for Life, and we don’t know if will continue next year. (SC-2)

It had to be an evidence-based program to get the funding, but they were only going to offer this one. It was like, why would we spend $1,500 to get $800 in funding? (SC-9)

Another interesting perspective is that the allocated funds are insufficient to adequately support the overall mission of these policies and initiatives:

You want to see the philosophy of the federal initiatives, look at the budget. Yes, Title IIID funds evidence-based programs, but really look at how much they are funding. It’s not funding the philosophy. (SC-9)

Availability of funding, perceived local competition, and nonacceptance of the innovation by center participants are factors that discourage SCs from choosing EB programs or continuing or expanding their EB programs. Although the AAAs are heavily influenced by national policies pertaining to EB programs and informal policies promoting the use of EB programs, the SCs had little awareness of or did not take into consideration national policies. Throughout the interviews, both the AAAs and the SCs expressed concerns regarding the complexity and length of some of the programs. In the following quotations, AAA and SC responses have been combined:

We do have feedback from people doing CDSMP is that they wish it would focus on one thing. (AAA-3)

There are just too many things that the programs want you to do. I just don’t want to have to fill out paperwork to be able to offer it here. (SC-8)

These quotations taken together underscore the difficulties and frustrations service providers expressed about implementing the various programs and raises concerns about whether the programs will have long-term success.

**Confirmation—AAAs advocate for the adoption of EB programs; senior centers question their effectiveness**

While the interviews with the AAAs provided little information directly related to the SCs’ choice to keep offering an EB program, they did provide insight into the AAAs’ process of deciding whether to continue to promote EB programs in the areas in which the SCs operate. In this case, the interviews with the AAAs include the beliefs that (1) the programs are making a difference for older adults, (2) EB program implementation will be a continued policy directive, from the OAA and AoA, and (3) they will continue to seek successful and creative partnerships in order to increase dissemination of the programs.
The AAAs reported receiving positive feedback about the programs offered in their areas. The following represents the feedback the AAAs received from SCs and other partners about the EB programs:

The falls, the prevention one was the best, and we have had such good feedback on that. (AAA-3)

This quote underscores the optimistic view the AAAs have about EB programs. Further, the AAAs feel that EB programs will continue to be a priority within the aging network. Comments from the AAA interviews indicate that efforts to extend the use and adoption of EB programs into the future would remain a priority within the OAA Title IIID funding. The following quote represents this sentiment:

Title IIID is the biggest incentive, and we are hopeful that more money will be put into IIID. (AI-3)

During the interviews, the AAAs discussed the importance of choosing partners that could increase the use of EB programs. In many cases, they choose organizations with the capacity to offer EB programs and appear invested in the effort. There were no AAAs interviewed that chose to only utilize one type of partner in these efforts. The following quote reflects the AAAs’ thoughts on choosing partners:

We can’t incentivize local partners by providing them with funds—so we are looking into local sites to provide space, promotion, candidates for training, participants. (AAA-1)

The SC interviews produced few consistent perspectives within the confirmation stage. For the SCs that were offering EB programs, it was difficult to determine what would continue to influence them to offer the program. The remaining centers were not offering EB programs but were offering other types of exercise programs that they were committed to continuing. While no consistent themes emerged in support of continuing EB programs, the centers using, or familiar with EB programs, expressed some ambiguity about whether these programs have successful outcomes, although many centers supported the need for wellness programs:

They liked it but felt they got just as much from this and are back here now. (SC-10)

We want our seniors to have better health and continue to live longer, and as that population becomes the largest population we need to serve them. (SC-7)

This set of responses highlights that SCs are not fully convinced that EB programs are working for their clients. The comments the SCs made about the importance of healthy aging programs is promising, but their
ambivalence regarding the efficacy of EB programs is an area that should be explored further.

Discussion

Because older adults are at high risk for chronic illnesses and related disabilities, encouraging older adults to be more active and practice good nutrition has become a national health priority (Belza, 2007; Center for Healthy Aging, 2006; Chodzko-Zajko et al., 2009). Many programs have been identified, through research, as being effective at helping older adults increase activity levels, practice better nutrition habits, and prevent or manage chronic diseases (AoA, 2012; Belza, 2007; Center for Healthy Aging, 2006). While the use of EB programs is recommended and promoted at the national level, there remains a gap between evidence and practice. Many communities are still not deploying EB strategies that could help them to meet their public health goals (Noonan et al., 2012).

The results of the study indicate that implementation of EB programs at regional and community levels is incomplete at best and that a gap exists between policy (the use of EB programs) and implementation. While information about approved EB programs is available via the AoA and NCOA websites, AAAs in the State of Illinois are primarily focusing on three programs due to ease of use, directives from within their network, and limited resources. All of the AAAs interviewed had some knowledge of a majority of the programs on the list; however, they were most familiar with three programs. In contrast, SCs reported an overall lack of knowledge of EB programs. Some recognized one or more of the three programs promoted by the local AAAs, but most had little or no knowledge of the additional programs promoted at the national level, and few were aware of any existing initiatives and/or incentives to offer EB programs. Lack of knowledge about an innovation is a significant obstacle in the implementation process.

For the AAAs, an important perspective that emerged from the interviews is that this initiative is here to stay due to a growing need for preventive services. However, SCs did not report being motivated by the OAA or other national policy or programming directives. Instead, an important finding from the SC interviews was that centers plan their programming based primarily on their clientele needs and interests. This result supports the findings from a recent study by Casteel, Nocera, and Runyan (2013) that found that 51% of SCs in their study listed “interest expressed by the older adult clientele” as the most important factor in choosing programs. This is significant because many of the SCs indicated that their clients are happy with current programming and did not wish to change or had previously tried an EB program and did not wish to continue it. The reports from the
SCs regarding clients who did not wish to continue EB programs is consistent with studies that have found a high dropout rate in the CDSMP as well as other EB programs (Hughes, Seymour, Campbell, Whitelaw, & Bazzarre, 2009; Verevkina, Shi, Fuentes-Caceres, & Scanlon, 2014). The SCs did not always perceive the EB programs as an advantage to their center or their clients. Most often, this was because the EB programs available to them were perceived to be targeting relatively sedentary older adults and thus were less attractive to younger and more active cohorts of seniors. This is important because in Rogers’ theory, the perceived advantage of a program is linked to how effective that program will be (Rogers, 2003).

A way to increase the use of EB programs is to educate and market directly to older adults so that consumer demand drives the use of EB programming in SCs. Fitzpatrick and McCabe (2008) suggest that regular exposure to information and education is crucial for helping older adults stay informed about the health benefits of SC programs. The literature on smoking cessation suggests that building consumer demand for programs and services related to stopping smoking was a critical factor in the success of the public health campaign to reduce smoking in the United States (Backinger et al., 2010). Similar efforts to build consumer demand for EB prevention programs is needed if we are to see widespread adoption of these programs across the aging network (Chodzko-Zajko & Schwingel, 2009). Educating older adults, as well as physicians and other health care providers who influence their health and wellness decisions, on the benefits of EB programs could build demand for these programs. In addition to being a source of funding, the aging network could take an active role in educating health care providers about EB programs and their advantages for older adults. According to Blumberg, Berger, Cook, and Ruby (2012), AAAs, in particular, could help community organizations by reaching out to medical professionals to establish partnerships and collaborations.

SCs and other organizations that serve older adults have long been facing challenges due to demographic changes as the baby boomers enter the 65+ age group and have struggled with decreasing participation (Pardasani, 2010; Walker, Bisbee, Porter, & Flanders, 2004). SCs are particularly concerned that the baby boomers are not utilizing their services (Pardasani, 2010). Based on the surveys and SC interviews, it is clear that some SCs in Illinois are closing and others are struggling to serve a population that is becoming increasingly diverse in their needs and preferences. An important finding of this study is that SCs did not find that the currently available, highest-tier EB programs were able to help them attract new clientele. While SCs recognize a need to provide options for their older, frailer participants, they also must find ways to attract the aging baby boomer population (Pardasani & Thompson, 2012; Markwood, 2013–14).
Of factors that persuaded centers to decide whether to adopt a program, funding was a prominent theme for both the AAAs and SCs. The result of this study concur with a recent study that was conducted at the community level with local health departments that found funding was an external barrier to the use of EB programs (Sosnowy, Weiss, Maylahn, Pirani, & Katagiri, 2013). However, there was a difference in how AAAs and SCs perceived funding. To the AAAs, OAA funding opportunities were incentives to offer EB programs. The SC interviews, on the other hand, indicate much ambivalence on the topic of funding. Some centers were not incentivized by funding opportunities because the amount was too little or implementing an EB program would cost them more than they actually received. Others felt they would have to forego programs they wanted to offer in order to receive Title IIID funding. Still, there were a few centers for which the funding or training resources they received were a sufficient incentive to offer EB programs, and they reported that additional funding would incentivize them to offer more. This is consistent with resource dependence theory, which suggest that organizational participation in programs is closely linked to the level of funding that accompanies them (Nienhüser, 2008). Therefore, those SCs that are most dependent on the AAAs for funding will be more likely to be influenced by funding offered through the AAAs. The question of funding is an important matter since OAA funding allocated to health promotion programs is very small. In addition, although the OAA is intended to provide seed money only for these EB programs, state agencies and AAAs have had difficulty leveraging other sources of sustainable funding for health promotion and disease prevention activities (Wiener et al., 2006).

An additional concern that AAAs and SCs expressed was the implementation requirements of EB programs. Reducing the amount of paperwork required by centers and participants could ease the administration of EB programs and encourage more participation. These programs also need more flexibility in their implementation. This is a controversial subject because adapting EB programs to fit a particular facility could affect the fidelity of the program, which, in turn, may affect the efficacy of the program (Carvalho et al., 2013). This study supports Carvalho et al.’s recommendation to increase research efforts on adapting EB interventions to determine whether outcomes remain significant. Other studies that support program flexibility recommend that researchers distinguish core elements of a program that must be maintained in order to uphold fidelity from nonessential elements that can be adapted to the needs of a facility without compromising program outcomes (Elliott & Mihalic, 2004; Smith, Hochhalter, Cheng, Wang, & Ory, 2011).

When asked about the continued use of EB programs, the AAAs were confident in their efforts to support EB programs to prevent and manage chronic diseases. All AAA directors interviewed felt that EB programs work
and that there is a need for these types of programs. In addition, the AAAs expressed hope that more resources will be available to assist with the implementation of the programs in the future. From the SC perspective, many SC staff remain unfamiliar with EB programming in general; therefore, more work needs to be done on educating centers about the importance of using programs that are backed by evidence.

Regardless of the support for the use of EB programs at the national level, interviews with the SCs indicate that the centers were not as confident about EB programs as were the AAAs. Perhaps this outcome is because there is conflicting information regarding the effectiveness of such programs (Chodosh et al., 2005). More research that contains objectively measured outcomes versus self-reported outcomes would help establish the credibility of these programs. In addition, because limited knowledge of such programs was an outcome of this study, detailed information about the importance of such programs and the variety of programs available needs to reach the community.

Although this study explored the dissemination and implementation of EB programs across SCs in Illinois, prior research in our laboratory has explored factors influencing organizational change across a broader range of organizations than just SCs. Park et al. (2010) found that the availability of funding for healthy aging initiatives had a significant and predictable impact on the behavior of organizations that had a mission to promote healthy aging. Employing the theoretical model of Burke’s System Theory of Organizational Change, Park et al. showed that the availability of external funding influenced the behavior of organizational culture, leaders, policies, programs, and individual/organizational performance. The present study suggests that SCs may be responding to EB programming in a similar way; however, the absence of significant external funding may be a barrier to the widespread adoption of these programs.

The degree to which the findings of the present study can be generalized to other states, AAAs, and SCs is unclear. The decentralized nature of the provision of services to older adults alluded to in the introduction suggests that it is may never be possible to select a single model of service provision that can be used as a national model. Levels of funding, numbers of employees, qualifications, and training vary considerably and each of these factors can have an influence on how EB programs are selected, implemented, and evaluated (Brownson, Colditz, & Proctor, 2012; Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004). Accordingly, caution is warranted when generalizing the findings of this study. However, to assist with the transferability of the research, detail on the methods and data analysis of our study is provided so that other researchers can have the opportunity to apply the procedures of this study. Another limitation is the utilization of a purposive rather than random sampling strategy for the interviews. Centers selected for the interviews served larger numbers of seniors than those not interviewed, a fact that could have
limited the representativeness of our sample. However, due to the qualitative nature of the study, the methods selected, including interviews and maximum variation sampling, were intentionally intended to capture a wide range of responses. Finally, the delivery sites were limited to SCs for the purpose of this study because SCs are recognized widely as providers of services to older adults and the other organizations that deliver programs are so varied that it was not within the scope of this study to include them. We recognize that other organizations are involved in the dissemination of EB wellness programs and other types of health promotion and disease prevention activities to varying degrees throughout the United States. Future studies could be aimed at another organization type or expanding to SCs outside of the Illinois area.

This study suggests that the diffusion of EB wellness programs to community-level SCs is incomplete and that a gap between policy (the use of EB programs) and implementation exists. This study advances the literature on factors that influence the implementation of EB programs and practices by identifying gaps in the stages of implementation of national policies and initiatives to organizations at regional and local levels. Despite the benefits associated with EB programs for older adults, lack of knowledge about the programs and policies that support their implementation and organizational barriers such as lack of funding or participant buy-in impede the implementation process in community-level organizations such as SCs. Understanding how current policies and initiatives impact community-level organizations will help researchers and practitioners develop future efforts to improve the implementation of EB programs.

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**References**


