Transformative learning partnerships: bridging research and practice to improve the lives of older people

Rhoda Helton Meador

Iowa State University

Follow this and additional works at: https://lib.dr.iastate.edu/rtd

Part of the Adult and Continuing Education Administration Commons, Adult and Continuing Education and Teaching Commons, and the Gerontology Commons

Recommended Citation
Meador, Rhoda Helton, "Transformative learning partnerships: bridging research and practice to improve the lives of older people" (2008). Retrospective Theses and Dissertations. 15718.
https://lib.dr.iastate.edu/rtd/15718

This Dissertation is brought to you for free and open access by the Iowa State University Capstones, Theses and Dissertations at Iowa State University Digital Repository. It has been accepted for inclusion in Retrospective Theses and Dissertations by an authorized administrator of Iowa State University Digital Repository. For more information, please contact digirep@iastate.edu.
Transformative learning partnerships: Bridging research and practice to improve the lives of older people

by

Rhoda Helton Meador

A dissertation submitted to the graduate faculty
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

Major: Family and Consumer Sciences Education

Program of Study Committee:
Leah Keino, Major Professor
Jan Flora
Beverly Kruempel
Peter Martin
Penny Ralston

Iowa State University
Ames, Iowa
2008

Copyright © Rhoda Helton Meador, 2008. All rights reserved.
This work is dedicated to my father,
who ignited my passion for lifelong learning;
and my mother and grandmother,
who taught me the beauty of growing old gracefully.
# TABLE OF CONTENTS

TABLE OF CONTENTS ........................................................................................................ iii 

ABSTRACT ......................................................................................................................... viii 

CHAPTER 1: INTRODUCTION ...................................................................................... 1 

Problem statement ........................................................................................................ 1 

Research context .......................................................................................................... 5 

Conceptual framework ................................................................................................. 6 

Dissertation organization .............................................................................................. 9 

CHAPTER 2: METHODS .............................................................................................. 11 

Research-practice partnerships in family and consumer sciences .............................. 11 

Community-based participatory research .................................................................. 13 

CITRA research-to-practice consensus workshop model ............................................ 16 

Appreciative Inquiry .................................................................................................. 19 

Case study .................................................................................................................... 22 

CHAPTER 3: LITERATURE REVIEW ........................................................................ 24
Overview.................................................................................................................. 24

Aging population........................................................................................................ 24

Social foundations of adult education ................................................................. 27

Constructivist learning theory ............................................................................. 29

Transformational learning theory ........................................................................ 31

Generative dialogue ............................................................................................... 33

Summary ................................................................................................................ 35

CHAPTER 4. TRANSITIONS OF CARE FOR FRAIL ELDERS: A CITRA RESEARCH-TO-PRACTICE CONSENSUS WORKSHOP ................................................ 37

Abstract .................................................................................................................. 37

Background ............................................................................................................. 37

Method ..................................................................................................................... 40

Population .............................................................................................................. 41

Procedures .............................................................................................................. 42

Evidence-based recommendations for practice ................................................. 45

Practice-based recommendations for research .................................................... 46
Implications for practice ................................................................. 75

References .................................................................................... 77

CHAPTER 6. APPLYING HOSPITALITY RESEARCH TO THE DELIVERY OF AGING
SERVICES: RESEARCHERS AND PRACTITIONERS AS LEARNING PARTNERS... 80

Abstract ........................................................................................... 80

Key words ....................................................................................... 80

Background .................................................................................... 81

Method ............................................................................................ 85

Evidence-based recommendations for practice ..................................... 90

Practice-based recommendations for research ....................................... 92

Discussion ...................................................................................... 92

Implications for research and practice .................................................. 94

References ..................................................................................... 96

CHAPTER 7. SUMMARY, CONCLUSIONS, AND IMPLICATIONS .................. 98

Summary ........................................................................................ 98

Findings and conclusions .................................................................. 98
Implications for research .......................................................................................................................... 108

Implications for practice .......................................................................................................................... 109

BIBLIOGRAPHY ........................................................................................................................................ 112

ACKNOWLEDGEMENTS ......................................................................................................................... 124

BIOGRAPHICAL SKETCH ...................................................................................................................... 126

APPENDIX A  Manuscript Specifications for *Health Promotion Practice* .............................................. 127

APPENDIX B  Manuscript Specifications for *Families in Society* ......................................................... 131

APPENDIX C  Manuscript Specifications for *Educational Gerontology* .................................................. 132

APPENDIX D  Care Transition Consensus Workshop Invitation ................................................................. 134

APPENDIX E  Care Transition Research Review ...................................................................................... 137

APPENDIX F  Care Transition Recommendations ..................................................................................... 149

APPENDIX G  Interview Protocol: Creating Senior Centered Services .................................................... 150

APPENDIX H  Hospitality Consensus Workshop Invitation ....................................................................... 153

APPENDIX I  Hospitality Research Review ............................................................................................... 154

APPENDIX J  Hospitality Consensus Workshop Recommendations ......................................................... 187

APPENDIX K  Institutional Review Board Approval Letters ........................................................................ 189
ABSTRACT

This dissertation focused on consensus building and learning partnerships between researchers and practitioners aimed at improving the lives of older people. A series of three papers used an exploratory qualitative approach to describe the application of innovative methods that bridge the gap between research and practice in three case studies. Three research questions guided these case studies: (1) What joint perspectives and recommendations emerge when participants in community-based participatory research partnerships reach consensus about issues that impact the lives of older people?, (2) What role does learning play in community-based participatory research partnerships involving researchers and practitioners?, and (3) How do the experiences of the participants in the CITRA research-to-practice consensus workshop compare to adult learning practice, and how does adult learning theory describe their experiences?

These papers (1) describe the planning and implementation of the studies, (2) report the recommendations resulting from them, and (3) frame the studies within the context of adult learning theory and practice. Taken together, these papers generated the proposition that participants in the consensus workshops and appreciative inquiry made recommendations for policy, practice and research in areas of critical importance to the improvement of aging services. Evidence was also provided to support the proposition that participants engaged in the acquisition of valuable new knowledge and skills that resulted in a transformation of their meaning schemes and frames of reference.
CHAPTER 1: INTRODUCTION

Problem statement

The U.S. population age 65 and over is projected to double in size within the next 25 years – both as an absolute number and as a percentage of the population. By 2030, almost 20% of Americans – approximately 72 million people – will be 65 years or older. The age group 85 and older is now the fastest growing segment of the U.S. population (U.S. Bureau of Census, 2006).

Figure 1. Number of persons 65+, 1900-2030 (U.S. Bureau of Census, 2006)

Several demographic and social changes in the early decades of the 21st century are likely to produce trends that will dramatically shape health and human services needs over
the coming years. These trends will affect the needs of older adults (aged 65+) and place demands not only on their families, but also on federal, state, and local programs serving the needs of older consumers (Wilmoth & Longino, 2006). This aging population will also be increasingly diverse. Minority populations are projected to increase (U. S. Bureau of Census, 2006) from approximately 6 million in 2000 (16.4% of the older adult population) to 8 million in 2010 (20% of the older adult population); and then to 13 million in 2020 (24% of the older population). By 2050, Hispanics are expected to be the largest ethnic minority in the population aged 65 and older, constituting 16% of that group (U.S. Administration on Aging, 2007).

The baby boom cohort will fuel the population expansion of older adults in the early part of the century. Due to its unprecedented size, this cohort has shaped each social institution it has come in contact with, as “at each stage of their lives, the Baby Boomers have become the dominant concerns of American business and pop culture” (Dychtwald & Flower, 1989, p. 13). While there are no indications that the fundamental social structures of aging will be altered, the sheer size of this cohort will have an impact like no other, because they will be experiencing all age-graded events at the same time (Karner, 2001).

Another important trend that will shape society is a decrease in the age dependency ratio (the number of youth, aged 0-17, per 100 adults) from 51 in 1950 to a projected 42 in 2050 (U.S. Administration on Aging, 2007). In contrast, the number of older adults per 100 people in the adult population (aged 18-65) will rise from 13 in 1950 to a projected value of 36 in 2050 (U.S. Administration on Aging, 2007). In addition to this decrease in the size of the young population relative to the older population, other economic, political, and social
forces will exert pressure on health and human services institutions as they face the challenge of delivering services to an increasingly diverse older population.

This expanding older population, made up of increasingly discriminating individuals, can be expected to motivate health and human services providers to develop new practice models that are more relevant to their evolving needs and desires (Karner, 2001). Provision of services and support will become an increasing challenge as institutions and communities struggle to serve these mixed groups with such varied service and health care needs (Clark, Stump, Hui, Wolinsky, 1998).

This expanding older population is made up of several distinct cohorts of diverse individuals. Strauss and Howe (1992) defined these three cohorts as 1) “Baby Boomers,” born between 1943 and 1960, 2) the “Silent Generation,” born between 1925 and 1942, and 3) the “G. I. Generation,” born between 1901 and 1924. Comprised as a whole, these groups have a wide range of consumer needs, ranging from aging baby boomers, who may be excessively meticulous about their service needs, to those in the "G.I. Generation," who may have complex medical needs.

**Need for new service delivery paradigm**

This challenging environment offers the opportunity to explore new paradigms of service delivery and support that not only improve service, but that provide completely new perspectives about how to design and deliver assistance to older adults (Karner, 2001). Practitioners seeking to serve their constituencies realize that the old model is not working and have been motivated to discover innovative practices that better serve their current and emerging customer base (Wodorski & Williams-Hayes, 2002).
Many visionary organizations have developed innovative practices aimed at incorporating a consumer-centered service paradigm into their practices and policies. Providers of long-term care have developed a variety of innovations aimed at systems change, known as “resident-centered care” and “culture change” (Grant, 1998; 2008). These innovations include practices that signal a shift away from an institutional model to a homelike model featuring empowered staffing, increased sensitivity to cultural diversity, peer-mentoring, consumer choice (Haran, 2006); and the development of smaller, non-traditional nursing homes built around a household model (Rabig, Thomas & Kane, 2006).

In a similar vein, providers of human services to community-dwelling older adults have developed innovative programs and services. Best practices, including health promotion activities, café-style meal programs, and culturally sensitive practices (Beisgen & Kraichman, 2002) offer new models that can be evaluated and replicated on a broader scale. While these innovative efforts to change systems of care and services are encouraging, they impact a small minority of older consumers. If major transformation is to occur within these systems, it is necessary to gain a greater understanding of the factors associated with deep, lasting structural change.

Research aimed at improving the lives of older people has built a strong body of knowledge documenting the success of practices and interventions aimed at improving the health and well-being of older people (Pillemer, Moen, Wethington & Glasgow, eds., 2000). Community leaders, policy makers, and advocates need to understand more about this evidence base in an effort to enable these policies and practices to become normative rather than innovative. There is a growing need to bridge the gap between these constituencies,
combine the knowledge and experience of these groups, and translate practice-informed empirical research into practical applications aimed at improving the lives of older people.

**Research context**

The research described here was conducted from 2005 to 2008 in the context of an organization that is dedicated to bridging this gap between research and practice. This organization, the Cornell Institute for Translational Research on Aging (CITRA), is a part of the Bronfenbrenner Life Course Center at Cornell. The CITRA approach is grounded in Urie Bronfenbrenner’s ecological model (BLCC, 2008).

CITRA was funded by the National Institute on Aging in October, 2003. It is one of four Edward R. Roybal Centers for Translational Research on Aging. CITRA is a unique collaboration of social science, clinical research, and education, encompassing researchers from Cornell's Ithaca campus; research clinicians at the Division of Geriatrics and Gerontology at the Weill Medical College of Cornell in Manhattan, and extension educators from Cornell Cooperative Extension of New York City. This group has joined with community-based aging services organizations from New York City in a partnership that involves researchers, educators, and community participants in joint decisions regarding every step of the research process (CITRA, 2008).

By having close ties to human services providers, the CITRA research collaboration ensures that research efforts are relevant to real-world problems. The major goal of CITRA is to leverage the combined knowledge of an interdisciplinary group of researchers and community partners to promote translational research. Resources and activities include: 1) pilot grant program; 2) methodological assistance for program evaluation and intervention
studies; 3) an on-going seminar which reviews works-in-progress (e.g., grant proposals); 4) a workshop series; and 5) facilitating connections among health and human services agencies in New York City, extension educators, and Cornell researchers in order to foster collaborative research projects (CITRA, 2008). CITRA's overarching mission is to improve the lives of older adults by promoting their full engagement within their communities; and to strengthen their connection with kin, neighbors, coworkers, friends, and significant others. The CITRA infrastructure provided the context for the research described in this dissertation, and, in doing so, allowed the researcher to explore learning within the context of an active research-practice partnership.

Conceptual framework

There were strong conceptual and research bases for these studies. The overarching purpose of this research was to construct a theoretical framework built on the body of knowledge relating to community-research partnerships and transformational learning, and to apply it to the understanding of building consensus and learning partnerships between researchers and practitioners to improve the lives of older people. Thus, three unifying themes bound these studies together. They were

1) the need for positive change in health and human services systems serving older adults and their families;

2) community-research partnerships, and;

3) adult learning.

All three papers examined efforts aimed at generating new knowledge intended to improve the lives of older people through improved aging services, practices, policies, and
research; all are situated within a community-based research paradigm that allows the flow of information and knowledge to pass from the community to researchers and back again into practice (Israel & Schultz, 1998); and all were aimed at building the capacity of researchers and practitioners through a process of adult learning in order to lead to improved practices in aging research and practice.

This dissertation investigated the central phenomenon of “learning partnerships between researchers and practitioners.” The research featured in the three papers was proposition generating, aimed at gathering evidence that will advance the understanding of adult learning within researcher-practitioner partnerships. The primary research questions were:

1. What joint perspectives and recommendations emerge when participants in community-based participatory research partnerships reach consensus about issues that impact the lives of older people?

2. What role does learning play in community-based participatory research partnerships involving researchers and practitioners?

3. How do the experiences of the participants in the CITRA research-to-practice consensus workshop compare to adult learning practice, and which adult learning theories best describe their experiences?

Adult learning, with its emphasis on contextualized learning and perspective change, is especially well-suited as a conceptual framework for learning in the context of CBPR partnerships. It provides the means for participants to (1) join together as equals (Israel & Schultz, 1998); (2) engage in group problem-solving on an issue of joint concern; and (3)
participate in a process of critical reflection potentially leading to perspective transformation (Mezirow, 1995).

I constructed a conceptual model for this research based on the steps in Lewin’s conceptualization of the action research process (Smith, 2001). In Lewin’s model (Figure 2), the initial step is identifying a general idea and examining the facts of the situation. Next the first step of action is taken. After this action is made, a cycle of evaluating, planning and fact finding continues leading to an overall plan and additional steps of action. This process continues throughout the action research process.

![Figure 2: Lewin’s action research process (Smith, 2001)](image)

The model (Figure 3) that I constructed for the research in this dissertation expands Lewin’s model by representing the unique roles that practitioners, researchers and consumers
play in community-based participatory research and the valuable inputs that each bring to the participatory research process. The role of the participants’ assets and the methods used is prominently featured in the context of the learning environment. This extends Lewin’s model to illustrate a comprehensive representation of the experiences as well as the actions of participants in community-based action research.

Figure 3. Meador’s learning model for research-practice partnerships

Dissertation organization

This dissertation is constructed around three papers that relate to the common theme of “transformative learning partnerships: bridging research and practice to improve the lives of older people.” It contains an abstract, introduction, review of literature, three separate papers, a conclusion, and a discussion of implications. The introduction contains an overview of the need for the study and the conceptual framework. The literature review discusses the
demographics of an aging population, generational cohorts, community-based participatory research, transformational learning, and two action research methodologies (appreciative inquiry and research-to-practice consensus workshops). It also contains a review of the literature relating to care transitions and customer service, both of which are relevant to the studies that are part of this research.

The first paper is titled “Transitions of care for frail elders: a research-practice consensus workshop.” The second is “Asset-based practices in aging services: an appreciative inquiry;” and the third is “Applying hospitality research to the delivery of aging services: researchers and practitioners as learning partners.” Due to the interrelated nature of these papers, some repetition occurs in several sections. Figure 4 lists the papers and the journals to which they will be submitted. Manuscript specifications for these journals are detailed in Appendices A, B, and C.

<table>
<thead>
<tr>
<th>Title of Paper</th>
<th>Name of Journal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transitions of care for frail elders: a research-practice consensus workshop</td>
<td><em>Health Promotion Practice</em></td>
</tr>
<tr>
<td>Asset-based practices in aging services: an appreciative inquiry</td>
<td><em>Families in Society</em></td>
</tr>
<tr>
<td>Applying hospitality research to the delivery of aging services: researchers</td>
<td><em>Educational Gerontology</em></td>
</tr>
</tbody>
</table>

**Figure 4.** Titles and journals of papers to be submitted
CHAPTER 2: METHODS

The research described here was accomplished through three studies that examined consensus building between researchers and practitioners through the lens of adult learning. These studies used two innovative research methodologies that are situated in the participatory research paradigm. The first method, the research-practice consensus workshop, brings together research and practitioners to participate in joint reflection and dialogue leading to group consensus. The second method, appreciative inquiry, brings together researchers and practitioners to participate in the joint creation of a new program delivery model.

Each separate paper includes a description of the specific methods and procedures used in each separate study, in addition to the description in this chapter. The methods employed were all qualitative, including semi-structured interviews and transcript analysis. It is also important to note that this research occurs in the context of a unique research paradigm, community-based participatory research. The subsequent section reviews the literature focused on community-based participatory research and describes a unique university-community partnership within which these studies are nested. It also reviews the literature relating to the two participatory research methods that were used: the research-to-practice consensus workshop, and appreciative inquiry.

**Research-practice partnerships in family and consumer sciences**

Health care and human services practitioners face significant challenges in addressing the needs of older people and their families. These problems are both complex and persistent. Family and Consumer Sciences (FCS) professionals have long been concerned with the link
between research and practice and, more recently, many FCS scholars have issued a call to action for university-based researchers in the core disciplines to become more involved in community-research partnerships (Kellett & Goldstein, 1999).

Structured partnerships between researchers and practitioners are a relatively recent phenomenon, but many FCS leaders have championed the idea of translating research to practical applications and partnering with empowered participants in order to improve people’s lives. In fact, these ideas are foundational concepts for the profession. Ellen Swallow Richards had a vision in the late nineteenth century for using science to improve quality of life and this vision led her to attend MIT as a student of science and engineering, which was virtually unthinkable in her time (Hunt, 1980). Even before she graduated, she initiated significant work into food contaminants and the environment. She went on to do field work testing streams, sewage, and water supplies, which led to improved living conditions for individuals and families (Simerly, Nickols & Shane, 2001).

Since a hallmark of FCS has often been this attempt to translate research into practice, FCS researchers have long been aware of the challenges associated with involving community members in the research process. These challenges include bureaucratic barriers within the university itself, time constraints, and the lack of rewards for both researchers and community partners within their practice settings (Perkins, Ferrari, Covey, & Keith, 1996). In fact, since these types of partnerships are not the norm, both groups are going against accepted modes of behavior to engage in them (Faridi, Grunbaum, Gray, Franks & Simoes, 2007).

Urie Bronfenbrenner was a developmental psychologist whose theories evolved in the context of the FCS profession. Most of Bronfenbrenner’s research was conducted during his
tenure at the New York State College of Human Ecology at Cornell University. He believed that research “must be carried out in real-life educational settings . . . with explicit recognition of the delimiting and distorting nature of the laboratory as a setting and deliberately designed to articulate closely with and complement companion research carried out in real-life situations” (Bronfenbrenner, 1979). His primary contribution was the Ecological Systems Theory, which was a holistic systems model intended to provide the framework for a better understanding of children and families in the context of the environments they live in (Bronfenbrenner, 1979).

Bronfenbrenner’s model (1979) included four nested systems, which he called the *microsystem* (the family or school), the *mesosystem* (where two microsystems interact), and the *exosystem* (external environments which influence development, such as the community), and the *macro-system* (the greater social-cultural context). He added the chronosystem in later years (Bronfenbrenner, 2005), to represent the temporal (evolution over time).

Bronfenbrenner’s perspective on human beings and the way they relate to their environment had a major influence on the social sciences, especially the field of child development. As a result of this “bioecological model,” psychologists, sociologists, and other researchers were able to view the relationship between human beings and their environment more holistically (Bronfenbrenner, 2005).

**Community-based participatory research**

The community-based participatory research (CBPR) paradigm has become an increasingly desirable way to unite researchers and practitioners who seek to address these perennial problems (Isreal & Schultz, 1998). This model, which emerged from a trend
toward increased engagement and commitment by universities in their communities (Boyer, 1996) is defined as “a partnership approach to research that equitably involves community members, organizational representatives, and researchers in all aspects of the research process” (Israel & Schultz, 1998).

CBPR has been defined more broadly as, “a collaborative research approach that is designed to ensure and establish structures for participation by communities affected by the issue being studied, representatives of organizations, and researchers in all aspects of the research process to improve health and well-being through taking action, including social change” (Viswanathan, Ammerman, Eng, Gartlehner, Lohr, Griffith, Rhodes, Samuel-Hodge, Maty, Lux, Webb, Sutton, Swinson, Jackman & Whitener, 2004). Within the CBPR context, community is defined as a unit of identity, such as membership in a social network, a geographic neighborhood, or any other socially constructed dimension of identity (Steuart, 1993).

CBPR includes a diverse array of approaches (Stoecker & Bonacich, 1992). The method reflects an increasing recognition that researchers and practitioners seeking to address the same community-related concern can benefit from regular interaction (Viswanathan, et al. 2004). Interaction between these two groups can improve the quality of research studies and produce findings that respond to the needs of practitioners, thus increasing utilization of research findings by practitioners (Israel, Schruman, & House, 1989).

Evidence suggests that modes of participation that are more egalitarian (collaborative and collegiate) lead to partnerships that have a greater likelihood of being sustained over time.
(Herman, 1993). More importantly, there are some indications that community members who experience empowering modes of participation are likely to develop skills that lead them to build stronger social networks, influence policy makers, and raise public awareness about specific challenges faced by themselves and their communities (Becker, Israel, Schultz, Parker, & Klem, 2002).

Previous research indicates that when CBPR is done properly, it has the potential to benefit community participants, researchers, and their constituencies by bringing them together to address shared concerns (Viswanathan, et al., 2004; Israel, et al. 2004). Most research conducted in the context of CBPR partnerships has been in the public health domain, examining a variety of process and health outcomes (Israel & Schultz, 1998).

To better understand the learning process that must take place within CBPR partnerships, there is a need for research that focuses on the development of conceptual models for CBPR based on the framework of adult learning theory. Moreover, little research specifically extends the conceptual framework of transformative learning (Mezirow, 1981) and other adult learning theories to CBPR partnerships.

There are numerous perceived advantages to using a CBPR model (Israel & Schultz, 1998), including the fact that it: 1) insures that the research topic includes topics relevant to the participating community; 2) enhances the application and relevant nature of the topic to both researchers and community members; 3) involves partners with differing skill sets, perspectives, and experience to address a problem; and 4) creates outcomes aimed at improving the well-being of the community. In the case of CITRA, these advantages combine to leverage the collective research knowledge and practice expertise to improve the lives of older people in New York City.
CITRA research-to-practice consensus workshop model

The first and third studies used an innovative method that was developed to bridge the gap between social science researchers and community practitioners. In the course of the CITRA partnership, the concept of a research-to-practice consensus workshop emerged from discussions of ways to bridge the gap between research and practice. The research-to-practice consensus workshop was designed to achieve several specific goals. First, it addressed the need for meaningful dialogue between researchers and practitioners. Opportunities for equal-status contact between researchers and practitioners in which serious research issues can be openly discussed are few (Minkler & Wallerstein, 2003). The consensus workshop model provides a venue for such dialogue.

Second, scientists’ agendas frequently do not reflect the real-world concerns of eventual end-users of research (Stokes, 1997). A primary goal of the consensus workshop model was to identify discrepancies between interventions recommended by research and the actual experience of community-based practitioners. CITRA researchers and community partners jointly assumed that practitioners would be able to shed light on why some programs do not achieve expected results, and could provide important contextual information useful for the design of future intervention research projects.

Third, Kitson, Harvey and McCormack (1998) suggest that effective movement of research evidence into practice requires researchers’ attention to the environment in which the research is to be placed and to the method of facilitating the knowledge transfer, rather than simply assuming that the rigor of the evidence is sufficient justification for adoption. Generally, translating research to practice has meant summarizing research findings and
disseminating them in ways perceived as “palatable” to practitioners, typically in the form of fact sheets or issue briefs. By encouraging practitioners to critique existing research and to place it in actual contexts where older persons are served, the consensus workshop aims to capture practitioner interest and to encourage discussion about the implications for practice.

To achieve the goal of facilitating meaningful dialogue between researchers and practitioners, CITRA modified an existing model popular in the scientific community. Many government agencies and scientific organizations organize “consensus conferences” or workshops (Black, Murphy, Lamping, McKee, Sanderson, Askham & Marteau, 1999; Ferguson, 1993; Goven, 2003). Notable sponsors of such consensus workshops include the National Institutes of Health, the National Academy of Sciences, the Rand Corporation, and major foundations. These events take several different forms, but they usually involve the following steps: (1) A topic is selected that is both an important problem and one on which there is scientific evidence; (2) A group of scientific experts on the topic is selected; 3) A preliminary report is prepared that summarizes available research findings; 4) Meetings of the scientific panel are held involving presentations and discussion of the report; and 5) A final consensus report is produced.
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>Selecting a topic</td>
</tr>
<tr>
<td>(2)</td>
<td>Producing an up-to-date, non-technical translation of the literature</td>
</tr>
<tr>
<td>(3)</td>
<td>Selecting a panel of expert researchers and expert practitioners</td>
</tr>
<tr>
<td>(4)</td>
<td>Convening a larger group of researchers and practitioners for discussion</td>
</tr>
<tr>
<td>(5)</td>
<td>Arriving at an initial consensus statement of research and practice recommendations</td>
</tr>
<tr>
<td>(6)</td>
<td>Convening a follow-up meeting to create a final consensus document</td>
</tr>
</tbody>
</table>

**Figure 5. Major steps in the CITRA research-to-practice consensus workshop**

Although such conferences are often successful in influencing the direction of a field of research, they focus on synthesizing empirical findings without significant input from front-line practitioners. Thus, the consensus findings may fail to reflect the practice wisdom of those who are involved in providing services on a day-to-day basis and thereby risk reduced effectiveness in addressing human problems. In response to this concern, CITRA adapted the standard consensus conference model by integrating practitioners throughout the process. As in conventional consensus conferences, CITRA researchers prepared a systematic review of the recent scientific literature on a particular question of interest. However, in an additional step, research findings were written in less technical language and presented to practitioners who then joined with researchers in a dialogue about the current research and future research priorities.
Previous CITRA research-to-practice consensus workshop have been conducted as a participatory process to reach consensus between researchers and practitioners on topics such as falls prevention in the home (Sabir, et al., 2006), chronic pain management, elder abuse, and social integration.

**Appreciative Inquiry**

In the study described in Chapter 5, the researcher teamed with the community group to conduct a study using the Appreciative Inquiry (AI) method, which was developed by researchers at Case Western Reserve University as an approach to facilitating personal and organizational change. Appreciative inquiry (AI) was developed by researchers at Case Western Reserve University as an approach designed to facilitate personal and organizational change, based on the idea that dialogue about values, dreams, strengths, and successes are themselves transformational (Cooperrider & Avital, 2004). AI often relies on interviews that are structured around a set of core questions (Whitney & Trosten-Bloom, 2003) designed to stimulate reflection and creative thinking on the general affirmative topic.

Appreciative Inquiry is characterized by focusing on the positive elements pre-existing in the system. The concentration on these pre-existing positive conditions is justified by the ideology that reinforcing such positive behavior and conditions will lead to an expansion of an overall sustained, improved system. Like CBPR, AI stems from the action research philosophy (Cooperrider & Avital, 2004; Minkler & Wallerstein, 2003). David Cooperrider and Diane Whitney (2005, p. 9) define AI as being:

… about the co-evolutionary search for the best in people, their organizations, and the relevant world around them. In its broadest focus, it involves systematic discovery of
what gives ‘life’ to a living system when it is most alive, most effective, and most constructively capable in economic, ecological, and human terms. AI involves, in a central way, the art and practice of asking questions that strengthen a system’s capacity to apprehend, anticipate, and heighten positive potential. It centrally involves the mobilization of inquiry through the crafting of the ‘unconditional positive question’ often-involving hundreds or sometimes thousands of people.

Appreciative Inquiry approaches research in a way that theoretically enlightens, in the case of an interview protocol, both the interviewer and the interviewee. By virtue of the structure of questioning, it calls for the illumination of an answer for the interviewer, and reflection on the positive elements of the context on the part of the interviewee. As a tool for management, it allows for the surveying of what creates a most supportive environment for creating change, focusing on the internally available traits and characteristics of the system instead of referencing external sources for support (Srivastiva & Cooperrider, 1990).

The basic principle of seeking out the “positive” as opposed to criticism of any given system is illustrated in the AI literature as a series of different case studies in which AI was performed, resulting in greater capacity constructed from within the organization or system due to a reinforcement of the positive pre-existing conditions (Cooperrider & Whitney, 2005).

In essence, the AI theoretical research perspective seeks to identify experiences when people or organizations are at their best (Cooperrider & Whitney, 2005). The AI technique supports an inquiry process that focuses on what is successful through the discovery of the participant’s peak experiences (Yballe & O’Connor, 2000). Appreciative inquiry questions are designed to facilitate an action research process throughout the four stages of discovery,
Participants are (a) encouraged through the discovery phase to describe who was involved, what occurred prior to the peak experience, and other contributing factors related to the event (Norum, Wells, Hoadley, & Geary, 2002); (b) invited to dream a shared image of an improved organization; (c) coached to design a clear purpose; and (d) inspired to realize the dream in the form of destiny (Cooperrider & Whitney, 2005).

AI is based on the assumption that individuals and the organizations they constitute function best when they are most alive, effective, and masterful. The nature of the AI is to identify the positive core of people (their attitudes, beliefs, and experiences) and organizations through individuals’ narratives of accomplishments and successes (Cooperrider & Whitney, 2005).

Their work is based on the idea that dialogue about values, dreams, strengths, and successes are themselves transformational (Cooperidder & Avital, 2004). AI often relies on interviews that are structured around a set of core questions (Whitney & Trosten-Bloom, 2003) designed to stimulate reflection and creative thinking on the general affirmative topic. Appreciative Inquiry is characterized by focusing on the positive elements pre-existing in the system. The concentration on these pre-existing positive conditions is justified by the ideology that reinforcing such positive behavior and conditions will lead to an expansion of an overall sustained, improved system.

Application of Appreciative Inquiry in research theoretically enlightens, in the case of an interview protocol, both the interviewer and the interviewee. Through intentional structuring of questions, AI calls for the illumination of an answer for the interviewer, and reflection on the positive elements of the context on the part of the interviewee. As a tool for management, it enables examination of what creates a most supportive environment for
creating change, focusing on the already internally-available traits and characteristics of the system instead of referencing external sources for support (Srivastiva & Cooperrider, 1990). The basic principle of seeking out the “positive” as opposed to the criticism of any given system is illustrated in the AI literature as a series of different case studies in which AI was performed, resulting in higher capacity constructed from within the organization or system due to a reinforcement of the positive pre-existing conditions (Cooperrider & Whitney, 2005).

Case study

The papers were developed using a case study design to document and examine single case studies jointly conducted by researchers and practitioners. The case study model is “a particularly suitable design if you are interested in studying process” (Merriam, 1998, P. 33). The intent of this research was to advance the understanding of the process of consensus building and transformational learning. Thus, the case study design supported the intention to explore a complex social phenomenon (adult learning) while at the same time understanding its importance.

These studies focused on the investigation of groups of people who participated in a shared consensus-building experience. Marshall and Rossman (1999, p.61) stated that “Studies focused on society and culture, whether a group, a program, or an organization, typically espouse some form of case study as an overall strategy.” Another advantage of the case study design is that it enhances reliability and validity. Merriam (1998, p.207), writes that when “using multiple methods of data collection and analysis, triangulation strengthens reliability as well as internal validity.” Thus, a case study design was specifically well-suited
because it will lead to the generation of theoretical propositions related to the central phenomenon of “transformational learning in researcher-practitioner partnerships.”
CHAPTER 3: LITERATURE REVIEW

Overview

The theoretical framework for these studies is an expanded conceptualization of community-based participatory research, viewed through the lens of adult learning theory, and applied to the problem of improving systems of care and support for older people. The first section of this chapter describes population aging and the challenges inherent in this demographic change. Next, the theoretical basis for adult learning, with an emphasis on constructivist and transformational learning is presented in order to provide an adequate expanded theoretical foundation for the studies.

Aging population

The U.S. population age 65 and over is expected to double in size within the next 25 years. By 2030, almost 20% of Americans – approximately 72 million people — will be 65 years or older (U.S. Administration on Aging, 2008). The age group 85 and older is now the fastest growing segment of the U.S. population (U.S. Bureau of Census, 2006). The population will be not only be growing older but also increasingly diverse. Minority populations are projected to increase from approximately 6 million in 2000 (16.4 % of the older adult population) to 8 million in 2010 (20% of the older adult population); and then to 13 million in 2020 (24% of the population).

The aging of the population is a trend that impacts virtually everyone living in today’s society (Hargrave & Hannah, 1997). As the human lifespan increases, so do the numbers of living generations co-existing together. It is important to note that there are many advantages
and opportunities presented by these multi-generational connections. Hayslip and Kaminski (2005) document multiple sources of evidence that grandparents and other older adult family members who reside in multi-generational households make significant contributions to the family by providing additional social support and contributing to the transmission of values across the generations.

These benefits are accompanied by new challenges associated with aging families. As aging individuals go through developmental transitions, so do other members of their families – sometimes creating cross-generational dynamics related to issues such as caregiving, housing, and health care needs (Brody, 1995; Hareven, 2000; Rachor, 1998).

The caregiving needs of families with aging family members are well documented (Levine, 1998). Nearly one in four families are currently responsible for the care of at least one family member (Rachor, 1998), and this number is projected to rise in coming years. Brody (1995) suggests that nearly 90 percent of this care is provided by females, including wives, adult children, and daughters-in-law. This poses challenges for two-career families. Based on this trend, Rachor (1998) predicts that caring for older family members will pose an increasing challenge to the workforce, generating such problems as absenteeism, lost wages, and increased work/life stress.

Aging family members, who are increasingly likely to continue living in community-based settings as they age, also experience evolving needs related to their physical and home environments. Most homes are not routinely designed to be accessible for people with physical impairments associated with aging. Some efforts have been made to examine and address these design-related needs (Pollack & DiGregario, 1988); but, many housing-related
needs remain, such as energy efficiency, adaptation for accessibility and safety, and affordability (Taira & Carlson, 2000).

Families that include aging adults face many health-related needs, ranging from the need for health promotion and wellness resources to consumer-related issues involving access to health care services and the related costs. Additionally, the entire family experiences many impacts associated with the health conditions of older family members who have chronic health-related conditions (Haber, 2003). The combined impact of these factors points to the increasing importance of community-based services and health care for these aging individuals and their family members.

**Multiple aging cohorts**

Multiple cohorts of older people constitute the consumer base for health and human services in the current marketplace. Strauss and Howe (1992) developed a model in which they viewed generational cohorts as a series of life cycles interacting with historical and social trends. In their model, nearly 18 generations, each approximately 20 to 25 years in length, have existed in the United States, from 1620 to the present day. They postulated that generations pass through life stages and develop an individual profile, based on historical trends that bind them together.

A number of researchers (Beisgen & Kraichman, 2002; Clark, 2001; Francese, 1993; Hareven, 2000) have theorized that these generational characteristics influence the behavior and values of these groups. These generational differences may, in turn, influence their behaviors in many ways; including the way they raise their children (Hareven, 2000); the way they behave as consumers (Clark, 2001); their health care preferences (Francese, 1993);
and their political and social orientation (Strauss & Howe, 1992). Figure 5 provides an overview of three generational groups that have been found to recur (Strauss & Howe, 1992) and that make up the majority of current consumers of health and human services for older adults.

<table>
<thead>
<tr>
<th>Generation Name</th>
<th>Baby-Boomers</th>
<th>Silent Generation</th>
<th>G.I. Generation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Historical Influences</td>
<td>Indulged youth, born after crisis, inspired awakening</td>
<td>Born during crisis, societal reconstruction, stability</td>
<td>Born post awakening, overcame crisis</td>
</tr>
<tr>
<td>Traits</td>
<td>visionary leaders, iconoclastic, rebellious, moralizers</td>
<td>Sensitive, other directed</td>
<td>Powerful midlifers, attacked during next awakening, heroic achievers, unified values</td>
</tr>
<tr>
<td>Source: Strauss &amp; Howe, 1991</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Figure 6. Names and types of multiple cohorts (Strauss & Howe, 1991)**

**Social foundations of adult education**

Adult learning theory has emerged as a synthesis of many disciplines, including social work, psychology, and education. The genesis of social work practice occurred in the urban settlement houses first created to assist immigrants and the impoverished at the turn of the last century during the Progressive Era (1893-1917). This era was characterized by several dominant cultural influences which combined to spur the development of unionism, feminism and a growing democratic consciousness (Lee, 1994).
John Dewey (1859-1952), one of America’s foremost social theorists, contributed to the development of adult learning theory (and later constructivist learning theory) through the analysis of the relationship of knowledge to action. Dewey introduced the important constructs of experience and reflection (Vanderstraeten & Biesta, 1998). Dewey saw reflection as a secondary phenomenon aimed at ensuring the continuity of action and leading to the development of knowledge over time. He believed that the social component of learning was crucial to the generation of new knowledge (Dewey, 1938/1997).

Dewey (1910/1997, p. 37) wrote that “experience is not a rigid and closed thing; it is vital, and hence growing . . . the business of education might be defined as just such an emancipation and enlargement of experience.” Dewey was a long-time friend of Jane Addams, who is regarded as the founder of the settlement movement.

Later in the Twentieth Century, adult education scholars proposed a paradigm shift in education from “power over” to “power with” in The Meaning of Adult Education, (Lindeman, 1926/1989). Lindeman joined other adult education theorists such as Malcom Knowles and Cyril Houle to help develop the theoretical foundations of the “adult education” movement. Together, these scholars conceptualized an approach to education that included such concepts as informal learning, self-directed learning, and andragogy, the process of engaging adult learners in the structure of the learning experience (Smith, 2002).

The educational theorist who has perhaps made the greatest contribution to the strength-based learning paradigm was Paulo Freire (1921 - 1997), a Brazilian educator whose *Pedagogy of the Oppressed* (1972) is one of the most quoted educational texts in the world. Freire combined several themes related to educational practice and liberation. His emphasis on dialogue informed the development of informal educational practice. Freire believed that
informal education was a dialogical (conversational) rather than a curricular form of learning that involved respect. He held that education should involve people “working with” people rather than “acting upon” them, an approach that fosters a leveling of the power relationship between learner and educator (Freire, 1972).

Another of Freire’s key concepts was praxis, a moral action that was informed and related to making a difference in the world. He believed that dialogue was a co-operative activity involving mutual respect that could enhance community and build social capital among participants in the learning process (Freire, 1995). Freire agreed with Addams and Dewey that educational experience was situated in the lived experience of learners and that context mattered for educators as well as participants. His attention to the importance of creating a safe learning environment where those who were “oppressed” could have a voice formed a significant impetus to his work (Taylor, 1993).

**Constructivist learning theory**

Constructivism, both a philosophy and a term used to describe a wide variety of learning theories, has had a profound impact on the way adult learning is viewed. While constructivist theories have been applied to learning in general, they are particularly well-suited for application in the realm of adult learning. Despite the diversity of views the term conveys, constructivism can be summarized as 1) a view that learning is a participatory process of constructing, rather than acquiring, knowledge, and 2) an instructional process that facilitates knowledge construction. Many philosophers contributed to the development of constructivist thought including Kant, Dewey, Vygotsky, Piaget, and von Glaserfeld (SEDL, 1995; von Glasersfeld, 1985).
Emmanuel Kant (1724-1804) was a pioneer of constructivist thought who viewed it as a blend of empiricism and rationalism. He described it as a process whereby knowledge was gained through perceptions of the world organized through cognitive structures (Heylighen, 1993). He also believed that learning was a process based on individual perceptions in which humans reflect on an event and analyze what occurred based on information gathered before and during the event (Brooks & Brooks, 1999).

Constructivist thought later took a social turn, when philosophers like Lev Vygotsky (1896-1934) contended that higher levels of mental functioning originated in social processes (Wertsch, 1985). Vygotsky valued both the individual and social realms of understanding. He also believed that knowledge was constructed from meaningful interactions with others (Gergen, 1995). Vygotsky identified the level of the highest potential development of learners, the “zone of proximal development” (Wertsch, 1985), as a level that can be reached through the guidance of teachers and collaboration with peers.

Modern constructivist thought was shaped by Jean Piaget, a natural scientist and developmental psychologist, who is widely credited as the father of the “constructivist theory of knowing” (Piaget, 1955). In addition to his many major contributions to the theory of cognitive development, Piaget theorized that learning is an iterative process of assimilation and accommodation that allows humans to adapt to their environments (Phillips & Soltis, 1991). Piaget also believed that learners attempt to achieve cognitive equilibrium when they encounter conflict between their internal perceptions and external reality, which leads to the development of cognitive structures that restore equilibrium and stability (Brooks & Brooks, 1999).
More recently, social scientist Ernst Von Glaserfeld extended constructivist learning theory into what is known as radical constructivism, described as a continuous “reconstruction of the concept of knowledge” (von Glaserfeld, 1985). He theorized that cognitive processes are fluid and not capable of producing a true representation of an objective world. Moreover, he contends that what is needed is a drastic modification of the relationship between the cognitive structures we build up and the “real” world we perceive as existing beyond our perceptual awareness (von Glaserfeld, 1985). Thus, cognition has an adaptive function, enabling learners to incorporate information from their environments in an attempt to make the most viable fit (von Glaserfeld, 2001). This approach to constructivism refers to viability rather than truth or reality, emphasizing the active nature of knowledge construction and the context in which each individual resides. Thus, the most viable models are constructed and utilized until new information renders them obsolete. In other words, knowing is by nature an adaptive activity, leading to change over time as new solutions emerge; solutions are highly contextualized and relative to the individual who constructed it (von Glaserfeld, 2001). Radical constructivist principles hold that personal reality is defined as the network of relationships and things that exist in our environment (von Glaserfeld, 2001).

**Transformational learning theory**

Jack Mezirow built on the existing body of adult education scholarship to theorize that all adult learning involves meaning-making based on life experience (1991). He stated that transformational learning is characterized by a “process of using a prior interpretation to construe a new or a revised interpretation of the meaning of one’s experience in order to
guide future action” (1995, p.49). He proposed that transformational learning involves ten phases (1995), including (1) experiencing a disorienting dilemma, (2) conducting a process of self-examination, (3) undergoing a critical assessment of role assumptions and feeling a sense of alienation from these traditional expectations, (4) relating to other peoples’ experiences, commonly through dialogue, (5) exploring options for new behaviors, (6) building competence and self-confidence in new roles, (7) developing an action plan, (8) acquiring knowledge and skills for implementing the plan, (9) making provisional efforts to try out new roles and gain feedback, and (10) reintegrating into society with new perspectives.

Transformative learning contrasts with instrumental learning, which is characterized (Bitterman, 1969) as “trial and error” learning, a theory first described by C. Lloyd Morgan, an English psychologist. Morgan (1894) explained changes in behavior of the animals he studied as a process of association, where the animals were motivated by anticipated rewards. Mezirow (2000) criticized instrumental learning for its reliance on hypotheses rather than negotiation between individuals to determine the truth. Instrumental learning dominates adult education practice and involves acquiring information, skills and competencies in order to “control and manipulate the environment and other people, as in task oriented problem-solving to improve performance and practice” (Mezirow, 2000, p. 8). Transformational learning is related to instrumental learning (Mezirow, 2000) in that instrumental learning can result in transformation by changing meaning schemes through reflection on assumptions related to process and content.

Transformative learning builds on Habermas’s theory of communicative action (Habermas, 1994), which works toward forming consensus through active negotiation and
the use of metaphors and narrative. Communicative learning involves “learning what others mean while they communicate with you” regarding feelings, expectations, values, and other intangibles such as justice, freedom and beauty (Mezirow, 2000, p. 8).

Mezirow (2000) theorized transformational learning as an integrative process that occurs within both communicative and instrumental learning, and he conceptualized four processes of learning, two of which occur in the two domains above and two of which are transformational. They are (1) building on existing meaning schemes, (2) creating new points of view, (3) transforming our meaning schemes and/or points of view, and (4) transforming our meaning perspectives or frames of reference.

**Generative dialogue**

In response to these perceived weaknesses in Transformative Learning Theory, theorists have recently generated a second-wave of modifications to the theory that broaden its scope. While critical reflection was the primary model for Mezirow’s ideal version of discourse (1995), more recent interpretations of Transformative Learning Theory provide a broader spectrum for communication. The concept of generative dialogue (Gunnlaugson, 2006; Scharmer, 2001) has been described as a conversational practice that draws on a variety of “ways of knowing” mediated by “meta-awareness.” As such it provides an ideal way to help support and catalyze the conditions of learning for transformative learning in groups (Gunnlaugson, 2006).

Scharmer (2001) developed a process model for generative dialogue that describes the movement of a group conversation through four successive fields of dialogue. These fields progress from (1) conventional, polite dialogue (talking nice); to (2) debate,
characterized by listening as reloading (talking tough); to (3) reflective inquiry, characterized by empathic listening (reflective dialogue); and, finally toward (4) a form of co-creative engagement (generative dialogue).

In contrast to Mezirow’s ideal of discourse, generative dialogue is structured by awareness of the present rather than past patterns of thought, memory or reflection (Gunnlaugson, 2006). Over time, this awareness provides an environment for dialogue that can support a wide array of learners’ needs. This function, described by Winnicott (1971) as a “holding environment”, has been recontextualized by Kegan (1982) as the psychosocial environment at each stage of development of one’s lifespan. In the same way that our forms of discourse are shaped by cultural norms and assumptions over time within peer cultures, generative dialogue can also provide a culture to support co-creative discourse (Gunnlaugson, 2006).

“Presencing” and “suspension” are two key constructs that play an important role in generative dialogue. “Presencing” is defined by Senge, Scharmer, Jaworski and Flowers (2004) as a practice “of letting go of old identities and the need to control . . . ultimately . . . all aspects of presence lead to a state of ‘letting come’ of consciously participating in a larger field of change” (p.13-14). When used in the practice of learning, presencing provides learners with the capacity to access both tacit knowledge and knowledge that emerges through contact with the un-manifest source of our experience (Scharmer, 2001).

“Suspension” is a practice of enhanced awareness of our thoughts, mental models, and habits of mind in an effort to set them aside and examine them without judgment. It involves suspending our assumptions (Bohm, 1996) in order to become more objective. “Suspension” does not require destroying or ignoring our existing mental models of reality. Instead, it
requires a willingness not to impose pre-established frameworks, beliefs, and thoughts on what we are seeing in an effort to observe without forming conclusions (Senge, Scharmer, Jaworski & Flowers, 2004).

Generative dialogue can be particularly effective as a holding environment because the practices of “presencing” and “suspension” (Scharmer, 2001) are especially conducive to promoting a sense of trust, safety, and openness as well as the opportunity to co-construct meaning from shared group experiences. This holding space has been interpreted as a metaphor for a series of “containers” where learners can develop a collective capacity to hold creative tension between differing perspectives, emotions, contrasting emotions, and diverse ways of knowing (Gunnlaugson, 2006). This construct provides an ideal environment where social learning can thrive in a setting where paradox and tension are not only tolerated but serve to foster creative problem-solving based on shared responsibility (Scharmer, 2001).

Summary

This literature review suggests the need to explore the role of learning in partnerships between researchers and practitioners. The absence of theory about this phenomenon suggests that it requires close examination for a number of reasons. First, it will contribute important findings that can inform the efforts of researchers and practitioners who seek to create these partnerships in order to address common goals. Second, theory related to the role of learning in research-practice partnerships will be expanded by examination of how involvement in these partnerships might lead to change in the perspectives of those who participate. Third, a model for facilitating adult learning in research-practitioner partnerships will be developed. This model will inform the development of learning environments that
foster learning among participants, and, in turn, optimize the conditions for organizational and systems change efforts. Finally, this study addresses the gap in the adult learning and community-based participatory research literatures by providing insights into the role of adult learning in the context of community-research partnerships.

This chapter described the main theoretical framework for this research. The theory on population aging, research-practice partnerships, and adult learning ground this research. The next three chapters describe studies that explored this central phenomenon.
CHAPTER 4. TRANSITIONS OF CARE FOR FRAIL ELDERS:
A CITRA RESEARCH-TO-PRACTICE CONSENSUS WORKSHOP

A manuscript to be submitted to the Journal of Health Promotion Practice

Abstract

This article is a case study of an innovative method called the Cornell Institute for Translational Research on Aging (CITRA) Research-to-Practice Consensus Workshop, which was developed to bridge the gap between science and practice. In this instance, the method was used to bring researchers and practitioners together to participate in a dialogue and create subsequent consensus recommendations about care transitions for frail elders. The article (1) describes the planning and implementation of the consensus workshop, (2) reports the recommendations resulting from the workshop, and (3) frames the workshop within the context of adult learning theory and practice.

Key words: care transitions, frail elders, consensus workshop, community-based participatory research, transformative learning, constructivist learning, adult learning

Background

This paper presents a case study analysis of an innovative methodology that was used to bridge the gap between social science researchers and community practitioners seeking to improve the lives of older people and their caregivers. The CITRA Research-to-Practice Consensus Workshop, (Sabir et al., 2006) was developed by investigators from the Cornell Institute for Translational Research on Aging (CITRA) and designed to foster a community-based participatory dialogue between researchers and practitioners based on empirical
findings in an area of research critical to community practice and social services. In this case, the model was applied to the issue of care transitions for frail elders. The goal of the workshop was to identify (1) evidence-based recommendations for practice, (2) practice-based recommendations for research, and (3) policy recommendations.

Transitions of frail elders from home to (and from) institutional care environments, such as hospital and long-term care facilities, have a significant impact on their physical and emotional well-being. Eric Coleman (2004, p. 1817) defined transitions of care as “a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location.” These transitions often magnify the impact associated with the inadequacies in the health care system (Coleman, 2004).

Frail elders, who often have multiple chronic conditions and high risk factors for poor outcomes, are increasingly discharged to their homes unprepared to manage their care needs (Chalmers & Coleman, 2006). These individuals sometimes find themselves returning to the hospital emergency department due to medication mismanagement, and due to their misunderstanding of their treatment regimens and their follow-up care (Coleman, Parry, Chalmers & Min, 2006).

Each year older people experience over 13 million transitions from acute or rehabilitation facilities to home (Chalmers & Coleman, 2006). In addition, acute care is now more apt to be delivered in long-term care settings. Care that was once provided in the hospital setting is now often provided in patients’ homes, physicians’ offices, nursing homes and in other community settings. The discharge planning needs of older adults, which are
influenced by race, culture, language differences, and urban or rural locations, are complex and involve many different systems (Chalmers & Coleman, 2006).

The discharge planning process in acute care differs from one institution to another, but the common thread is the development of a comprehensive plan for moving the patient to the next level of care. All too often, the goal is to hurriedly move the patient out of the acute care setting, and the destination is determined as much by available funding mechanisms as it is by need or desire (Graham, Anderson, & Newcomer, 2005).

The push to decrease length of stay has motivated efforts by hospital case managers and discharge planners to move patients as quickly through the system as possible. This urgency forces expediency at the cost of thorough planning (Chalmers & Coleman, 2006). The resulting shorter hospital stays give discharge planners less time to develop complex discharge plans and to educate patients and caregivers.

Family caregivers, who provide most of long term care needed by older adults, are often left out of the decision-making process. Family caregivers can become frustrated with their exclusion from the decision-making process and the lack of adequate preparation for meeting the needs of the frail older adult once they are home (Levine, 1998).

A comprehensive information management infrastructure, which could seamlessly transfer information between providers, does not exist in our current health care delivery system (Mistiaen, Francke, & Poot, 2007). The transfer of information from hospital to the patient and to the patient’s care providers is also impeded by privacy considerations. This information is needed by follow-up providers, the patient, and the caregiver(s); and each may require it in a slightly different format and at different reading levels. Naylor, Ware, Kurtzman and Pauly (2007, p. 12) state, “There is no recognized ‘point person’ in our current...
health care system for managing care across time, place, and profession, and little
acknowledgment that individuals with chronic disabilities shift among physicians, hospitals,
nursing homes and their own homes.”

The purpose of this study was to investigate the central phenomenon of consensus-
building relating to care transitions for frail elders within the context of a research-practice
learning partnership. This research is proposition generating, aimed at gathering evidence
that will advance the understanding of care transitions through analysis of these primary
research questions:

1. What joint perspectives and recommendations emerge when participants in
   community-based participatory research partnerships reach consensus about care
   transitions for frail elders?
2. What role does learning play in this consensus process involving researchers
   and practitioners? How can the experiences of the participants in the CITRA
   research-to-practice consensus workshop be described in the context of adult
   learning theory and practice?

Method

The topic for the consensus workshop was identified by a group of health services
leaders in Central New York State. The group identified the general topic “transitions of
care” as a critical emerging issue and invited CITRA researchers to partner with them to plan
and implement a consensus workshop aimed at better understanding the issue. The CITRA
Research-to-Practice Consensus Workshop model (Sabir, et al., 2006) was developed to
bring together researchers and practitioners who share a joint goal, and unite them in a
structured learning environment where they can engage in discourse leading to eventual
consensus on a topic of interest. As such, it meets one of the primary aims of community-
based participatory research (CBPR), which is to focus the attention of researchers and
practitioners on empirical research in a specific research area (Israel & Schultz, 1998).
Previous CITRA consensus workshops have been based on issues identified by community groups and have included topics such as falls prevention, social integration, and elder abuse. The Research-to-Practice Consensus Workshop Model is reviewed in detail elsewhere (Sabir, et al., 2006).

**Population**

The organizing group consisted of six practitioners, including health and human services administrators from two hospitals, a long-term care facility, and two human services organizations, all of whom were participants in the Western and Central New York Community Health Foundation’s (WCNYCHF) Leadership Fellows Program. The aim of this program is to offer participants individual leadership development and the chance to apply the core competencies needed to improve health outcomes for frail elders and children in communities of poverty in Western and Central New York (WCNYCHF). The Leadership Fellows Program specifically includes skill development in the Institute of Medicine’s five key competencies for healthcare in the 21st century (IOM, 2001).

Attendance in the consensus workshop was by invitation only, and included practitioners, administrators and policy makers – all selected based on their experience with care transitions among frail elders. The (WCNYCHF) Leadership Fellows Team selected individuals from a broad range of relevant organizations across central New York who could provide a diversity of perspectives, including direct care workers, nurses, doctors, social workers, executives, and administrators in both institutional and community-based settings. The team also invited representatives from the New York State Office for the Aging, IPRO (a health care quality review and improvement organization), and the sponsoring organization,
the Western and Central New York Community Health Foundation. It should be noted that, while the invitees were primarily professionals, several were caregivers of older adults who had experienced care transitions. Prior to the event, 54 participants were sent invitations with an agenda and background materials explaining the purpose and goal of the consensus workshop (Appendix D), as well as copies of the draft research review. Of these invitees, thirty-eight participants attended the workshop.

**Procedures**

The steps involved in conducting the consensus workshop are presented in summary form in Figure 7. The first step (*Step 1*) of the process was selecting and refinement of the topic. The group decided to focus specifically on the topic of “care transitions for frail elders” in a desire to further define an issue of critical importance.

<table>
<thead>
<tr>
<th>(1) Selecting a topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>(2) Producing an up-to-date, non-technical translation of the literature</td>
</tr>
<tr>
<td>(3) Selecting a panel of expert researchers and expert practitioners</td>
</tr>
<tr>
<td>(4) Convening a larger group of researchers and practitioners for discussion</td>
</tr>
<tr>
<td>(5) Arriving at an initial consensus statement of research and practice recommendations</td>
</tr>
<tr>
<td>(6) Convening a follow-up meeting to create a final consensus document</td>
</tr>
</tbody>
</table>

**Figure 7. Major Steps in the CITRA Research-to-Practice Consensus Workshop Model**

After the topic was selected, the (WCNYCHF) Leadership Fellows Team produced a current non-technical review (*Step 2*) of the research on care transitions and discharge planning for frail elders, utilizing research assistance from students at Syracuse University.
The research review was further edited and put into draft format by CITRA researchers. The draft paper included an overview of the care transition and discharge planning issue, regulations and financial considerations, research on screening and assessment tools, the nature and effectiveness of pre- and post-discharge planning interventions, and research reviews of intervention studies (Appendix E). The draft paper was used as a working document and provided the basis of discussion for the consensus workshop.

Next, 6 panelists were selected to participate (Step 3) in the consensus workshop. Three academic researchers from the fields of sociology and gerontology were chosen to participate, including an expert on rural health and human services delivery systems, an expert on informal caregivers and care transitions, and an expert on community research partnerships and the informal and formal support networks of older adults. Three community practice experts were also selected for participation in the event. They included a geriatrician practicing in an upstate New York research and teaching medical center, a “transition coach” practicing in an innovative hospital transition program, and the public health director for a rural New York county health department. Panelists were selected based upon their experience with care transitions as practitioners in the field and/or their research on care transitions or related topics.

The three-hour consensus workshop was convened (Step 4) in February, 2008. The workshop included an overview of CITRA’s consensus workshop process, a brief (10 minutes) summary of the findings of the research review; brief (5 to 7 minutes) remarks from each expert researcher/practitioner on the panel, and a facilitated dialogue involving all workshop participants. Comments of workshop participants were captured on newsprint and
displayed in the room. In addition, detailed notes of participant comments were taken, and the event was videotaped in order to compile a complete transcript of the discussion.

After the large group discussion, workshop participants voted on their top three recommendations for further action, and were given “dots” to cast their votes on the newsprint. The group was informed that these recommendations would later be synthesized into a bulleted list and distributed to all participants. At the conclusion of the consensus workshop, participants were invited to attend a follow-up Roundtable Discussion, where research and policy recommendations would be synthesized and further action steps would be determined. Finally, participants were asked to complete an evaluation of the consensus workshop.

After the consensus workshop was conducted, the CITRA researchers collected the newsprint lists containing the participant’s votes, the written transcript of the discussion, and other materials that documented the discussion, and synthesized them into a comprehensive document. The researchers completed a content analysis of the documented responses. Key words, repetitive ideas, and emergent themes were identified, noted and organized into categories. These items were organized into three categories of synthesized recommendations and ranked in order of the number of votes each had received from the group (Appendix F).

Twenty-three people attended the Roundtable Discussion (Step 6) which was held on April 1, 2008, approximately one month after the consensus workshop. Prior to the Roundtable Discussion, all participants were sent the full transcript of the workshop discussion; the synthesized, ranked recommendations from the workshop; and another copy of the research review. The following overview is a summary of the results of the consensus
workshop and subsequent roundtable, including a discussion of the highest prioritized recommendations for practice, research and policy.

**Evidence-based recommendations for practice**

There was strong consensus among the group about the need to improve practices that support care transitions at the systems, institutional and consumer level. The overarching theme that emerged from the discussion was the need for current care transitions practices to undergo deep, comprehensive change. Among these recommendations, some were aimed at broad systems change while others emphasized change at the organizational level.

The group noted the need for the development of multi-disciplinary, cross-institutional collaborations aimed at coordinating the care transition process. They recommended that these collaborations should involve the entire spectrum of service providers and staff, including practitioners from health care (doctors, nurses, discharge planners); social services (social workers, case managers, administrators), and private institutions (financial, insurance, faith-based organizations).

The group also recommended increased coordination efforts between local, state, and federal support systems. They specifically cited the need for coordinated efforts at the state and federal level involving long-term care councils, family caregiver councils, the Alzheimer Association, IPRO, and the Center for Medicare and Medicaid Services.

Moreover, participants agreed that consumers (including frail elders, their families, and caregivers) should be placed at the center of the care transition process, signaling a shift from an institutional to a strength-based, person-centered paradigm. They noted the need to mount a health literacy campaign directed at educating caregivers and consumers about care
transitions through deploying educational resources and training that are grounded in good adult educational practice. It was also noted that many consumer education resources already exist and that these resources need to be disseminated more effectively, particularly through readily accessible means such as the Internet.

Recommendations were made regarding organizational practices that could improve care transition outcomes. These included the need to identify and replicate best practice models; especially those involving enhanced external case management, coaching practices, and a more pro-active discharge planning process that brings together all who are involved.

**Practice-based recommendations for research**

The participating researchers and practitioners recommended additional research to explore the relationship between best practices (such as coaching and enhanced discharge planning) and specific measurable outcomes (including re-hospitalization rates, medical costs, health status, and patient satisfaction). However, the groups’ slightly different perspectives relating to care transitions influenced their attitude toward research and their subsequent recommendations. The practitioners, who encounter the consumers and caregivers in the context of their day-to-day practices, tended to view care transitions as processes which are embedded in the community setting. The researchers tend to view care transitions as a set of components and processes that can be broken down to narrow and specific research questions. This was exemplified in their discussion of design and measurement issues. The researchers emphasized the importance of using reliable, valid measures and rigorously maintained research protocols, while the practitioners expressed their desire to participate in flexible, field-based data collection practices. After further
In conclusion, the group recommended an increased emphasis on the creation of research designs that might enable researchers to conduct interviews, surveys and other data collection procedures in practice-based settings where practitioners could partner with them in some of the research activities. In addition, they recommended increased funding for research that involved community-based practitioners and consumers in every part of the research process. The group noted that some very promising research has been done to demonstrate the efficacy of several (particularly Coleman’s) multi-dimensional care transition interventions. However, they concluded that there is a need for more large scale studies to demonstrate the effectiveness of these interventions among larger and more diverse samples of individuals.

**Policy recommendations**

The main policy recommendations from the group related to the need to re-vamp Medicare, Medicaid, and other funding mechanisms that reimburse costs associated with care transitions. For instance, several group members who practiced in health care settings stated that the health care system, which has been designed to provide acute care, is not effective at providing chronic care. Thus, it was recommended that policy changes occur to address this structural problem and provide more funding for programs, services, and treatments that address chronic needs.

In addition, increased funding was recommended for services that address care transitions needs more holistically, and that build community capacity to support care transitions at the community level. These include care management, enhanced discharged
planning, home and community-based services, transportation services, and educational resources.

The group also recommended that efforts be directed at creating a comprehensive policy aimed at developing and implementing an information technology infrastructure that could support a secure system of electronic medical records that could be shared among consumers, their caregivers, providers, pharmacists, and other members of the care transitions network. In particular, it was recommended that funding be made available for demonstration projects that could be rigorously evaluated in order to build a substantial evidence base of technology best practices that could be implemented at the local level.

Finally, the group noted the need for federal, state and local governments to coordinate their policies related to care transitions; that lack of coordination would decrease the effectiveness of new initiatives that are currently being funded.

**Additional community-based outcomes**

Following the implementation of the consensus workshop, the (WCNYCHF) Leadership Fellows Team prepared a report that documented their experience. This report listed the following outcomes that they considered to be important, in addition to the formal recommendations from the consensus workshop.

1. The *research review on care transitions for frail elders and the report on results from the consensus workshop* were disseminated among regional and state health care providers, researchers, policy makers and funders. Workshop participants recommended that these tools could be useful to practitioners for gaining a greater understanding of care transitions, adopting evidence-based practices, and developing
grant proposals. “Reading the research review helped me understand that there are some excellent evidence-based programs out there to address care transitions,” stated one participant.

2. In addition, consensus workshop organizers planned and implemented a regional workshop on “The Role of Family Caregivers in Discharge Planning” that involved nurses, social workers, and staff of various institutions and organizations. This workshop featured Dr. Carol Levine of the United Hospital Fund, a research expert who participated in the consensus workshop and whose research focuses on the inclusion of family caregivers as an integral participant in the delivery of health care (Levine, 1998). Levine’s presentation provided the workshop participants with practical tools to disseminate to family caregivers; tools designed to help them navigate across various health care divides.

3. Another important outcome noted by community practitioners was that the workshop brought local and state policy makers together with researchers and practitioners and informed them about the topic. “Getting the policy makers to the table to discuss care transitions was an excellent opportunity for them to hear and understand our perspectives,” stated one participant. The experience also created a shared sense of ownership of the issue of care transitions and led to the creation of a policy workgroup aimed at continued dialogue and dissemination of the workshop recommendations to the New York State Department of Health, Office for the Aging, and Governor’s Office.

4. Participants also reported a sense of increased capacity in their ability to understand research and engage in meaningful collaboration with researchers, reporting that
their experience with the consensus workshop model was valuable and that they plan to apply it to other pertinent issues in health care. Specifically, members of the (WCNYCHF) Leadership Fellows Team plan to utilize the consensus workshop methodology in other issue areas, including children in poverty and pediatric care. One of the organizers of the workshop stated, “this method could be useful in addressing many of the problems that occur in pediatric medicine, as well.”

**Discussion**

The consensus workshop described in this case study yielded many new insights about the issues related to care transitions for frail elders based both on empirical research and practice knowledge. As articulated above, the group developed consensus recommendations regarding a variety of research, education, and policy implications of the issue. In addition, there was evidence that members of both groups gained a broadened perspective on the issue.

What role did learning play in this consensus process? How can the experiences of the participants in the CITRA research-to-practice consensus workshop be described in the context of adult learning theory and practice? The promotion of joint learning by researchers and practitioners is prominent in community-based participatory research programs (Israel, Schultz, Parker, & Becker, 1998). The learning process that occurred in the context of the consensus workshop can be better understood when viewed through the framework of adult learning theory and practice.

This consensus workshop’s positive outcomes can be better understood when viewed through the framework of constructivist learning theory. While constructivist theory has
been applied to learning in general, it is particularly well-suited for application in the realm of learning experiences contextualized in real world group settings. Constructivism can be summarized as a view that learning is a participatory process of constructing, rather than acquiring, knowledge (SEDL, 1995; von Glasersfeld, 1985). This summary is an apt description of what participants experienced during this consensus workshop.

The theories of Jean Piaget, a natural scientist and developmental psychologist, who is widely credited as the father of the “constructivist theory of knowing” (Piaget, 1955), are especially descriptive of the iterative process of assimilation and accommodation that workshop participants experienced as they adapted their perspectives about care transitions in response to input from other participants (Phillips & Soltis, 1991). Piaget’s idea that learners attempt to achieve cognitive equilibrium when they encounter conflict between their internal perceptions and external reality is also relevant here (Brooks & Brooks, 1999).

Social scientist Ernst Von Glaserfeld’s description of learning as a continuous “reconstruction of the concept of knowledge” (von Glaserfeld, 1985) also describes the adaptive function that enabled participants in the consensus workshop to incorporate information from others in an attempt to make a viable fit between their past and current perspectives on care transitions (von Glaserfeld, 2001).

Implications

The purpose of this study was to better understand a partnership between researchers and practitioners, the consensus that emerged from that partnership, and the nature of the learning that occurred in the context of the partnership. Findings of the study revealed that the researchers and practitioners participated as active partners in the exchange of ideas,
perspectives and meaningful dialogue; and that this dialogue resulted in consensus between the two groups, enabling meaningful recommendations for research, practice, and policy. In addition, the study framed the consensus workshop process within the context of adult learning theory and practice, suggesting that participants engaged in a transformational learning experience and emerged from the consensus workshop with new perspectives about care transitions for frail elders.

While community-based participatory research has received increased interest as a promising approach to solving problems of interest to policy makers, researchers and practitioners, more knowledge is needed about the specific types of activities that can be most effective in bringing them together. The data suggest that the recommendations that emerged from this consensus workshop provided a significant degree of added value over recommendations that might have emerged from either one of the groups alone.

Another recommendation of this study is that researchers and practitioners need additional structured opportunities to become partners through experiences such as the one described in this research. Findings of the study also suggest that learning plays an important role in partnerships between researchers and practitioners. For this reason, further research is recommended to explore the role of adult learning in the context of community-research partnerships. Further research should investigate the role of specific group processes, such as the consensus workshop, in building group consensus between researchers and practitioners. Additional research is also needed to examine the effectiveness of these methods, leading to their improvement over time.

One striking change in perspective occurred on the part of workshop participants as a result of their participation. When the idea to implement the workshop was presented by the
group of community leaders, it was described in the context of the service system (care transitions). During the course of the consensus workshop, this perspective shifted from an emphasis on the care transition process to an emphasis on the frail elders (and their caregivers), who are experiencing the transition. During the workshop dialogue and deliberation, care transitions were framed on the basis of their relationship to those who are experiencing them.

There are several important implications that can be identified from the change in perspective that participants experienced following the consensus workshop. First, conceptualizing care transitions from a consumer-centric perspective can motivate service providers to seek input from consumers relating to the design and delivery of services. Second, an increased awareness of the nature of consumers’ concerns can lead to services that are more responsive to their evolving needs.

In conclusion, this consensus workshop resulted in valuable recommendations for research, policy and practice that were constructed by those who participated. The development of these recommendations and the change in perspective that participants experienced were the result of the transformative learning experience they all shared.
References


CHAPTER 5. ASSET-BASED PRACTICES IN AGING SERVICES: AN APPRECIATIVE INQUIRY

A manuscript to be submitted to

Families in Society: the Journal of Contemporary Social Practice

Rhoda Meador, Karl Pillemer, Elaine Wethington, Bill Dionne, Igal Jellenik

Abstract

Organizations that serve older people need effective practices and leadership in order to bring out the best in people, organizations, and the constituencies they serve. This qualitative study was based on interpretive research using Appreciative Inquiry (AI), which is situated in the action research paradigm and is a radically affirmative approach to searching for the best in people and their organizations. AI is based on social constructivist theory and is a collaborative and highly participatory approach to inquiry which employs a 4-D cycle: discovery, dream, design, and destiny. The participants in this Appreciative Inquiry engaged in interviews using provocative positive questions aimed at eliciting responses about innovative practices in senior centers. By integrating the AI technique with the topic (best practices in senior centers), a vision for ideal organizational policies and practices in aging services emerged. This study also addresses questions about the role of adult learning theory and practice among participants in the AI technique.

Key words

Aging services, senior centers, appreciative inquiry, community-research partnership, adult learning, constructivist learning, transformational learning
Introduction

This article presents a case study of a project that was implemented within the context of a community-research partnership between researchers at the Cornell Institute for Translational Research on Aging and community-based practitioners of aging services in New York City. These groups joined forces in a joint project aimed to (1) address the perceived lack of innovative aging services by identifying organizations where unique, cutting-edge practices were being developed at the grass-roots level, and (2) use these practices to design and define a new paradigm of responsive, customer-centered aging services delivery. This research resulted from an expressed need on the part of community-based aging services providers to improve the service delivery process in their organizations.

A major activity of the project involved the identification and documentation of best practices among senior centers providing services to older people living in a selection of diverse neighborhoods in the New York metropolitan area, using a participatory research methodology called appreciative inquiry.

Project rationale

The age group 85 and older is now the fastest growing segment of the U.S. population (U.S. Bureau of Census, 2006). The U.S. population age 65 and over is expected to double in size within the next 25 years. By 2030, almost 20% of Americans – approximately 72 million people – will be 65 years or older. The population will be not only growing older but also increasingly diverse. Minority populations are projected to increase from approximately 6 million in 2000 (16.4% of the older adult population) to 8 million in 2010 (20% of the older adult population), and then to 13 million in 2020 (24% of the population).
The expanding older population consists of diverse, increasingly discriminating individuals. These consumers are motivating health and human services providers to develop new practice models that are more relevant to their evolving needs and desires. As a result, these demographic and social changes in the early decades of the 21st century are combining to produce trends that will dramatically shape health and human services needs over the coming years.

These social and economic forces are currently exerting pressure on health and human services institutions as they face the challenge of delivering services to an increasingly diverse older population. Provision of services and support has become an increasing challenge as institutions and communities struggle to serve these mixed groups with such varied service and health care needs (Clark, Stump, Hui & Wolinsky, 1998).

Strauss and Howe (1992) observed that this expanding older population is made up of several distinct cohorts of diverse individuals. They (1992) defined these three cohorts as (1) “Baby Boomers,” born between 1943 and 1960, (2) the “Silent Generation,” born between 1925 and 1942, and (3) the “G. I. Generation,” born between 1901 and 1924. Comprised as a whole, these groups have a wide range of consumer needs, ranging from aging baby boomers who may be excessively meticulous about their service needs, to those in the "G.I. Generation" who may have complex medical needs.

**Need for new service delivery paradigm**

This challenging environment offers the opportunity to explore new paradigms of service delivery and support that not only improve services, but also provide completely new perspectives about how to design and deliver assistance to older adults. Research aimed at
improving the lives of older people has built a strong evidence base documenting the success of practices and interventions aimed at improving the health and well-being of older people. However, there is a need for additional research leading to the development of successful models for community-based services that respond to the needs of these new emerging cohorts of older people.

Many practitioners seeking to serve their constituencies realize that the old model is not entirely effective and have been motivated to discover innovative practices that better serve their current and emerging customer base. Some visionary organizations have developed practices at the grass-roots level aimed at incorporating a person-centered service paradigm into their practices and policies (Beisgen, 2002).

The purpose of this study was to investigate the central phenomenon of consensus-building as it relates to the development of a vision for aging services within the context of a research-practice partnership. This research is proposition generating, aimed at gathering evidence that will advance the understanding of aging services delivery through analysis of these primary research questions:

1. What is the nature of the joint vision that emerges when participants in a community-based participatory research partnership participate in an appreciative inquiry focused on the delivery of aging services?

2. What role does learning play in the appreciative inquiry? How can the experiences of the participants in the appreciative inquiry be described in the context of adult learning theory and practice?
Research design and methodology

This study utilized three methods that were grounded in a participatory research paradigm. First, it was conducted within the context of a community-based participatory research partnership between researchers at Cornell University and aging services practitioners in New York City. Second, it employed a research design known as Appreciative Inquiry (AI), which was used to engage stakeholders to develop a vision for the provision of aging services. Finally, the investigators selected the sample of interview participants through an approach called positive deviance.

This project was implemented by researchers and practitioners through the Cornell Institute for Translational Research on Aging (CITRA), a research institute that was funded primarily by the National Institute on Aging in October, 2003. Comprising a unique blend of social science, clinical research, and education, CITRA brings together researchers from Cornell's Ithaca, NY campus; research clinicians at the Division of Geriatrics and Gerontology at the Weill Medical College of Cornell in Manhattan, and extension educators from Cornell Cooperative Extension of New York City... This group partners with community-based aging services organizations from New York City to conduct research that involves researchers, educators, and community participants in joint decisions regarding every step of the research process (CITRA, 2008).

The major goal of CITRA is to leverage the combined knowledge of an interdisciplinary group of researchers and community partners to participate in (1) a pilot grant program; (2) methodological assistance for program evaluation and intervention studies; (3) an on-going seminar which reviews works-in-progress (e.g., grant proposals); and
(4) a workshop series (CITRA, 2008). CITRA’s overarching mission is to improve the lives of older adults by promoting their full engagement within their communities, and to strengthen their connection with kin, neighbors, coworkers, friends, and significant others. There are numerous perceived advantages to using a community-based participatory research (CBPR) model (Israel & Schultz, 1998), including the fact that it: (1) insures that the research topic includes topics relevant to the participating community; (2) enhances the application and relevant nature of the topic to both researchers and community members; (3) involves partners with differing skill sets, perspectives, and experience to address a problem; and (4) creates outcomes aimed at improving the well-being of the community. In the case of CITRA, these advantages combine to leverage the collective research knowledge and practice expertise to improve the lives of older people in New York City.

Appreciative Inquiry (AI) was developed by researchers at Case Western Reserve University as an approach designed to facilitate personal and organizational change, based on the idea that dialogue about values, dreams, strengths, and successes is itself transformational (Cooperrider & Avital, 2004). AI often relies on interviews that are structured around a set of core questions (Whitney & Trosten-Bloom, 2003) designed to stimulate reflection and creative thinking on the general affirmative topic.

AI is an approach to problem-solving and solution-seeking that attempts to identify the best in an organization or system. David Cooperrider and Diane Whitney (2005, p. 9) define AI as being:

… about the co-evolutionary search for the best in people, their organizations, and the relevant world around them. In its broadest focus, it involves systematic discovery of
what gives ‘life’ to a living system when it is most alive, most effective, and most constructively capable in economic, ecological, and human terms. AI involves, in a central way, the art and practice of asking questions that strengthen a system’s capacity to apprehend, anticipate, and heighten positive potential. It centrally involves the mobilization of inquiry through the crafting of the ‘unconditional positive question’ often-involving hundreds or sometimes thousands of people.

AI approaches research in a way that, in the case of an interview protocol, theoretically enlightens both the interviewer and the interviewee. By virtue of the structure of questioning it calls for the illumination of an answer for the interviewer, and reflection on the positive elements of the context on the part of the interviewee. As a tool for management, it allows for the surveying of what creates a more supportive environment for creating change, focusing on the already internally available traits and characteristics of the system instead of referencing external sources for support (Srivastiva & Cooperrider, 1990). The basic principle of seeking out the “positive” as opposed to criticism of any given system has been illustrated many times in the AI literature, in which documented case studies of AI have been shown to result in increased capacity by community members to improve their organizations or systems, due to a reinforcement of the positive pre-existing conditions (Cooperrider & Whitney, 2005).

In essence, the AI theoretical research perspective seeks to identify experiences in which people or organizations are at their best (Cooperrider & Whitney, 2005). The interview protocol also served as a method of community-participatory research, which holds that by working with the community, researchers will come to better understand the current situation (Israel & Schultz, 1998) which, in this case, was the service practices of senior
centers serving older people living in New York City. Notably, the interviewees at these senior centers regularly engaged in interactions with the older people they serve, and were capable of providing anecdotes about their firsthand experiences relating to the needs of the participants in their respective centers and the methods they use to meet those needs.

Sample

The sample of organizations that were selected to be interviewed for this study was based on an approach known as positive deviance (PD), which is:

… a development approach that is based on the premise that solutions to community problems already exist within the community. The positive deviance approach thus differs from traditional "needs based" or problem-solving approaches in that it does not focus primarily on identification of needs and the external inputs necessary to meet those needs or solve problems. Instead it seeks to identify and optimize existing resources and solutions within the community to solve community problems. (Sternin & Choo, 2000 p. 14)

The PD approach is based on the principle that certain individuals, termed “positive deviants,” are able to develop creative solutions for challenges that present themselves to their community despite, and possibly aided by, the fact that they have been marginalized in some way. PD is based on the belief that solutions are available from within the community and that solutions that emerge from community members themselves are more likely to make progress in the community sustainable and long lasting. The PD perspective was developed by researchers who were investigating the nutritional needs of Vietnamese children in developing countries in the post-Vietnam War era (Sternin, Sternin & Marsh, 1999).
The scope of PD’s applicability was subsequently expanded beyond the nutrition field, where it has been used in the health care environment for the express purpose of reconciling “medicine at discharge and patients medication management after discharge” (Sternin, 2002). More recently, it has been used by a variety of researchers and practitioners as a catalyst to foster grassroots organizational change (Lapping, Marsh, Rosenbaum, Swedberg, Sternin, Sternin & Schroeder, 2002).

The sample was selected based on three criteria: The centers (1) were located in geographically diverse areas of the New York metropolitan area, (2) served ethnically and racially diverse consumers, and (3) were perceived by their peer colleagues and the leaders of their affiliate organizations to be innovators (positive deviants) in the delivery of aging services.

The first interview site was located in Lower Manhattan and served older people who were predominantly Asian immigrants and Asian-Americans. Due to the limited ability of many interviewees to speak English, some interviews were conducted in Mandarin and/or Cantonese, and subsequently translated into English. These interviews were conducted by Cornell University graduate students who were fluent in English, Mandarin, and Cantonese.

The second site was located in Brooklyn and housed in a former synagogue. The community at this senior center was predominantly Russian, Eastern European, and Jewish. Located in Queens, the third site, served Hispanic, Filipino and Korean participants.
**Procedures**

The appreciative inquiry procedures used in this study were designed to facilitate an action research process throughout the four stages, known as discovery, dream, design, and destiny (Cooperrider & Whitney, 2005). These steps were carried out during a series of meetings that were held over a nine month period from March through December of 2006.

Step 1. *Discovery phase.* The initial step of AI, known as the discovery phase, involves appreciating the best of "what is" by focusing on peak moments of community excellence. The genesis of the study occurred in 2004 when CITRA stakeholders participated in a needs assessment process using concept mapping methodology (Trochim, 2004). This concept mapping process identified “increased service utilization” as a critical high-priority issue. Next, a working group consisting of fourteen aging services practitioners and CITRA researchers was convened to organize the study. The group wanted to discover and build on the many successful best practices that had been developed by service providers whose rates of service utilization had improved. In response to this need, the researcher suggested the option of utilizing the Appreciative Inquiry methodology because of its potential to engage a group in expanding the positive elements within a system (Whitney & Trosten-Bloom, 2003). Based on this recommendation, the group decided to use the Appreciative Inquiry methodology.

In order to discover the best service practices, the group planned and conducted interviews in organizations that were perceived to be leaders in innovative service practices. They deliberately chose not to analyze deficits, but rather systematically sought to isolate and learn from practices that were working in these organizations.
The instrument developed for these interviews was an AI interview protocol (Appendix G) which was characterized by focusing on the positive elements pre-existing in the system (Cooperrider & Whitney, 2005). The instrument was jointly developed by the group of practitioners and researchers, who chose the metaphor of “delighting the customer” as the provocative proposition that framed the interview questions. The questions in the interview focused on what is successful through the discovery of the interviewee’s peak experiences, including who was involved, what occurred prior to the peak experience, and other contributing factors related to the event (Norum, Wells, Hoadley, & Geary, 2002).

The face-to-face interviews were conducted with twenty-four aging services staff members on site at three different senior centers, each of which was located in a different borough of New York City. The interviews were taped on digital voice recorders to enable transcription following the event. Two interviews were not taped because the interviewees asked not to be recorded. Instead, the interviewers took notes and wrote down the responses of the interviewees. All of these interviews were conducted according to the protocol, using a conversational, rather than formal, tone of inquiry (Yballe & O'Connor, 2000). The tapes were transcribed and all identifiers were removed from the transcriptions. These transcripts were distributed to the group.

Findings

Step 2. Dream phase. The dream phase of AI is intended to allow people to challenge the status quo by envisioning more valued and vital futures (Cooperrider & Whitney, 2005). During this phase, participants held a meeting where they began to visualize a shared image of an improved system by analyzing the interview transcripts. The group used this phase to
ground their dream in their community's history, and generate an expansion of their potential by identifying the themes that emerged from the interviews. The themes generated in this brainstorming discussion were captured on newsprint and sorted into categories.

The following themes were identified during the **dream phase** of the AI process.

*Need for a fundamental paradigm shift in attitudes toward older people*

An important theme that was often mentioned was the importance of treating the older people who received services as capable, resourceful adults. Several interviewees reported that they had often observed the practice of treating older people as though they are children (infantilization). They spoke disparagingly of this practice, reflecting their own attitude of respect toward the older people who received services in their centers. Many interviewees commented about the importance of changing the perception of aging to emphasize older adults’ assets rather than their impairments. One commented that “the people who come to our center don’t want to be treated like they are second-class citizens.” Additionally, many interviewees mentioned that consumers expressed positive opinions about the organizations at which visitors were treated with respect.

This shift was vividly illustrated through the language that these interviewees used. This language included terms that they used to refer to the people who used their services such as “member,” “participant,” and “consumer.” It was noted that these terms contrast with the standard usage of words like “client” and “seniors” to refer to service recipients. The interviewees also used a variety of innovative terms to refer to their services, such as “lunch club,” “lifelong learning,” “wellness program,” and “dance party,” in contrast to standard usage terms such as “feeding program.”

*The need for high quality volunteer support*
Many interviewees alluded to the importance of volunteering and the need for more volunteer involvement in the senior centers. They described many important contributions that the volunteers made to the centers. For example, they reported that volunteers can relieve paid staff of certain duties and often have time to socialize with consumers, who were reported to enjoy their companionship. Some interviewees mentioned the need to recruit more young volunteers such as college students. One interviewee stated, “the room really lights up when an enthusiastic young person shows up to help out.” Several benefits of intergenerational volunteer experiences were also mentioned, which included co-learning and increased diversity.

Interviewees also stated that they retained good volunteers due to their ability to provide ongoing, high-quality training, supervision, and support. Several also cited the need to maintain a high degree of quality control over volunteer participation, ensuring that volunteers are providing services that reflect the values of the organization.

The need for increased financial resources

Almost all the interviewees mentioned that more funding is necessary in order to better serve the consumers who utilize their centers, stating that funding is necessary in order to provide more resources, programs, and services. They noted that their funding base is declining while, at the same time, the need for services in their neighborhoods is increasing. Participants stated that they were often demoralized by this situation because they come into direct contact with the consumers on a daily basis and were frequently reminded of these unmet needs. “It’s difficult to know what our seniors need and not to be able to provide the services to them,” stated one interviewee, “I often get discouraged because our funding is cut more and more each year.”
All the interviewees reflected what could be best described as an entrepreneurial attitude toward financial support. They reported many accounts of initiating grassroots development efforts aimed at raising funds for routine program operations as well as for specific projects, such as the purchase of recreational equipment (Nintendo’s Wii Fit), transportation services (bus and subway tickets), or a social event (museum tour, concert, dinner dance).

The importance of valuing diversity

Since all the participating organizations were located in New York City, they were all very diverse, both ethnically and culturally. Most of the interviewees mentioned this issue and talked about the importance of multiculturalism in the senior center environment. One stated, “Our center is a reflection of the multicultural neighborhood where we’re located.” Several interviewees noted the importance of communication skills and stated that it was a great advantage to have staffs available who speak more than one language. Language skills were perceived as a tool for providing better services for older consumers of services.

The need to involve consumers in developing programs and services

All interviewees described ways that their programs and activities are responsive to the needs of the people they serve. They described many practices that they used to elicit recommendations from consumers, such as routine daily conversation, suggestion boxes, and program committees which included consumers, staff and volunteers. One interviewee stated that the older people themselves come up with the best ideas about programs and activities. “The people who come to our center are filled with creative ideas about the activities they want us to provide. Why should we dream up programs on our own when we can just ask
them what they need?‖ she stated. Some interviewees noted that consumer participation creates a more welcoming and satisfying environment for everyone in the center.

**Step 3. Design phase.** This phase consisted of a meeting where the group interpreted the themes that emerged from the interviews. This interpretation process was aimed at using the themes to design a model that redefined aging service delivery approaches. During this meeting they were coached by the researcher to design a model that incorporated the qualities of organizational practices that they wanted to replicate and the relationships that they wanted to achieve.

The **design phase** of the process resulted in a model depicting the new vision of aging services delivery that emerged from the interpretation of the interviews. This vision vividly mapped the changing landscape in a model illustrating the move from conventional to responsive and asset-based methods of service delivery to older adults. This model was designed in the form of a continuum in order to depict the fact that change from the conventional to the responsive, asset-based system is a unique, developmental journey for each organization.

<table>
<thead>
<tr>
<th></th>
<th><strong>Conventional</strong></th>
<th><strong>Responsive/Asset-based</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumers, members, participants are . . .</td>
<td>Clients with service needs</td>
<td>Evolving, dynamic, based on consumer needs and desires</td>
</tr>
<tr>
<td>Services are . . .</td>
<td>Pre-determined, static</td>
<td>Are capable, engaged, lifelong learners</td>
</tr>
<tr>
<td>Resources . . .</td>
<td>Receive little ongoing staff development</td>
<td>Can be accessed from many different sources</td>
</tr>
<tr>
<td></td>
<td>Conventional</td>
<td>Continuum</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Language used to describe services</td>
<td>Sometimes includes words like “feeding programs” “illness/disease” “dependence”</td>
<td></td>
</tr>
<tr>
<td>includes . . .</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change is . . .</td>
<td>Sometimes seen as a threat to the status quo</td>
<td></td>
</tr>
<tr>
<td>The practice environment is . . .</td>
<td>Of limited importance</td>
<td></td>
</tr>
<tr>
<td>The relationship between staff and</td>
<td>Is sometimes uni-dimensional, adds neutral value</td>
<td></td>
</tr>
<tr>
<td>consumers . .</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication between staff and</td>
<td>Is mono-directional</td>
<td></td>
</tr>
<tr>
<td>consumers . .</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 8. Asset-based model of aging services delivery

Step 4. Destiny phase. This final phase was initiated by a series of four meetings in which the group developed a plan aimed at realizing the dream that emerged from the previous steps of the process. This phase involved the generation of new images of a service delivery process intended to sustain the dream by nurturing a collective sense of destiny. The group acknowledged that this phase would continue into the future and would involve continuous learning, adjustment, and improvisation. They constructed an action plan designed to encourage innovation within the system by re-aligning and co-creating
organizational practices and policies that would embody the new vision for aging services
delivery.

The group acknowledged that Appreciative Inquiry is a continual cycle. In doing so,
they recognized that the destiny phase leads naturally to new discoveries of community
strengths, beginning the process anew. They created a series of action steps designed to
provide structure to their efforts to support the dissemination and adoption of the model.

The group observed that current research from disciplines such as management,
organizational development, and human resources could be used to inform the development
of a responsive, needs-driven service delivery model. Since research from the hospitality
evidence-base builds on all three of these disciplines, it was deemed appropriate for
adaptation to the service experiences of older adults.

Based upon this insight, the group recommended the planning and implementation of
a CITRA Research-to-Practice Consensus Workshop aimed at translating empirical research
from hospitality research to the practice of aging services. This recommendation was
specifically aimed at using hospitality research to further develop the responsive, asset-based
model of aging services into an educational curriculum for aging services staff. This
consensus workshop model, (Sabir, Breckman, Meador, Wethington, Reid & Pillemer, 2006)
was developed by investigators from the Cornell Institute for the Cornell Institute for
Translational Research on Aging (CITRA) and designed to foster a community-based
participatory dialogue between researchers and practitioners based on empirical findings in
an area of research critical to community practice and social service.
Finally, the group agreed to continue to meet as a working group, in order to take leadership for the development, funding, implementation, and dissemination of this curriculum and model.

**Discussion**

The appreciative inquiry yielded many new insights about the issues related to the delivery of aging services based both on empirical research and practice knowledge. As articulated above, the group developed a vision for aging services that embodied the best in their system. In addition, there was evidence that all participants, including the planners, interviewers, and interviewees, gained a broadened perspective on the issue.

How can the experiences of the participants in the appreciative inquiry be described in the context of adult learning theory and practice? The learning process that occurred in the context of the appreciative inquiry can be better understood when viewed through the framework of adult learning theory and practice.

The Appreciative Inquiry builds on the ideas of several adult education theorists. John Dewey (1859-1952), one of America’s foremost social theorists, believed that social learning, which is a key component of the Appreciative Inquiry process, is crucial to the generation of new knowledge (Dewey, 1938/1997).

The appreciative inquiry exemplifies the paradigm shift from “power over” to “power with” described by Paulo Freire (1921-1997), a Brazilian educator whose *Pedagogy of the Oppressed* (1972) is one of the most quoted educational texts in the world. His emphasis on dialogue, which informed the development of informal educational practice, is particularly
relevant in the context of the appreciative inquiry, since dialogue is a key attribute of the interview process.

The concept of praxis, a moral action that was informed and related to making a difference in the world, is convergent with the appreciative inquiry’s goal of generating a shared vision of excellence for aging service delivery. Both Freire and Jurgen Habermas, a German philosopher and sociologist (Habermas, 1994) believed that dialogue was a co-operative activity involving mutual respect that could enhance community and build social capitol among participants in the learning process (Freire, 1995).

Constructivism, can be summarized as (1) a view that learning is a participatory process of constructing, rather than acquiring, knowledge, and (2) an instructional process that facilitates knowledge construction. It was developed by educational theorists including Lev Vygotsky and Jean Piaget (SEDL, 1995; von Glasersfeld, 1985). The Appreciative Inquiry process described in this paper builds on constructivist theory by bringing people together to participate in the joint construction of a vision of aging services delivery.

**Implications for research**

While community-based participatory research has received increased interest as a promising approach to solving problems of interest to policy makers, researchers and practitioners, more knowledge is needed about the specific types of activities that can be most effective in bringing them together. The data suggest that the recommendations that emerged from this appreciative inquiry provided a significant degree of added value over recommendations that might have emerged from any of the organizations or researchers working in solitude.
Another recommendation of this study is that researchers and practitioners need additional structured opportunities to become partners through experiences such as the one described in this research. Findings of the study also suggest that learning plays an important role in partnerships between researchers and practitioners. For this reason, further research is recommended to explore the role of adult learning in the context of community-research partnerships. Further research should investigate the role of specific group processes, such as the appreciative inquiry, in building group consensus between researchers and practitioners. Additional research is also needed to examine the effectiveness of these methods, leading to their improvement over time.

**Implications for practice**

The purpose of this study was to better understand the best practices that have emerged from the aging services delivery network. The study was supported through the existence of a partnership between researchers and practitioners. Findings of the study revealed that the interviewers, interviewees and planners of the inquiry were active partners in the exchange of ideas, perspectives and meaningful dialogue; and that this dialogue resulted in the development of an innovative aging services delivery model. In addition, the study framed the appreciative inquiry process within the context of adult learning theory and practice, suggesting that participants engaged in a transformational learning experience and emerged from the appreciative inquiry with new perspectives about aging services delivery practices that they could apply in their own organizations.

Practitioners are often encouraged to innovate, but there are few opportunities that enable them to learn exactly how to do so. The appreciative inquiry provides the opportunity
for participants to learn about the best practices that are emerging from their own systems.

The result of this process can be practice models that have been co-authored by stakeholders who bring a high degree of collective knowledge and experience to the process.

Practitioners are sometimes limited in their motivation to participate in interactions with others in their systems. One motivating factor to do so could be a greater awareness of the perspective of others who are working in their systems. This heightened awareness could be an outgrowth of the appreciative inquiry process, especially if it is framed as an integral part of the destiny process.

While this study took place within the context of a partnership between researchers and practitioners, it is also important to note that there are great benefits to practitioners to engage in dialogue and knowledge building activities with other practitioners. Too often, busy researchers and practitioners limit their interaction solely to others within their own disciplines and professions, leading to a “silo” effect (Stone, 2004), characterized by turf wars, non-cooperation, and poor information-sharing. This study demonstrated the benefits that can result from cooperation and collaboration with others in similar organizations throughout a system.
References


CHAPTER 6. APPLYING HOSPITALITY RESEARCH TO THE DELIVERY OF AGING SERVICES: RESEARCHERS AND PRACTITIONERS AS LEARNING PARTNERS

A manuscript to be submitted to *Educational Gerontology*

Rhoda Meador, Judi Brownell, Karl Pillemer, Elaine Wethington

**Abstract**

This article is a case study of an innovative method called the Cornell Institute for Translational Research Institute (CITRA) Research-to-Practice Consensus Workshop, which was developed to bridge the gap between science and practice. In this instance, the method was used to bring researchers and practitioners together to participate in a dialogue and create subsequent recommendations about the application of empirical research from the hospitality field to the enhancement of aging services. This process resulted in the design of a curriculum aimed at applying hospitality research to the delivery of aging services. The article (1) describes the planning and implementation of the consensus workshop, (2) reports the recommendations resulting from the workshop, and (3) frames the workshop within the context of adult learning theory and practice.

**Key words**

aging services, senior centers, hospitality, consensus workshop, community-based participatory research, transformative learning, constructivist learning, adult learning
Background

By 2030, almost 20% of Americans – approximately 72 million people – will be 65 years or older. The U.S. population age 65 and over is expected to double in size within the next 25 years. The age group 85 and older is now the fastest growing segment of the U.S. population (U.S. Bureau of Census, 2006). The population will be not only growing older but also increasingly diverse. Minority populations are projected to increase from approximately 6 million in 2000 to 8 million in 2010; and then to 13 million in 2020. This expanding older population is made up of diverse, increasingly discriminating individuals.

These demographic and social changes in the early decades of the 21st century will drive several trends that will dramatically shape health and human services needs over the coming years. Health and human services providers will need to develop new practice models that are more tailored to the unique needs and desires of these constituencies (Pew, 2005).

In addition to these demographic trends, there are many economic, political, and social forces currently exerting pressure on health and human services institutions as they face the challenge of delivering services to this increasingly diverse older population. Provision of services and support becomes an increasing challenge as institutions and communities struggle to serve these mixed groups with such varied service and health care needs (Clark, 2001).

This expanding older population consists of several distinct cohorts, which have been labeled in various ways. Strauss and Howe (1992) defined these three cohorts as (1) “Baby Boomers,” born between 1943 and 1960, (2) the “Silent Generation,” born between 1925 and 1942, and (3) the “G. I. Generation,” born between 1901 and 1924. These groups have a
wide range of consumer needs, ranging from aging baby boomers who may be excessively meticulous about their service needs, to those in the "G.I. Generation" who may have complex medical needs. 

Research aimed at improving the lives of older people has built a strong evidence base that documents the success of practices and interventions aimed at improving the health and well-being of older people (Gelfand, 2006). However, there is a need for additional research leading to the development of successful models for community-based services that respond to the needs of these new emerging cohorts of older people. This changing environment offers the opportunity to explore new paradigms of service delivery and support that not only improve services, but also provide completely new perspectives about how to design and deliver assistance to older adults. Many practitioners seeking to serve their constituencies realize that the old model is not entirely effective, and they have been motivated to discover innovative practices that better serve their current and emerging customer base. These visionary organizations have developed practices at the grass-roots level aimed at incorporating a person-centered service paradigm into their practices and policies. 

A group of aging services providers and CITRA researchers conducted a joint study that explored aging service delivery models (Meador, 2008) and vividly mapped the changing landscape in a model that illustrates the move from conventional methods of delivering services to older adults to ones that are responsive and asset-based (Figure 11). Their study recommended further inquiry into existing evidence-based service models that could be translated to the aging services setting.
<table>
<thead>
<tr>
<th></th>
<th>Conventional</th>
<th>Continuum</th>
<th>Responsive/ Asset-based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumers, members, participants are . . .</td>
<td>Clients with service needs</td>
<td></td>
<td>Diverse, multi-dimensional consumers with social, physical, spiritual, knowledge capital</td>
</tr>
<tr>
<td>Services are . . .</td>
<td>Pre-determined, static</td>
<td></td>
<td>Evolving, dynamic, based on consumer needs and desires</td>
</tr>
<tr>
<td>Staff at all levels . .</td>
<td>Receive little ongoing staff development</td>
<td></td>
<td>Are capable, engaged, lifelong learners</td>
</tr>
<tr>
<td>Resources . .</td>
<td>Are limited, finite</td>
<td></td>
<td>Can be accessed from many different sources</td>
</tr>
<tr>
<td>Language used to describe services include . .</td>
<td>Sometimes includes words like “feeding programs”</td>
<td>Sometimes seen as a threat to the status quo</td>
<td>An opportunity to evolve and create more responsive programs</td>
</tr>
<tr>
<td></td>
<td>“illness/disease”</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>“dependence”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change is . .</td>
<td>Of limited importance</td>
<td></td>
<td>Integral element of service delivery-is welcoming, pleasant, stimulating, possibly virtual</td>
</tr>
<tr>
<td>The practice environment is . .</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The relationship between staff and consumers . .</td>
<td>Is sometimes uni-dimensional, adds neutral value</td>
<td></td>
<td>Adds mutually-satisfying positive value to both groups</td>
</tr>
<tr>
<td>Communication between staff and consumers . .</td>
<td>Is mono-directional</td>
<td></td>
<td>Is an ongoing bi-directional conversation between equals who engage in dialogue about needs and services</td>
</tr>
</tbody>
</table>

**Figure 9. Asset-based Model of Aging Services Delivery**

Current research from disciplines such as management, organizational development, and human resources offers insights for evidence-based practices that can inform the development of a responsive, needs-driven service delivery model that engages older
consumers in programs leading to enhanced health and well-being (Meador, Pillemer, Dionne, Jellinek, 2008). Research from the hospitality evidence base touches on all three of these disciplines, thus it seems appropriate for adaptation to the service experiences of older adults.

The purpose of this study was to investigate the central phenomenon of consensus-building as it relates to the development of a vision for aging services within the context of a research-practice learning partnership. This research is proposition generating, aimed at gathering evidence that will advance the understanding of aging services delivery through analysis of the following primary research questions.

(1) What is the nature of the joint vision that emerges when participants in a community-based participatory research partnership participate in an appreciative inquiry focused on the delivery of aging services?

(2) What role did learning play in these processes? How can the experiences of the participants in the CITRA Research-to-Practice Consensus Workshop be described in the context of adult learning theory and practice?

The CITRA Research-to-Practice Consensus Workshop (Sabir, Breckman, Meador, Wethington, Reid & Pillemer, 2006) was developed by investigators from the Cornell Institute for the Cornell Institute for Translational Research on Aging (CITRA) and designed to foster a community-based participatory dialogue between researchers and practitioners based on empirical findings in an area of research critical to community practice and social service. This paper presents a case study analysis of this innovative methodology that was used to bridge the gap between social science researchers and community practitioners.
seeking to improve the lives of older people and their caregivers. In this case, the model was applied to the application of empirical research from the hospitality field to the practice of aging services. The goal of the workshop was to identify (1) evidence-based recommendations for practice, (2) practice-based recommendations for research, and (3) policy recommendations.

**Method**

This study utilized the CITRA Research-to-Practice Consensus Workshop model (Sabir, et al, 2006), which was developed to unite researchers and practitioners in a structured learning environment in which they can engage in discourse leading to eventual consensus on a topic of interest. As such, it meets one of the primary aims of community-based participatory research (CBPR), which is to focus the attention of researchers and practitioners on empirical research in a specific research area (Israel & Schultz, 1998).

Previous CITRA Research-to-Practice Consensus Workshops have been based on topics identified by community groups and have included topics such as falls prevention, social integration, care transitions for frail elders, and elder abuse. The Research-to-Practice Consensus Workshop Model is reviewed in detail elsewhere (Sabir, et al., 2006).

The topic for the consensus workshop was identified by a group of nineteen aging-services practitioners from the New York Metropolitan area. This organizing group consisted of (1) researchers from Cornell University; (2) practitioners from a variety of health care and aging services settings, including senior centers, hospitals, and advocacy organizations; and (3) consumers of services for the aging. In several preliminary steps, the group identified the general topic “service utilization” as one of many critical issues that
emerged through the implementation of a needs assessment using concept mapping methodology (Trochim, 2004). As one of the outcomes of a subsequent joint study, they later reframed the topic as a “strength-based aging service delivery model” (Meador, et al., 2008).

Attendance in the consensus workshop was by invitation only, and included a representative group of practitioners, administrators and policy makers who were selected based on their experience with aging services delivery. The organizers selected individuals from a broad range of relevant organizations located in the New York metropolitan area, targeting those who could provide a diversity of perspectives, including social workers, case managers, advocates, and administrators in both institutional and community-based settings. They also invited representatives from the New York City Department for the Aging. It should be noted that several consumers, volunteers, and aging services board members also participated. Prior to the event, forty-two participants were sent invitations with an agenda and background materials explaining the purpose and goal of the consensus workshop (Appendix H), as well as copies of the draft research review. Of these invitees, thirty-eight participants attended the workshop.

**Procedures**

The steps involved in conducting the consensus workshop are presented in summary form in Figure 10. The first step of the process was refinement of the topic. The group decided to focus specifically on the topic of “**applying hospitality practice to aging services**” in a desire to further define an issue of critical importance.
(1) Selecting a topic

(2) Producing an up-to-date, non-technical translation of the literature

(3) Selecting a panel of expert researchers and expert practitioners

(4) Convening a larger group of researchers and practitioners for discussion

(5) Arriving at an initial consensus statement of research and practice recommendations

(6) Convening a follow-up meeting to create a final consensus document

**Figure 10. Major Steps in the CITRA Research-to-Practice Consensus Workshop**

The hospitality researcher from the Cornell School of Hotel Management was commissioned to produce a current non-technical review (*Step 2*) documenting selected research on service quality that could be applied in aging service settings. This paper discussed service quality from the perspective of both individual level as well as organizational level concerns.

The research review began by restating the importance of a service orientation, particularly in fostering customer loyalty or what has recently been called customer relationship management. Key elements of the specific service environment were discussed as they applied to hospitality settings. This was followed by a discussion of how service experiences can be customized as well as the employee characteristics and competencies required in this new service environment. Current methods of evaluating service quality were then reviewed. Regarding the organizational concerns, the research review examined the concept of service within the organization and presented recent research on creation and maintenance of strong service cultures. Finally, the paper described a macro view and
discussed the importance of organizational learning with an exploration of how customers form images of the organization as a whole—brand management. Throughout the process, questions were asked that assisted readers/participants in “translating” research findings and in determining the usefulness of these applications to the aging services environment. The draft research review (Appendix I) was used as a working document and provided the basis of discussion for the consensus workshop.

Next, six panelists were selected to participate (Step 3) in the consensus workshop. Two academic researchers were chosen to participate: an expert on management, leadership, and communication from the Cornell School of Hotel Management; and a sociologist who was an expert on community research partnerships, and the informal and formal support networks of older adults. Four practice experts were also selected for participation in the event. Panelists were selected based on their experience with aging services delivery, hospitality research, and human resources practice. They included (1) the executive director from a senior center, (2) a program administrator practicing in an innovative community health care setting, (3) a human resources professional from the hospitality management field, and (4) the executive director from an organization serving a special needs population (visually impaired).

The three-hour consensus workshop was convened (Step 4) in December, 2007. The workshop included an overview of CITRA’s consensus workshop process, a brief (10 minute) summary of the findings of the research review, brief (5 to 7 minute) remarks from each expert researcher/practitioner on the panel, and a facilitated dialogue involving all workshop participants. Comments of workshop participants were captured on newsprint and
displayed in the room. In addition, detailed notes of participant comments were taken, and
the event was videotaped in order to compile a complete transcript of the discussion.

After the large group discussion, workshop participants voted on their top three
recommendations for further action, and were given “dots” to cast their votes on the
newsprint. The group was informed that these recommendations would later be synthesized
into a bulleted list and distributed to all participants.

At the conclusion of the consensus workshop, participants were invited to attend a
follow-up Roundtable Discussion, where research and policy recommendations would be
synthesized and further action steps would be determined.

After the consensus workshop was conducted, the CITRA researchers collected the
materials that documented the discussion, including the newsprint lists containing the
participant’s votes and the written transcript of the discussion, and synthesized them into a
comprehensive document. The researchers completed a content analysis of the documented
responses. Key words, repetitive ideas, and emergent themes were identified, noted, and
organized into three categories of synthesized recommendations, and then ranked in order of
the number of votes each had received from the group (Appendix J).

Nine people attended the Roundtable Discussion (Step 6) which was held in February,
2008. Prior to the Roundtable Discussion, all participants were sent the full transcript of the
workshop discussion; the synthesized, ranked recommendations from the workshop; and
another copy of the research review. The following overview is a summary of the
recommendations resulting from the consensus workshop and the subsequent roundtable.
Evidence-based recommendations for practice

There was a high degree of consensus among the participants that the key to responding to the emerging needs of a multi-dimensional older population is a service culture orientation. One participant stated, “We need to treat our program participants like valued customers, not clients.” Moreover, the group expressed their agreement that learning (both organizational and individual) was the key to this culture change process. They also recognized that the policies and practices revealed in the research review should be carefully tailored to aging services settings, rather than translated directly from other service settings without modification. To this end, they defined hospitality in aging services as “a compassionate, responsive, asset-based, customer-centered service delivery process.” This definition served as the foundation for a “culture change” process that was designed to transform aging services into an asset-based paradigm.

The group expressed a sense of urgency regarding the need to engage their stakeholders in this change process as soon as possible. “Education is the key to changing the centers. It needs to happen as soon as possible, and everyone involved needs to be part of the paradigm shift,” said one participant. The group wanted to shape their recommendations in a form that could lead to immediate action, so they structured them in the form of a program plan that was designed to drive the change process. The proposed program consisted of three major components:

- a leadership development component aimed at teaching leaders from aging services organizations how to initiate and manage the change process, leading to a transformation from the current service delivery paradigm to the asset-based, service excellence paradigm;
- **a training component** for the staff of aging organizations aimed at teaching them how to deliver asset-based, customer-centered services, and;

- **a rigorous evaluation component** aimed at measuring the outcomes of the program.

The **leadership development component** was aimed at training leaders to manage and initiate the change process. It consisted of a three step process in which leaders from aging services organizations will (1) attend a 2-day intensive training program focused on leadership development, change management, and hospitality practices; (2) return to their organizations and lead a process to transform their organizations through the use of training and change management practices; and (3) implement a training program over the period of one year, in which they will coach learners in their organization to complete the training program, attend monthly meetings with participating leaders from other aging services organizations, and participate in evaluation activities.

The **staff training component** was aimed at training staff to deliver services based on the asset-based service-excellence paradigm. In this component, they recommended that all staff should: (1) complete a four-hour training program focused on hospitality and asset-based service delivery practices (delivered via a blended learning methodology). The training will be designed to seamlessly integrate with the larger systems-change trends from city, state and federal initiatives (e.g. wellness, point-of-entry, health promotion, etc.); (2) receive a packet containing materials that will be personalized and used as a professional-development portfolio over the course of the program; and (3) attend monthly classes involving facilitated discussions related to service excellence delivery practices and organizational culture change efforts.
Practice-based recommendations for research

The recommendations that the group made for research were framed as program evaluation. This was consistent with the highly contextualized nature of all the recommendations that emerged out of the workshop.

A rigorous evaluation component was aimed at evaluating the program in an effort to gain insights leading to program improvements as well as to build an evidence base relating to asset-based service delivery for aging services. The group recommended the implementation of (1) questionnaires designed to measure outcomes associated with individual, organizational, and systems change resulting from the program; (2) interview questionnaires (in the form of face-to-face interviews) to be administered to participating organizational leaders, staff, and consumers before and after the training program; and (3) organizational assessments to be developed and administered before and after program implementation for measuring quality improvement and program impact.

The specific instruments that were recommended were conceptualized as tools that could be replicated in other settings and continuously used as quality improvement measures.

Discussion

The consensus workshop yielded many new insights about the issues related to aging services delivery based on both a synthesis of hospitality research and practice knowledge. As articulated above, the group developed consensus recommendations that were designed to drive a major systems change process. It is important to note that evidence-based recommendations for practice were of primary interest to the group, while practice-based
recommendations for research were of secondary importance. This is a departure from the recommendations that resulted from previous consensus workshops, in which practice-based recommendations for research were of primary importance. In addition, **there was significant evidence that members of both groups gained a broadened perspective on the issue and translated that knowledge into immediate action.** The curriculum that they designed could not have been developed by either group alone.

What role did learning play in this consensus process? How can the experiences of the participants in this CITRA research-to-practice consensus workshop be described in the context of adult learning theory and practice? The promotion of joint learning by researchers and practitioners is prominent in community-based participatory research programs (Israel, Schultz, Parker, & Becker, 1998). The learning process that occurred in the context of the consensus workshop can be better understood when viewed through the framework of adult learning theory and practice.

Reflection, especially when rooted in the critical paradigm, is well suited to application in non-formal learning settings like this consensus workshop. It can be a strategy for emancipation from ‘false’ beliefs and assumptions that do not lead to valued ends for the participants in the learning process. New understandings based on critical reflection can lead to transformation in perspectives and changed practice (Emden, 1995).

More specifically, critical reflective inquiry, a more structured form of reflection, is an excellent theoretical framework to describe the consensus workshop. Critical reflective inquiry can be defined as a three-step process. Kim (1999) describes these three stages as 1) the descriptive phase, which includes viewing the current reality with some degree of objectivity, 2) the reflective phase, which involves a reflective analysis of objectives and
intentions leading to self-awareness, and 3) the critical/emancipatory phase, which involves a critique of the current reality regarding distortions, inconsistencies leading to self-critique and emancipation.

This process of critical reflective inquiry has been successfully implemented in various non-formal educational settings, included health and community-based human services (Cameron, 2000). Participants who attended the consensus workshop described here participated in these three steps and emerged with new perspectives about the aging services practice paradigm.

**Implications for research and practice**

The purpose of this study was to better understand a partnership between researchers and practitioners, the consensus that emerged from that partnership, and the nature of the learning that occurred in the context of the partnership. Findings of the study revealed that the researchers and practitioners participated as active partners in the exchange of ideas, perspectives and meaningful dialogue. Furthermore, this dialogue resulted in consensus between the two groups, resulting in meaningful recommendations that could be immediately translated into action. The study framed the consensus workshop process within the context of adult learning theory and practice, suggesting that participants engaged in a transformational learning experience, and, in turn, emerged from the consensus workshop with new perspectives about service delivery.

While community-based participatory research has received increased interest as a promising approach to solving problems of interest to policy makers, researchers and practitioners, more knowledge is needed about the specific types of activities that can be
most effective in bringing them together. The data suggests that the recommendations that emerged from this consensus workshop provided a significant degree of added value over recommendations that might have emerged from either of the groups alone.

Another recommendation of this study is that researchers and practitioners need additional structured opportunities to become partners through experiences such as the one described in this research. Findings of the study also suggest that learning plays an important role in partnerships between researchers and practitioners. For this reason, further research is recommended to explore the role of adult learning in the context of community-research partnerships. Further research should investigate the role of specific group processes, such as the consensus workshop, in building group consensus between researchers and practitioners. Additional research is also needed to examine the effectiveness of these methods, leading to their improvement over time.
References


CHAPTER 7. SUMMARY, CONCLUSIONS, AND IMPLICATIONS

Summary

The collective aims of these studies was to better understand partnerships between researchers and practitioners, the consensus that emerged from these partnerships, and the nature of the learning that occurred in the context of these partnerships. Findings of the studies revealed that the researchers and practitioners who were involved participated as active partners in the exchange of ideas, perspectives and meaningful dialogue. This dialogue resulted in consensus between the participating groups, resulting in valuable recommendations that could be immediately translated into action. In addition, the studies framed the consensus workshop and appreciative inquiry processes within the context of adult learning theory and practice, suggesting that participants engaged in a transformational learning experience, and, in turn, emerged from these participatory research activities with new perspectives about their ongoing research and practice.

Findings and conclusions

These studies yielded many new insights about the issues related to the service and health care delivery systems based in a synthesis of both research and practice knowledge. The participants in each group developed consensus recommendations and conclusions that were designed to drive major systems change processes. It is important to note that evidence-based recommendations for practice were of primary interest to the groups, while practice-based recommendations for research were of secondary importance. This was a departure from the recommendations that resulted from previous consensus workshops, in which
practice-based recommendations for research were of primary importance. One interpretation for this departure is that these three cases all involved research that was initiated by the practitioners themselves. In addition, there was significant evidence that members of both groups gained a broadened perspective on the issue and translated that knowledge into immediate action. The recommendations, models, and curriculum that they designed could not have been developed by either group alone.

What role did learning play in these processes? How can the experiences of the participants in the CITRA Research-to-Practice Consensus Workshops and the Appreciative Inquiry be described in the context of adult learning theory and practice? The promotion of joint learning by researchers and practitioners is prominent in community-based participatory research programs (Israel, Schultz, Parker, & Becker, 1998). The learning process that occurred in the context of these action research processes can be viewed through the framework of adult learning theory and practice.

The consensus workshop and Appreciative Inquiry methods build on Dewey’s ideas about the relationship of knowledge to action. Dewey’s constructs of experience and reflection (Vanderstraeten & Biesta, 1998) were powerfully illustrated by the participants’ engagement in joint reflection, which Dewey believed was a secondary phenomenon aimed at ensuring the continuity of action and leading to the development of knowledge over time. Dewey’s concept of social learning as crucial to the generation of new knowledge was a key component of the consensus workshops and Appreciative Inquiry (Dewey, 1938/1997).

The consensus workshop model, as utilized in these studies, exemplified the paradigm shift from “power over” to “power with” described in The Meaning of Adult Education, (Lindeman, 1962/1989). This paradigm shift, which Paolo Freire further
developed in *Pedagogy of the Oppressed* (1972), combined themes such as emancipatory educational practice and liberation. Freire’s emphasis on dialogue, which informed the development of informal educational practice, is particularly relevant in the context of the consensus workshop, since dialogue is a key attribute of the consensus workshop group process. Freire’s belief that informal education is a dialogical (conversational) rather than a curricular form of learning, further supports the consensus workshop design. Freire’s vision that education should involve people “working with” people rather than “acting upon” them, could be used to describe the leveling of the power relationship between practitioners and researchers that takes place during the workshop (Freire, 1972).

Freire’s concept of praxis, a moral action that was informed and related to making a difference in the world, is convergent with the consensus workshop’s goal of generating recommendations for improvements in research, practice and policy. He believed that dialogue was a co-operative activity involving mutual respect that could enhance community and build social capitol among participants in the learning process (Freire, 1995). In addition, Freire’s description of the importance of a safe learning environment where those who were “oppressed” could have a voice (Taylor, 1993), describes the consensus workshop infrastructure, which enables researchers and practitioners to have equal time to share their perspectives.

A consensus workshop can be regarded as a structure that supports the constructivist approach to learning, which is both a philosophy and a term used to describe a wide variety of learning practices and theories. Despite the diversity of views the term conveys, constructivism can be summarized as (1) a view that learning is a participatory process of constructing, rather than acquiring, knowledge, and (2) an instructional process that
facilitates knowledge construction. Many philosophers contributed to the development of constructivist thought, including Emmanuel Kant, John Dewey, Lev Vygotsky and Jean Piaget (SEDL, 1995; von Glasersfeld, 1985).

Emmanuel Kant (1724-1804), a pioneer of constructivist thought who viewed it as a blend of empiricism and rationalism, described it as a process whereby knowledge was gained through perceptions of the world organized through cognitive structures (Heylighen, 1993). He also believed that learning was a process based on individual perceptions in which humans reflect on an event and analyze what occurred based on information gathered before and during the event (Brooks & Brooks, 1999). This opportunity to reflect and analyze is provided to participants in the consensus workshop when they read a research review prior to the workshop event as well as reflecting on it during the workshop itself.

Lev Vygotsky (1896-1934) was a constructivist theorist who contended that higher levels of mental functioning originated in social processes (Wertsch, 1985) and that knowledge was constructed from meaningful interactions with others (Gergen, 1995). The consensus workshop provides an infrastructure for what Vygotsky identified as the “zone of proximal development” (Wertsch, 1985), an ideal level for learning which can be reached through the guidance of facilitators and collaboration with peers.

A consensus workshop also builds on the ideas of Jean Piaget, a natural scientist and developmental psychologist, who is widely credited as the father of the “constructivist theory of knowing” (Piaget, 1955). Piaget theorized that learning is an iterative process of assimilation and accommodation that allows humans to adapt to their environments (Phillips & Soltis, 1991). During the consensus workshop, researchers and practitioners attempt to achieve cognitive equilibrium when they encounter conflict between their internal
perceptions and external reality through dialogue, which leads to the development of
cognitive structures that restore equilibrium and stability (Brooks & Brooks, 1999) during the
process of reaching consensus.

As a result of their participation in the consensus workshop, it appears that
participants experienced what social scientist Ernst Von Glaserfeld has described as a
continuous “reconstruction of the concept of knowledge” (von Glaserfeld, 1985). He
theorized that cognitive processes are fluid and not capable of producing a true representation
of an objective world. Moreover, what is needed is a drastic modification of the relationship
between the cognitive structures we build up and the “real” world we perceive as existing
beyond our perceptual awareness (von Glaserfeld, 1985). Thus, cognition has an adaptive
function, enabling learners to incorporate information from their environments in an attempt
to make the most viable fit (von Glaserfeld, 2001). This approach to constructivism refers to
viability rather than truth or reality, emphasizing the active nature of knowledge construction
and the context in which each individual resides. Thus, the most viable models are
constructed and utilized until new information renders them obsolete. Knowing is by nature
an adaptive activity, leading to change over time as new solutions emerge. The consensus
workshop supports this process by providing participants with an environment where highly
contextualized solutions can emerge relative to the individual(s) who construct them (von
Glaserfeld, 2001).

The consensus workshop conforms closely to transformative learning theory (TLT) as
described by Jack Mezirow, who theorized that all adult learning involves meaning making
based on life experience (1991). He stated that transformational learning is characterized by
a “process of using a prior interpretation to construe a new or a revised interpretation of the
meaning of one’s experience in order to guide future action” (1995, p.49). Mezirow proposed that transformational learning involves ten phases (1995), including (1) experiencing a disorienting dilemma, (2) conducting a process of self-examination, (3) undergoing a critical assessment of role assumptions and feeling a sense of alienation from these traditional expectations, (4) relating to other peoples’ experience, commonly through dialogue, (5) exploring options for new behaviors, (6) building competence and self-confidence in new roles, (7) developing an action plan, (8) acquiring knowledge and skills for implementing the plan, (9) making provisional efforts to try out new roles and gain feedback, and (10) reintegrating into society with new perspective. These same steps parallel the consensus workshop and Appreciative Inquiry processes.

<table>
<thead>
<tr>
<th>Transformative Learning Phase</th>
<th>Appreciative Inquiry Steps</th>
<th>Consensus Workshop Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Disorienting dilemma</td>
<td>Discovery-decide to conduct inquiry</td>
<td>Conceptualize and plan workshop</td>
</tr>
<tr>
<td>2. Process of self-examination</td>
<td>Design-construct interview questions</td>
<td>Research review</td>
</tr>
<tr>
<td>3. Critical assessment of assumptions</td>
<td>Design-construct interviews</td>
<td>Responses to research review</td>
</tr>
<tr>
<td>4. Relating through dialogue</td>
<td>Design-conduct interviews</td>
<td>Workshop dialogue</td>
</tr>
<tr>
<td>5. Exploring options for new perspectives and behaviors</td>
<td>Dream-interpret interviews</td>
<td>Workshop dialogue</td>
</tr>
<tr>
<td>6. Building competence and confidence in new roles</td>
<td>Dream-conclusions emerges from interpretation</td>
<td>Workshop dialogue</td>
</tr>
<tr>
<td>7. Developing action plan</td>
<td>Dream-articulate vision</td>
<td>Recommendations</td>
</tr>
<tr>
<td>8. Acquiring knowledge and skills for implementation</td>
<td>Destiny-communicate vision and plan for future</td>
<td>Recommendations</td>
</tr>
<tr>
<td>9. Try out new roles and get feedback</td>
<td>Destiny-feedback on vision</td>
<td>Roundtable</td>
</tr>
<tr>
<td>10. Reintegration with new perspective</td>
<td>Destiny-vision feedback cycle</td>
<td>Final report to participants and broader dissemination</td>
</tr>
</tbody>
</table>
Moreover, Habermas’ theory of communicative action (Habermas, 1994) which is situated within the transformative learning paradigm, refers to forming consensus through active negotiation and the use of metaphors and narrative. Communicative learning within the consensus workshop process involves “learning what others mean while they communicate with you” regarding feelings, expectations, values, and other intangibles such as justice, freedom and beauty (Mezirow, 2000, p. 8).

While critical reflection was the primary model for Mezirow’s ideal version of discourse (1995), more recent interpretations of Transformative Learning Theory provide a broader spectrum for communication that can also illuminate our understanding of the role that learning plays in the consensus workshop. The concept of generative dialogue (Gunnlaugson, 2006; Scharmer, 2001) has been described as a conversational practice that draws on a variety of “ways of knowing” mediated by “meta-awareness.” As such, it provides an ideal description for the nature of dialogue that occurs in the consensus workshop. Scharmer (2001) developed a process model for generative dialogue that describes the movement of a group conversation through four successive fields of dialogue. These fields consist of (1) conventional, polite dialogue (talking nice), to (2) debate, characterized by listening as reloading (talking tough), to (3) reflective inquiry, characterized by empathic listening (reflective dialogue), and, finally, toward (4) a form of co-creative engagement (generative dialogue). The fields in this model parallel the progression of group conversation in the consensus workshop.
Generative dialogue is structured by awareness of the present rather than past patterns of thought, memory or reflection (Gunnlaugson, 2006). Over time, this awareness provides an environment for dialogue that can support a wide array of learner’s needs. This function, first described by Winnicott (1971) as a “holding environment,” is an apt description of the consensus workshop infrastructure. In the same way that our forms of discourse are shaped by cultural norms and assumptions over time within peer cultures, generative dialogue within the safe environment of the consensus workshop can also provide a culture to support co-creative discourse (Gunnlaugson, 2006).

“Presencing” and “suspension” are also two key constructs that play an important role in describing the generative dialogue that takes place in the consensus workshop. “Presencing” is defined by Senge, Scharmer, Jaworski and Flowers (2004) as a practice “of letting go of old identities and the need to control . . . ultimately . . . all aspects of presence lead to a state of ‘letting come’ of consciously participating in a larger field of change” (p.13-14). “Suspension” is a practice of enhanced awareness of our thoughts, mental models, and habits of mind in an effort to set them aside and examine them without judgment. It involves suspending our assumptions (Bohm, 1996) in order to become more objective. “Suspension” does not require destroying or ignoring our existing mental models of reality. Instead, it requires a willingness not to impose pre-established frameworks, beliefs, and thoughts on what we are seeing in an effort to observe without forming conclusions (Senge, Scharmer, Jaworski and Flowers, 2004).

Generative dialogue, as it exists within the consensus workshop infrastructure, can be particularly effective as a holding environment because the practices of “presencing” and “suspension” (Scharmer, 2001) are especially conducive to promoting a sense of trust, safety,
and openness (Taylor, 1993) as well as the opportunity to co-construct meaning from shared group experiences. This holding space has been interpreted by Isaacs (1993) as a metaphor embodied by a series of “containers” where learners can develop a collective capacity to hold creative tension between differing perspectives, emotions, contrasting emotions, and diverse ways of knowing. Thus, the consensus workshop provides an ideal environment where social learning can thrive in a setting where paradox and tension are not only tolerated but serve to foster creative problem-solving based on shared responsibility (Scharmer, 2001).

In conclusion, the consensus workshops and appreciative inquiry brought together a broad range of individuals, each of whom shared a unique, valuable perspective on this complex multi-dimensional issue. Taken as a whole, these perspectives led to the achievement of group consensus and several important learning goals. These models supported the exchange of ideas between groups and individuals by providing an environment for equal status learning and deliberation.

When examined through the lens of adult learning theory, learning within these models was closely aligned with Mezirow’s (2000) description of transformational learning as an integrative process that occurs within both communicative and instrumental learning domains. Participants appeared to experience four processes of learning, including (1) building on existing meaning schemes, (2) creating new points of view, (3) transforming our meaning schemes and/pr points of view, and (4) transforming our meaning perspectives or frames of reference. Thus, researchers and practitioners who engaged in these processes united, added new points of view to their existing meaning schemes, and emerged from the experiences with new, more valuable perspectives on issues of critical importance. Their motivation to translate this knowledge into immediate action also motivated them to engage
in actions, such as curriculum design, practice, policy and research recommendations, that were aimed at transforming the meaning perspectives of individuals within their organizations.

Based on this research, there is a reasonable amount of evidence to generate the proposition that participants in the consensus workshops and appreciative inquiry engaged in a learning process that involved acquisition of valuable new knowledge and skills. Evidence also points to the conclusion that they participated in a process that resulted in transformation of their meaning schemes and frames of reference. Participants also gained an increased awareness that recommendations for policy, practice and research are interconnected and cyclical, constituting a continuous feedback loop (Figure 12).

Figure 12. Meador’s transformative learning model for research-practice partnerships
Implications for research

While community-based participatory research has received increased interest as a promising approach to solving problems of interest to policy makers, researchers and practitioners, more knowledge is needed about the specific types of activities that can be most effective in bringing these groups together. The data suggest that the outcomes that emerged from this consensus workshop provided a significant degree of added value over outcomes that might have emerged from either one of the groups alone.

Another outcome of this research is that researchers and practitioners need additional structured opportunities to become partners through experiences such as the one described in this research. Findings of the study also suggest that learning plays an important role in partnerships between researchers and practitioners. For this reason, further research is recommended to explore the role of adult learning in the context of community-research partnerships.

Further research is also needed to investigate the role of specific action research methods, such as the consensus workshop and appreciative inquiry, in building group consensus between researchers and practitioners. Additional research is also needed to examine the effectiveness of these methods, leading to their improvement over time.

There is a need for more research aimed at rigorously evaluating community-research partnerships. Qualitative methods such as interviews and focus groups could be used to conduct process evaluation aimed at gaining a greater understanding of how these
partnerships work. More knowledge is also needed about the specific outcomes of the studies that are conducted within the context of these community-research partnerships.

Most of the studies investigating community-research partnerships are conducted by researchers themselves (Israel, 1998). This research could be strengthened by greater involvement by practitioners. This is often challenging, due to limitations in the knowledge of research methods and time availability. **Accessible action research methods such as the consensus workshop and appreciative inquiry** enable researchers and practitioners to participate as equals in a process that produces products for both groups.

**Implications for practice**

Practitioners are often encouraged to engage in implementation of evidence-based practices, but there are few opportunities that enable them to learn exactly how to do so. The consensus workshop provides the opportunity for participants to explore this question in an equal status environment. The result is **research-based practice recommendations that have been co-authored by a select group or research and practice experts who bring a high degree of collective knowledge and experience** to the process.

However, practitioners are sometimes limited in their motivation to participate in these partnerships. One motivating factor for practitioners could be a **greater awareness of the benefits that result from implementing evidence-based practices**. This heightened awareness could be gained through workshop and training events that teach practitioners how to assess various forms of evidence in order to make program decisions favoring the use of evidence-based program and practices.
While the focus of these studies has been the partnership between researchers and practitioners, it is also important to note that **there are great benefits to practitioners to engage in dialogue and knowledge building activities with other practitioners**. Too often, busy researchers and practitioners limit their interaction solely to others within their own disciplines and professions, leading to a “silo” effect (Stone, 2004), characterized by turf wars, non-cooperation, and poor information-sharing. The negative consequences of this “silo” effect were vividly illustrated through the case study of the care transitions consensus workshop. During that workshop, a picture emerged of uncoordinated health care services, social services, and policies. Group discussion revealed that this lack of coordination leads to less than positive outcomes for frail elders and their caregivers. This study demonstrated the many **benefits that can result from cross-disciplinary cooperation and collaboration**.

One striking change in perspective occurred on the part of study participants as a result of their participation. When the idea to implement the workshops and inquiry was presented by the group of community leaders, they were described in the context of the service system (care transitions, service utilization, hospitality practices). During the course of the consensus workshop, **this perspective shifted from an emphasis on these processes, to an emphasis on the older people themselves (and their caregivers)**. During the workshop dialogue and deliberation, issues were increasingly framed on the basis of their relationship to those who are experiencing them.

There are several practice implications resulting from this important change in perspective. First, conceptualizing issues from a consumer-centric perspective can motivate service providers to seek input from consumers relating to the design and delivery of
services. Second, an increased awareness of the nature of consumers’ concerns can lead to policies and practices that are more responsive to their evolving needs.

In conclusion, these three studies provided the opportunity to explore research-practice partnerships in a variety of ways. The studies yielded valuable recommendations for research and practice. In addition, the studies explored the learning experiences that the participants engaged in throughout the process. In the final analysis, this area of inquiry proved to be critical to the understanding of the process as well as the outcomes of research-practice partnerships.
BIBLIOGRAPHY


Bronfenbrenner Life Course Center. (2008). Retrieved May 3 from:
http://www.human.cornell.edu/che/BLCC/index.cfm

Constructivist Classrooms. Alexandria, Virginia USA: ASCD - Association for
Supervision and Curriculum Development.

and design.* Cambridge, MA: Harvard University Press.


Clark, D., Stump, T., Hui, S., Wolinsky, F. (1998). Predictors of mobility and basic ADL
difficulty among adult aged 70 years and older. *Journal of Aging and Health*, 10(4):
422-440.

Clark, B., (2001). Older, sicker, smarter, and redefining quality: the older consumer’s quest

Coleman, E. (2004). Lost in transition: Challenges and opportunities for improving the
quality of transitional care. *Annals of Internal Medicine, 140*, 533-536.

Coleman, E., Parry, C., Chalmers, S., & Min, S. (2006). The Care Transitions Intervention,
Results of a randomized controlled trial. *Arch of Internal Medicine*, 18221828.

Community Health Foundation of Western and Central New York. (2008). Retrieved April 2,
2008 from: http://www.chfwcny.org


Morgan, C.L. (1894). *Introduction to Comparative Psychology*, 1-382.


ACKNOWLEDGEMENTS

My enduring gratitude is extended to each of the individuals who provided support and assistance in completing my graduate studies and this dissertation. I had the good fortune to have been mentored in different ways by faculty at two premier educational institutions: as a graduate student at Iowa State University and as a fledgling researcher at Cornell University.

My committee chair, Leah Keino, provided me with invaluable guidance in constructing the dissertation and negotiating the accompanying administrative process. Beverly Kruemple helped me to formulate my vision and provided me with the moral support necessary to persevere through the entire graduate program. Jan Flora’s invaluable expertise and input relating to working with communities helped me to contextualize my vision. Peter Martin’s critical appraisal of my model enabled me to refine my vision and apply it to the needs of an aging population. Penny Ralston’s knowledge and wisdom relating to leadership helped me to better understand and apply these insights to systems change.

My colleagues at Cornell were thoroughly supportive during every step of the process. Karl Pillemer mentored me through my transformation from extension educator to social scientist. He served as a role model in the practice of applied research and taught me the intricacies of conducting research in real world settings. Elaine Wethington taught me how to access and synthesize literature from various academic disciplines. Leslie Schultz provided moral support and a grounded perspective on all aspects of the research process.
Myra Sabir and Linda Waganet served as excellent role models for the adventures involved in mid-life learning.

Finally, and most importantly, I could not have done this without the support, encouragement, and love from my dear family. My husband, Michael, was a constant source of strength throughout the highs and lows. My children, Lauren and Tristan, believed in me and encouraged me to pursue this dream from start to finish. My mother, Jessie, and sister, Angela, provided many inspirational words along the way.
Rhoda Helton Meador was born on March 8, 1952 in Hardburly, Kentucky. She received the Bachelor of Science in Sociology from Marshall University in 1973 and the Master of Science in Adult Education in 1982. She has spent much of her career working with practice and applied audiences as an adult educator and administrator in a variety of education, human service, and health care settings. She has served as an Extension Associate in the Cornell Institute for Translational Research on Aging, where she has developed, evaluated and implemented many successful programs aimed at improving the lives of older people and their caregivers.
APPENDIX A Manuscript Specifications for Health Promotion Practice

Manuscripts are invited on a variety of topics related to the application of health promotion/health education programs in various settings. Manuscripts addressing the following topics are encouraged:

* Innovative linkages between academics/researchers and practitioners
* Community and/or clinical applications of new or state-of-the-art intervention strategies
* Policy advocacy and social environmental interventions to promote health
* Evaluations of community and/or clinical interventions focusing on the utility for practitioners
* Sustainability/durability of interventions and policy initiatives, and
* Other applied practice topics.

When considering the development and submission of manuscripts to Health Promotion Practice, the journal’s mission statement should be considered: The journal publishes authoritative articles devoted to the practical application of health promotion and education. It publishes information of strategic importance to a broad base of professionals engaged in the practice of developing, implementing, and evaluating health promotion and disease prevention programs. The journal's editorial board has made a commitment to focus on the applications of health promotion and public health education interventions, programs and best practice strategies in various settings, including but not limited to community, health care, worksite, educational and international settings.

Additionally, the journal focuses on the development and application of public policy conducive to the promotion of health and prevention of disease. The journal includes issues related to the professional preparation and development of health educators. The journal recognizes the critical need to (1) promote linkages between researchers in the academic and private sectors with health promotion and education practitioners; and (2) address the health issues of ethnic and racial minority populations. These partnerships and collaborations are reflected in the editorial philosophy and the broad scope of published articles and contributed sections. The journal adheres to the ethical principles of the profession as reflected in SOPHE's code of ethics.

Authors are asked not to use the following terms:

* Subjects when referring to participants;
* Target populations when referring to Priority populations

Manuscript Types and Format Guidelines

Please follow the guidelines below based on the type of manuscript you are submitting.

* Manuscripts should be submitted in English
* Manuscripts must be typed double-spaced, font size 12-point, Times New Roman
* 20 pages MAXIMUM, including references, tables & figures (Note: this does not include cover page or abstract)
* 1” margins on all sides
* Please include a cover letter
* Identifying information MUST be placed ONLY on the title page and title page (and) MUST be a separate document from the manuscript
* Manuscript should not contain any identifying information regarding the author of the paper, acknowledgements, project funding or author’s notes
* Acknowledgements and author’s notes should be entered in the “comments” field in Editorial Manager during the submission process

Items Required for Submission

* Abstract
* Keywords
* Classifications
* Complete name, email address, and one line bios for all authors on the manuscript
  
  Dr. John Q. Public, PhD, is Director of Health Education at Public Health University in Anytown, State. (Longer bios will be edited to fit this example.)

* Title page
* Manuscript with tables, charts and figures
* Transfer of copyright

  Our publishers require us to submit a signed Transfer of Copyright agreement for each author on the manuscript. Please print, sign, and fax it back to Sarah Leonard at (202) 408-9815. (Note: Please write the name of your manuscript on the form.)

* The entire manuscript, including references and citations, must be written according to the Publication Manual of the American Psychological Association, 5th edition. Citations in the text should use the author-date method inserted at the appropriate point and are listed alphabetically in the reference section in APA style. For example, in text citations:

  It is widely recognized that tobacco prevention and control programs should use policy advocacy interventions (Jones & Brown, 1998; Samson, Robb, and Dunn, 1996).

* All manuscripts not submitted in the correct referencing/citation style will be returned to the author.

  Tables, Charts, Figures and Graphs

  Tables, charts, figures and graphs must be in black and white and printed at 1200 dpi or better. Power Point, Excel and Word are encouraged. Tables, etc. should be placed at the end of the paper- placement notations can be made throughout the text (e.g., “Insert Figure 1 here”). Please submit images exactly as you wish to see them when published.

  Photos and Grayscale Images

  Photos and grayscale images should be scanned in the size they will appear in the journal, or larger. Photos are best sent as originals or scanned in at the correct size and resolution (300 dpi).

Special Guidelines

Applications/Interventions Manuscripts (Peer-Review Article)

Each applications/intervention manuscript must include:

1. Cover letter
2. Title page including title, name and affiliations of authors, address, phone number, fax number and email of corresponding author
3. Abstract of 150 words or less
4. Keywords
5. Maximum length of twenty type written, double-spaced pages (including references, tables & figures). Times New Roman 12-point font, 1‖ margins all the way around.
6. The following sections should be included:
(Note: It is strongly suggested that you include these titles in your manuscript)
* Introduction
* Background/Literature Review
* Methods/Strategies/Intervention Applications
* Discussion
* Conclusions - must include recommendations and implications for applications.
* References - (Note: All references must be written according to the Publication Manual of the American Psychological Association, 5th edition [i.e. (author, year) inserted in the text.]
Other types of manuscripts such as extensive literature reviews, policy case studies, or commentaries will be accepted (see below).

Literature Review Articles

Literature review articles must be comprehensive in nature, that is, go beyond a cursory review of a topic. Literature review articles must include the following:
1. Cover letter
2. Title page including title, name and affiliations of authors, address, phone number, fax number and email of corresponding author
3. Abstract of 150 words or less
4. Keywords
5. Maximum length of twenty type written, double-spaced pages (including references, tables & figures). Times New Roman 12-point font, 1” margins all the way around.
6. The following sections must be included:
* Introduction including rationale/timeliness of topic being reviewed
* Extensive literature review
* Discussion
* Conclusions—implications for applied practice
* References (Note: All references must be written according to the Publication Manual of the American Psychological Association, 5th edition [i.e., (author, year) inserted into the text.]

Policy Analysis/Policy Case Studies

Policy Analyses and policy case studies must include the following:
1. Cover letter
2. Title page including title, name and affiliations of authors, address, phone number, fax number and email of corresponding author
3. Abstract of 150 words or less
4. Keywords
5. Maximum length of twenty typewritten, double-spaced pages (including references, tables & figures). Times New Roman 12-point font, 1” margins all the way around.
6. The following sections must be included:
* Introduction
* Background/Literature Review
* Policy Analysis or Case Study
* Discussion
* Conclusions—implications for applied practice or policy
Commentaries on current, timely topics of interest to health promotion and education practice, policy and professional development are encouraged. Commentaries must include the following:

1. Cover letter
2. Title page including title, name and affiliations of authors, address, phone number, fax number and email of corresponding author.
3. Keywords
4. Approximate length of eight to ten typewritten, double-spaced pages.
5. References (Note: All references must be written according to the Publication Manual of the American Psychological Association, 5th edition [i.e. (author, year) inserted in the text.])

To submit a manuscript to Health Promotion Practice, you may do so through our online manuscript submission, review and monitoring system, Editorial Manager, at http://www.editorialmanager.com/hpp.

OnlineFirst / Publish Ahead of Print
Effective May 2006, Health Promotion Practice is pleased to announce the implementation of OnlineFirst, a SAGE Journals Online feature where completed articles are published online prior to their inclusion in a print issue (also referred to as “publishing ahead of print”). This feature offers you the advantage of making your research accessible to our readers and the public in a more timely manner. For your information, “FAQs about OnlineFirst” can be found on the Health Promotion Practice Editorial Manager® website at http://hpp.edmgr.com.

During the production process each manuscript is assigned a Digital Object Identifier (DOI), a unique identification number similar to the ISBN assigned to book publications. (You can find this number on the bottom left-hand corner of the first page of your proofs.) While available through OnlineFirst, your manuscript should be cited using the DOI as follows:


After the article is assigned to a specific issue, new citations can be made using volume and page number information, while still using the DOI:


As the corresponding author on your manuscript, you will automatically receive a separate email notification with detailed information about the article once it has been assigned to an issue. If you would like to receive email notification for ongoing HPP tables of contents, and alerts by author name, you can register for HPP Email Alerts at http://hpp.sagepub.com/cgi/alerts.

Questions may be directed to
Sarah Leonard, Editorial Assistant and Project Coordinator
Society for Public Health Education
750 First St., NW Suite 910
Washington, DC 20002-4242
Phone: 202-408-9804
Fax: 202-408-9815
Email: sleonard@sophe.org
APPENDIX B  Manuscript Specifications for *Families in Society*

Now in its 89th year, *Families in Society: the Journal of Contemporary Social Services* is the oldest and one of the most respected journals in North America on social work and related social and human services. The journal serves social workers and related professionals in direct practice, management, supervision, education, research, and policy and planning.

Articles should be no more than 20 pages in length, double-spaced, excluding references and accompanying figures and tables. Each copy should include a cover sheet with the name, position title and the affiliation of each author. The next page should include the manuscript title and abstract (limited to 120 words), followed by the main body of the article (including tables and figures); this page and those following should not include indication of authorship. The cover letter should identify the corresponding author with contact information, including an e-mail address.

Manuscripts should have clear contextual information, i.e., content should clearly identify the context(s) in which the topic arose; in which any or all information and findings can be applied; and who, in what types of circumstances, should take notice of the article. For example, where might the content of the article be applied, under what circumstances, and for what purpose(s)? With such information near the beginning, readers are more likely to ascertain the pertinence of the article to their own circumstances. Such information can be part of the abstract.

Similarly, articles should conclude with a detailed and thoughtful ‘Implications for Practice’ section – an exposition of how the material can appropriately be used in/with rethinking practice settings, formulating policy, informing further research, strengthening the administration of social services agencies, and/or benefiting clients and communities.

If the manuscript is accepted, authors may be invited to present a 60-minute teleconference, develop a discussion guide with talking points, or prepare sample continuing education course questions.

Queries regarding the suitability of potential articles are welcome. Please contact the editor at 11700 West Lake Park Drive, Milwaukee, WI 53224-3099
APPENDIX C  Manuscript Specifications for *Educational Gerontology*

Educational Gerontology: An International Journal publishes refereed materials in the fields of gerontology, adult education, and the social and behavioral sciences. According to the double-blind procedures established for critiquing papers, copies of materials received by the Editor-in-Chief are reviewed by panels appointed by the Editor-in-Chief. The peer review process consists of three or more persons knowledgeable in the areas covered by the materials. Original and two copies of each manuscript should be submitted to the editor, D. Barry Lumsden, University of North Texas, P.O. Box 310829, Denton, Texas 76203-0829.

Authors are required to submit manuscripts on disk. The disk should be prepared using MS Word or WordPerfect and should be clearly labeled with the authors’ names, file name, and software program.

Each manuscript must be accompanied by a statement that it has not been published elsewhere and that it has not been submitted simultaneously for publication elsewhere. Authors are responsible for obtaining permission to reproduce copyrighted material from other sources and are required to sign an agreement for the transfer of copyright to the publisher. All accepted manuscripts, artwork, and photographs become the property of the publisher.

All parts of the manuscript should be typewritten, double-spaced, with margins of at least one inch on all sides. Number manuscript pages consecutively throughout the paper. Authors should also supply a shortened version of the title suitable for the running head, not exceeding 50 character spaces.

Each article should be summarized in an abstract of no more that 100 words. Avoid abbreviations, diagrams, and reference to the text. Manuscripts, including figures, tables, and references, must conform to the specifications described in the Publication Manual of the American Psychological Association (5th ed., 2001). Manuscripts that do not adhere to this style will be returned for revision.

Illustrations. Illustrations submitted (line drawings, halftones, photos, photomicrographs, etc.) should be clean originals or digital files. Digital files are recommended for highest quality reproduction and should follow these guidelines:

- 300 dpi or higher
- sized to fit on journal page
- EPS, TIFF, or PSD format only
- submitted as separate files, not embedded in text files

Color illustrations will be considered for publication; however, the author will be required to bear the full cost involved in their printing and publication. The charge for the first page with color is $900.00. The next three pages with color are $450.00 each. A custom quote will be provided for color art totaling more than 4 journal pages. Good-quality color prints or files should be provided in their final size. The publisher has the right to refuse publication of color prints deemed unacceptable.

Tables and Figures. Tables and figures should not be embedded in the text, but should be included as separate sheets or files. A short descriptive title should appear above each table with a clear legend and any footnotes suitably identified below. All units must be included. Figures should be completely labeled, taking into account necessary size reduction.
Captions should be typed, double-spaced, on a separate sheet. All original figures should be clearly marked in pencil on the reverse side with the number, author’s name, and top edge indicated.

Proofs. One set of page proofs is sent to the designated corresponding author. Proofs should be checked and returned promptly.

Reprints. The corresponding author of each article will receive one complete copy of the issue in which the article appears. Reprints of an individual article may be ordered from Taylor & Francis by using the reprint order form included with page proofs.
APPENDIX D  Care Transition Consensus Workshop Invitation

The Community Health Foundation Health Leadership Fellows of Western and Central New York

And

The Cornell Institute for Translational Research on Aging (CITRA)

invite you* to attend

a Research and Practice Consensus Workshop on

Transitions of Care for Frail Elders

*Attendance is by invitation only.

Date: Thursday, February 28, 2008
Time: 8:30 AM-12:30 PM
Place: Kendal at Ithaca Auditorium
2230 North Triphammer Road, Ithaca, NY 14850

Continental breakfast will be served

You must RSVP to attend.

Please RSVP by February 19th to Crystal Wyant at crystal.wyant@dfa.state.ny.us

The Community Health Foundation Health Leadership Fellows of Central New York has partnered with the Cornell Institute for Translational Research on Aging (CITRA) to convene a regional discussion on the important topic of care transitions for frail elders. The goals of the consensus workshop are to:

- Produce an up-to-date non-technical review of the research literature;
- Convene a select group of research, practitioner and policy experts for discussion;
- Arrive at a consensus regarding research, practice and advocacy recommendations; and
- Disseminate recommendations to the various aging communities.

CITRA’s goal is to create and model a forum for a continuous loop of communication between research, practice, and advocacy to create a joint conception of aging-related problems and solutions. So, please RSVP and Save the Date—and we will be in touch soon with more details.
The Community Health Foundation of Western and Central New York  
Health Leadership Fellows  
www.chfweny.org  
The CHF Health Leadership Fellows of Central New York is a group of health care and human  
service professionals concerned with frail elders and children living in poverty in Cortland,  
Onondaga and Tompkins Counties. Transitions of Care for Frail Elders is a topic which touches  
all of our organizations and communities. This collaborative project will stimulate discussion  
and follow-up among researchers and practitioners with a goal of improving the health outcomes  
of frail elders in Central New York.

Cornell Institute for Translational Research on Aging (CITRA)  
Consensus Workshops  
www.citra.org  

What are CITRA Consensus Workshops?  
CITRA selects several aging-related topics per year on which (1) to produce an up-to-date non-  
technical translation of the literature; (2) to convene a select group of research, practitioner, and  
policy experts for discussion; (3) to arrive at a consensus regarding research, practice, and  
avocacy recommendations; and (4) to disseminate recommendations to the various aging  
communities. CITRA’s goal is to create and model a forum for a continuous loop of  
communication between research, practice, and advocacy such that there is joint conception of  
aging-related problems and solutions.

What are the criteria for topic selection?  

a. Sufficient research must be available on the topic.
b. The topic must be practice relevant, and preferably policy relevant.
c. The topic must be compatible with the needs assessment already conducted by  
   CITRA and CITRA’s Community Advisory Committee.
d. The effort must not duplicate a recent very similar effort.

What happens after topic selection?  

1. Two-three scientific experts are identified who serve as consultants to the research review and  
   writing process and who join the consensus workshop discussions.
2. CITRA staff review the available scientific literature and prepare a written research review  
   that (a) sets out the practice-relevant research in a non-technical way, and (b) makes practice and  
   policy recommendations based on the research.
3. A consensus workshop is held to discuss the written research review. An attempt is made to  
   achieve consensus on research, practice, and policy recommendations. The workshop is small, by  
   invitation only, and involves members of the advisory committee, the research experts, several  
   additional practitioners and policy advocates who have special expertise, and CITRA personnel.
4. A follow-up roundtable discussion is held to arrive at final recommendations and to discuss  
   plans for dissemination.
Research/Practitioner Consensus Workshop:  
Translating Aging Research to Transitions of Care for Frail Elders

Sponsored by

The Community Health Foundation Health Leadership Fellows of Western and Central New York and The Cornell Institute for Translational Research on Aging (CITRA)

8:30 – 9:30 am  Continental Breakfast  
Sign-In (handout Packets & Nametags)

9:30 – 10:30 am  Opening Remarks
  • Welcome/Introductions of Panel – Linda Wright
  • Framing the day – Leola Rodgers
  • Description of Methodology – Rhoda Meador
  • Presentation of Research Review Paper – Joan Skawski
  • Researcher/Practitioner Expert Reactions (5 – 7 minutes each)

10:30 – 11:30 am  Facilitated Discussion
  • How does the research apply to the institutions and agencies represented?
  • What are the implications for the patient and/or caregiver?
  • How does the research apply to policy making and reimbursement?

11:30 – 11:50 am  Break – Refine recommendations

11:50 – 12:30 pm  Next steps
  • Timeline for Roundtable @ Kendal: April 1, 1-3 pm
  • Feedback & Action steps
  • Written Evaluations
APPENDIX E  Care Transition Research Review

Transitions of Care for Frail Elders: A Research Review

Rhoda Meador, Elaine Wethington, Liz Norton, Lisa Holmes, Joan Skawski,
Maureen Cerniglia, Linda Wright, Leola Rodgers

Draft (Do Not Distribute)

Introduction

Transitions of frail elders from home to (and from) institutional care
environments, such as hospital and long-term care facilities, has a significant impact on
their physical and emotional well-being. Eric Coleman (2004) defined transitional care as
“a set of actions designed to ensure the coordination and continuity of health care as
patients transfer between different locations or different levels of care within the same
location.” These transitions often magnify the impact associated with the inadequacies in
the health care system.

Each year older people experience over 13 million transitions from acute or
rehabilitation facilities to home. In addition, acute care is now more apt to be delivered
in long-term care settings. Care that was once provided in the hospital setting is now
often provided in patient's homes, physician's offices, nursing homes and in other
community settings. The discharge planning needs of older adults, which are influenced
by race, culture, language differences, and urban or rural locations are complex and
involve many different systems.

Current discharge planning process

The discharge planning process in acute care differs from one institution to
another, but the common thread is the development of a comprehensive plan for moving
the patient to the next level of care. All too often, the goal is to hurriedly move the patient out of the acute care setting, and the destination is determined as much by available funding mechanisms as it is by need or desire.

The push to decrease length of stay has motivated efforts by hospital case managers and discharge planners to move patients as quickly through the system as possible. This urgency forces expediency at the cost of thorough planning. Shorter hospital stays give discharge planners less time to develop complex discharge plans and to educate patients and caregivers.

Family caregivers, who provide most of older adults’ long term care needs, are often left out of the decision-making process. Family caregivers can become frustrated with their exclusion in the decision-making process and their poor preparation for meeting the needs of the frail older adult once they are home.

Frail elders, who often have multiple chronic conditions and high risk factors for poor outcomes, are increasingly discharged to their homes unprepared to manage their care needs. These individuals, who are often ill-prepared for discharge, sometimes find themselves returning to the hospital emergency department due to medication mismanagement, and due to their misunderstanding of their treatment regimens and their follow-up care.

A comprehensive information management infrastructure, which could seamlessly transfer information between providers, does not exist in our current health care delivery system. The transfer of information from hospital to the patient and to the patient’s care providers is impeded by privacy considerations, as well. This information is needed by follow-up providers, the patient, the caregiver(s) and each may require it in a slightly
different format and at different reading levels. Naylor (2006) states, “There is no recognized ‘point person’ in our current health care system for managing care across time, place, and profession, and little acknowledgment that individuals with chronic disabilities shift among physicians, hospitals, nursing homes and their own homes.”

**Regulations and financial considerations**

All of the major healthcare-related regulatory agencies and accrediting agencies require facilities to plan for discharge, including the Centers for Medicaid and Medicare (CMS), the state Departments of Health (DOH), and the Joint Commission, each having standards by which facilities are judged. These standards are intentionally broad to account for differences in capabilities at various institutions. However, if the concern with transitions in care escalates, and the industry does not rectify these issues, it is possible that these agencies will step in to further regulate the standards.

Another issue involves payment. Discharge opportunities for frail seniors are vastly limited by the available payment options. In general, Medicare and the majority of the private insurances only cover home care if it requires a skilled provider and is limited to a finite illness. Care needs for frail elders do not always fit these tight objective definitions. Consequently, care must be pieced together with multiple payment sources and typically involves multiple home care providers resulting in a fragmented plan of care. Medicare and Medicaid, who are the primary funders of long term care, provide few incentives for providing coordinated care transitions.

**Care transition research**

There is an abundance of research that documents the difficulties older adults and their caregivers experience during these transitions. This is a review and synthesis of the
research on care transitions developed by aging-related researchers to improve the health outcomes of frail elders as they move from these institutional settings to, and from, home. This paper examines articles which are grouped into three categories. The first group of articles examines the topic of screening and assessment tools related to care transitions; the second group examines the nature and effectiveness of pre- and post-discharge planning interventions aimed at improving care transitions; and, the third group examines research reviews of multiple interventions related to improving care transitions.

**Group 1 - Research on screening and assessment tools**

There are two main tools which provide a means for assessing patients’ needs and the corresponding treatment: the MDS for rehabilitation and long-term care and the OASIS for home care. These tools serve two predominant purposes: to assist in tracking and quantifying care and to bill appropriately. In New York State, the Patient Review Instrument (PRI) and SCREEN are assessments used to determine the appropriate post-acute level of care and the appropriate rate of reimbursement for the long-term care provider. These tools are discreet and unrelated to one another, reinforcing the fragmented nature of our system of care.

There is research underway which evaluates assessment tools aimed at enhancing the safety of care transitions by coordinating discharge planning across care settings. The following chart presents a summary table of these articles examining assessment tools, with an analysis of objectives, measures, findings and implications.

<table>
<thead>
<tr>
<th>Author, et al., 2003</th>
<th>Objective</th>
<th>Measures</th>
<th>Findings</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>This study tested the predictive ability of the</td>
<td>PRA screen was administered; use of non-routine</td>
<td>The study produced very small significant</td>
<td>The clinical utility of using the PRA as a screen for early identification of</td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>Use</td>
<td>Methodology</td>
<td>Findings</td>
<td>Implications</td>
</tr>
<tr>
<td>-------</td>
<td>-----</td>
<td>-------------</td>
<td>----------</td>
<td>--------------</td>
</tr>
<tr>
<td>Grimmer, et al. (2006)</td>
<td>To describe the development of a pre-discharge checklist which patients and their caregivers generated</td>
<td>The checklist contains some prompts for concerns, such as transportation to medical appointments after discharge or paying bills. There are spaces for additional patient specific concerns. Allows for individualization.</td>
<td>The authors present the checklist, but do not document the benefits of its use.</td>
<td>Assessment could be useful, but this paper presents little evidence related to the efficacy of the assessment.</td>
</tr>
<tr>
<td>Kramer, et al. (2006)</td>
<td>Uniform Patient Assessment for Post-acute Care. Describes the attempt to design a uniform assessment tool for post-acute care.</td>
<td>Study outlines the limits of the three existing CMS assessment tools: MDS, OASIS, IRF-PAI and</td>
<td>None of the existing tools adequately covers the spectrum of patients and domains to be measured across care settings</td>
<td>Recommended the development of a comprehensive two-stage tool for use in national demonstrations</td>
</tr>
</tbody>
</table>

**Summary**

This summarized research indicates that there are some standard tools being used in a variety of settings to assess a variety of domains related to care transitions. While there is some evidence that these tools are effective, no one comprehensive assessment tool has been developed.
Questions to consider

1. What characteristics would the ideal assessment tool for care transitions possess?
2. Ideally, what settings should an assessment tool be tested in?
3. Ideally, who should be involved in the development and testing of an ideal assessment tool?

Group 2-The nature and effectiveness of pre- and post-discharge interventions

The following articles discuss interventions aimed at the development of a comprehensive transition plan either pre- or post-discharge. Effective interventions are especially important to meet the needs of frail elders, who are most likely to have complex illnesses, cognitive impairments, multiple medications, limited supports, limited income, and LTC needs that do not relate to the acute system of care and reimbursement.

Some researchers have focused their efforts on the identification and testing of effective interventions aimed at improving care transitions. The following chart presents a summary table of articles examining pre-and post-discharge interventions, with an analysis of objectives, measures, findings and implications.

<table>
<thead>
<tr>
<th>Author</th>
<th>Objective</th>
<th>Measures</th>
<th>Findings</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coleman et al., 2004</td>
<td>Tested model “Care Transitions Intervention” involving: promoting cross-site communication, encouragement to take more active role in care, assert preferences &amp; guidance from ‘transitions coach’</td>
<td>Rehospitalization rates and patient surveys (n=158)</td>
<td>Intervention associated with some positive effects</td>
<td>Intervention could prove to be effective; this study establishes need for more research</td>
</tr>
<tr>
<td>Reference</td>
<td>Study Description</td>
<td>Methods</td>
<td>Findings</td>
<td>Conclusion</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------------</td>
<td>---------</td>
<td>----------</td>
<td>------------</td>
</tr>
<tr>
<td>Tempkin-Greener, et al., 2004</td>
<td>To test the hypothesis that social support is an important predictor of mortality in a frail older population receiving formal long-term care services.</td>
<td>Individual risk factors, program effect, and social support were assessed using statistical modeling (n=3138)</td>
<td>Certain aspects of informal caregiving are important factors enhancing survival in a population of frail, nursing home-certifiable individuals enrolled in a health program (PACE)</td>
<td>Further research is needed to better differentiate between the affective versus the instrumental dimensions of social support.</td>
</tr>
<tr>
<td>Graham, et al., 2005</td>
<td>To track usage and satisfaction with “Providing Assistance to Caregivers in Transition” (PACT) program, interdisciplinary case management program designed to enhance nursing home discharge planning and case management support for the transitional period following a return to the community</td>
<td>Utilization rates, Participant satisfaction (n=38)</td>
<td>Caregivers reported satisfaction with instrumental and emotional support; nursing home cooperation mixed</td>
<td>More work is needed to develop a broader referral base for the program.</td>
</tr>
<tr>
<td>Kane et al., 2006</td>
<td>Comparison of two different variants of the Program for All-Inclusive Care of the Elderly (PACE)</td>
<td>Outcomes include hospital admission, days in hospital, ER visits</td>
<td>PACE implemented through hospitals is more effective than a more liberal variant, the Wisconsin Partnership Program (WPP)</td>
<td>Hospital-based transitions programs may result in improved outcomes for participants</td>
</tr>
<tr>
<td>Coleman et al, 2006</td>
<td>Experimental trial of model “Care Transitions Intervention” involving: promoting cross-site communication, encouragement to</td>
<td>Rehospitalization rates at 30, 90 and 180 days; prevalence of same/similar diagnosis (n=750)</td>
<td>Intervention resulted in significant reduction in rehospitalization</td>
<td>“Care Transitions Intervention” featuring client coaching, cross-site communication, encouragement to take more active role in care, assert preferences is likely to result in positive outcomes</td>
</tr>
<tr>
<td>Study</td>
<td>Description</td>
<td>Methodology</td>
<td>Results</td>
<td>Conclusion</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
<td>-------------</td>
<td>---------</td>
<td>------------</td>
</tr>
<tr>
<td>Naylor et al., 2006</td>
<td>Randomized trial to examine the effectiveness of an advanced practice nurse-centered discharge planning and home follow-up intervention for elders at risk for hospital readmissions</td>
<td>Readmissions, time to first readmission, acute care visits after discharge, costs, functional status, depression, and patient satisfaction (n=363)</td>
<td>Control group patients more likely than intervention group patients to be readmitted at least once; intervention group had fewer hospital days per patient; increased time to first readmission. Medicare reimbursements for health services were about twice in the control vs. intervention group.</td>
<td>Intervention demonstrated great potential in promoting positive outcomes for hospitalized elders at high risk for rehospitalization while reducing costs.</td>
</tr>
<tr>
<td>Friedman, et al., 2006</td>
<td>To determine whether participants in the Program of All-Inclusive Care for the Elderly (PACE) with an informal caregiver have a higher or lower risk of nursing home admission than those without caregivers</td>
<td>Rates of nursing home admission (n=3189)</td>
<td>Participants in PACE who lack an informal caregiver are not at higher risk of institutionalization, compared to individuals in the general population.</td>
<td>Further research required to ascertain whether PACE’s comprehensive formal services compensate for the lack of informal caregiving in limiting the risk for institutionalization.</td>
</tr>
<tr>
<td>Hershkovitz et al., 2007</td>
<td>To identify factors associated with postacute rehabilitation outcome of disabled elderly patients with proximal hip fracture.</td>
<td>Functional ability, cognitive status, activities of daily living, depression (n=133)</td>
<td>Cognitive function, nutritional status, preinjury functional level, and depression were the most important prognostic factors</td>
<td>Of these, depression and nutritional status are correctable, and early intervention may improve rehabilitation outcome.</td>
</tr>
</tbody>
</table>
Summary

The research indicates that interventions have been developed to address various aspects of the care transition process. In addition, the findings indicate that the interventions that address multiple dimensions involved in the transition process, (including the patient’s needs/goals; the informal caregiver’s needs/ goals; and financial constraints), are most effective.

Questions to consider

1. What aspects of the care transition process must be addressed in a successful intervention?

2. Ideally, who needs to be involved in care transitions?

3. What strategies might be employed to get the necessary people involved?

Group 3-Research reviews of intervention studies

The following chart presents a summary table of three research review articles on the topic of care transitions, with an analysis of objectives, measures, findings and implications.

<table>
<thead>
<tr>
<th>Author</th>
<th>Objective</th>
<th>Measures</th>
<th>Findings</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coleman, 2006</td>
<td>Review of descriptive and experimental research relating to improvement</td>
<td>Various</td>
<td>Few empirical studies aimed at improving care transitions; however, some</td>
<td>Need for more empirical research</td>
</tr>
<tr>
<td>Study</td>
<td>Description</td>
<td>Participants</td>
<td>Findings</td>
<td>Conclusion</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
<td>--------------</td>
<td>----------</td>
<td>------------</td>
</tr>
<tr>
<td>Hick et al., 2007</td>
<td>Review literature of experimental evidence describing interventions to manage older adults in acute care hospital settings</td>
<td>Various</td>
<td>Multidisciplinary team approach, using gerontological expertise, is recommended.</td>
<td>Need for more research</td>
</tr>
<tr>
<td>Mistiaen et al., 2007</td>
<td>Systematic, formal meta-analytic review of interventions to reduce problems of older patients discharged from hospital to home</td>
<td>Various</td>
<td>Interventions having positive impact include those that combine educational components, and pre-discharge and post-discharge interventions</td>
<td>Overall, limited summarized evidence that discharge planning and discharge support interventions positively affect patient health at discharge, or patient functioning, health care use and costs after discharge</td>
</tr>
</tbody>
</table>

**Summary**

These research reviews indicate that some type of care coordination leads to positive outcomes for older people who are experiencing care transitions. In addition, the findings indicate that this coordination must address multiple dimensions involved in the transition process, including the patient's needs; the patient/family goals; and financial constraints.

**Questions to consider**

1. What source(s) of funding could provide for a transitions coordinator?
2. What role could CMS play to support good outcomes in care transitions?
3. What roles do Long Term Care insurance, managed Long Term Care and New York State’s ‘Point of Entry’ programs play in:

- reducing costs,
- hospital readmissions, and
- improved patient satisfaction?

References


APPENDIX F Care Transition Recommendations

Prioritized Recommendations:

Care Transitions Consensus Workshop
February 28, 2008

Systems Change Recommendations (63)
Need involvement with:
- Caregivers-17
- Patient/consumers; educated/health literacy-14
- Entire community/cross- institutional/cross systems collaboration-16
- A multi-disciplinary approach (nurses, social workers, discharge planners)-5
- Coordination between NYS efforts, LTC Councils, NYSOFA-Family Caregiver Council, Alzheimer’s Coord. Council, IPRO/CMS-6

Discharge planning should start at admission, earliest possible time-2
Health care workforce shortages/ need more and better-trained staff-3

Research Recommendations (27)
Need to translate practices into measurable outcomes (coaching, safety, medication management, re-hospitalization rates, patient satisfaction)-14
Community-based research desirable, involve those working in the field in research-part of every grant-7
Need more research to show effectiveness, raise awareness of best practices-5
Focus on quality improvement-1

Policy/Advocacy Recommendations (24)
Create position paper to advocate for the following-22
- Revamp Medicare reimbursement
- Revamp home care reimbursement
- Fund social workers
- Research, data collection
Need simultaneous advocacy on federal, state and local levels-2

Dissemination Recommendations (16)
Highlight these best practice models-12
- Pediatric care system;
- Coaching to navigate complexity;
- External case management;
- Caregiver education;
- Identify other evidence-based best practices
Distributed in web-based tool kit form- 2
Strength based approach/ adult learning model-2
Creative innovations are occurring within the world of aging services. The successful best practices that have been developed by practitioners like you will help us create a new model to respond to the challenges of serving an ever-evolving group of older consumers. During this interview, we hope to discover from your stories, values and dreams, the ingredients which will serve as building blocks for igniting and sustaining positive change in aging services. With this in mind, please share with me:

1. How long have you worked in aging services?

2. How long have you worked in your current job?

3a. What first attracted you to your profession?

   Anything else?

3b. What were your early hopes and aspirations in your career?

   Anything else?
3c. Tell me a story about a peak experience you have had in this job – a time when you felt a sense of pride and personal accomplishment, when you were particularly glad about working in this organization.

- What was your role in creating this experience?
  - Anything else?
- What other people and factors contributed to this exceptional experience?
  - Anything else come to mind?

4. Think back to a time when you provided unusually excellent service and interacted with the older consumers in the center. This was a moment where you felt energized, committed and connected with them.

   a. Please describe the situation in detail.
      i. Who was involved? (Anyone else you remember?)
      ii. What role did you and others play in this success? (Anything else?)
      iii. What makes it stand out as such a highpoint for you? (Anything else?)
      iv. What other factors helped make such an outstanding success possible?
   b. What impact did this service have on your consumer(s)? (Anything else?)

5. Now, let’s talk for a moment about some of the things that matter deeply to you.

- Without being too humble, what is it that you most value about yourself as it relates to your work? (Anything else?)
6. Now, I’m going to ask you some questions about learning and its relationship to your work. This could be an event you learned something in school or on-the-job. Tell me the story of a time of great learning in your life, a time where you were able to learn and grow in ways that were most important and meaningful. Please describe this learning as vividly as possible for me.

7. Imagine that it is 2016, 10 years in the future, and senior centers have evolved to meet all of your desired expectations. Describe what you see, this new landscape of senior-centered services.

- What are you and your co-workers doing? (Anything else?)
- How are you working together differently? (Anything else come to mind?)
- What is different about the way your services relate to older consumers? (Anything else?)
- What was one of the smallest steps you took which ignited this positive change?
APPENDIX H  Hospitality Consensus Workshop Invitation

The Cornell Institute for Translational Research on Aging (CITRA) and the Council of Senior Centers and Services (CSCS) invite you* to attend a Consensus Workshop on

Translating Hospitality Practices into Aging Services

Date: Monday, December 3, 2007

Time: 9:30 AM-12:30 PM

Place: Cornell Cooperative Extension
16 East 34th St, 8th Floor

Continental breakfast will be served

You must RSVP to attend.

Please RSVP by November 26th to Carrie Chalmers at cc284@cornell.edu

What are CITRA Consensus Workshops?

In cooperation with our Community Advisory Committee, CITRA selects several aging-related topics per year in order to:

- Produce an up-to-date non-technical review of the research literature;
- Convene a select group of research, practitioner and policy experts for discussion;
- Arrive at a consensus regarding research, practice and advocacy recommendations; and
- Disseminate recommendations to the various aging communities.

CITRA’s goal is to create and model a forum for a continuous loop of communication between research, practice, and advocacy to create a joint conception of aging-related problems and solutions. So, please RSVP and Save the Date—and we will be in touch soon with more details.

*Attendance is by invitation only.
Research Review

For the CITRA Consensus Workshop

Creating Centers that Serve:

How Current Thinking in Hospitality Can Benefit Older People

December 3, 2007
Creating Centers that Serve:

How Current Thinking in Hospitality Can Benefit Older People

**Introduction**

Service quality has become a competitive advantage in all segments of the hospitality industry. Economic, political, and social forces exert pressure on senior services as providers face the challenge of service delivery to an increasingly older customer base. This growing population is made up of diverse consumer groups who range from the aging baby boomers, who have high expectations with regard to their service needs, to the "oldest old," many of whom have more complex service requirements. Service quality becomes an increasing challenge as organizations struggle to serve these mixed groups with available financial and human resources.

This changing environment offers the opportunity to explore new paradigms of service delivery in search of best practices that will assist providers in meeting the challenges of the growing senior population. Leaders of aging services realize that existing models need to be revisited and are prepared to adopt innovative practices that are more responsive to the needs of the current and emerging customer bases.

Evidence-based practices that have emerged from research in hospitality provide models that can be tailored for senior service delivery. Meador (2007) vividly mapped the changing landscape in a model illustrating the move from conventional to responsive, asset-based service delivery to older adults (Figure 1). It is apparent that current research offers
insights for evidence-based practices which can inform a responsive, needs-driven service delivery model that engages older consumers in programs leading to enhanced health and well-being. This paper moves through a number of topics related to service enhancement and delivery and suggests how best practices from traditional hospitality organizations might be adapted to enhance the service experiences of older adults.

We begin by restating the importance of a service orientation, particularly in fostering customer loyalty or what has recently been called customer relationship management. Key elements of the specific service environment are discussed as they apply to hospitality settings. This is followed by a discussion of how service experiences are customized as well as the employee characteristics and competencies required in this new service environment. Current methods of evaluating service quality are then reviewed. Shifting our focus to the organization itself, we examine the concept of service within and present recent research on how strong service cultures are created and maintained. Finally, we move to a macro view as we discuss the importance of organizational learning and explore how customers form images of the organization as a whole—brand management. Throughout, questions are asked that assist readers/participants in “translating” research findings and in determining the usefulness of these applications to the senior living environment.

Questions for Consideration:

(a) What specific attributes or unique characteristics of older people should be kept in mind as the hospitality-oriented customer service literature is “translated” into a senior service context?

(b) In what ways do older people themselves influence the service experience and create a unique dynamic?
Service Quality – Individual Level Concerns

Quality Service and Customer Loyalty

Customers today are confronted with numerous choices. Decisions need to be made about nearly all aspects of their daily activities—where to eat, what to buy, how to travel. As service options increase, organizations have become increasingly interested in developing long term relationships with customers—they recognize the importance and impact of customer loyalty.

Researchers who have focused attention on this aspect of service suggest that the service relationship is mediated not by evidence and reasoning but rather by the customer’s emotional response (Pullman & Gross, 2003). While psychologists have known for decades that emotions drive behavior, hospitality researchers and executives alike have largely neglected this important aspect of the service experience (White & Yu, 2005). Recently, however, the emotion-behavioral intention link has captured the attention of those interested in cultivating customer loyalty.

Questions for Consideration:

(a) What would “customer loyalty” look like with regard to Senior Centers?

(b) What is the “choice set” with regard to senior services—what options are available to this market in addressing their needs?

(c) What specific emotions would be appropriate to cultivate in the senior population to encourage loyalty behavior?

Just as emotions are associated with positive affect and the likelihood of repeat business and psychological ownership so, too, research has identified a relationship between
specific emotions and consumer complaining behavior (White & Yu, 2005). It appears that customers have a threshold over which they must move before voicing dissatisfaction regarding their service or service experience. As word of mouth travels quickly, understanding this dynamic becomes important to service providers.

**Questions for Consideration:**

(a) With regard to the Senior Center service experience, what emotions are most likely to result in complaining behavior?

(b) Is it possible to reduce or eliminate factors that are likely to create these emotions?

**Customer Relationship Management**

The increasing interest in creating loyal customers has led to a field of study called customer relationship management (CRM). Focus on long-term relationships has become increasingly critical as individuals have access to more information and resources that enable them to explore a greater number of options. Hospitality organizations today view a customer as a lifetime partner. As one author states (Cohen, 1997), it is important to treat every guest as if your relationship with him or her was permanent.

Among the desirable outcomes of repeated exchanges with the same employee or provider is for customers to experience psychological ownership of the service or provider. In this circumstance, the customer begins to feel as though the target is “theirs” (Asatryan, 2006). In such circumstances, the customer often refers to “my hairdresser” or “my doctor” or “my Senior Center.” As you might imagine, psychological ownership strengthens customer loyalty.
Questions for Consideration:

(a) What are the most common reasons why clients do not stay “loyal” to a Senior Center?

(b) What are the benefits of older people’s psychological ownership of their Senior Center?

(c) How could this perception of “ownership” best be created or enhanced?

Traditionally, service providers have aimed to satisfy customers by meeting their expectations. Satisfaction has been, in fact, defined as meeting customer expectations. Often, managers choose to terminate customer relationships in order to avoid customer disappointment and the potential for word of mouth dissatisfaction (McCole, 2004). Recently, however, researchers have established the fact that customer satisfaction alone does not correlate with loyalty behavior. Satisfaction is insufficient to motivate customers to repeat their business (Torres & Kline, 2006). Only when service is distinctive—only when customers experience the emotion of delight or a similar positive affect—do providers benefit from behavioral loyalty intentions.

Questions for Consideration

(a) Is it more difficult to “delight” older people than other demographic groups?

(b) What characteristics of a Senior Center are most likely to “delight”?

(c) What characteristics are most likely to cause dissatisfaction?

“Customer delight” is a combination of joy and surprise in the service experience. Researchers have concluded that, in order for customers to promote a service organization by word of mouth, they must feel delighted by their experience. Delighting guests or clients requires that service providers explore innovative means of addressing customer needs. Service innovation is consequently becoming another important area of research focus (Victanno, Verma, Plaschka, Dev, 2005).
One example of providing customer delight is by doing the unexpected. Cohen (1997) gives the example of the “wait party,” a mini-event provided to guests who had to wait a particularly long time for service at a restaurant. Hemmington (2007) suggests that employees provide “lots of little surprises,” and that customers feel safe and satisfied when service is personalized and they are in the “security of strangers.”

Questions for Consideration:

(a) Are older people likely to respond favorably to surprises?

(b) Is there a way to “translate” the element of surprise—and this finding—to enhance the senior service experience?

Customizing the Service Experience

The emphasis on service innovation fits well with the growing importance of service customization. As Bowen (1997) explains, service customization requires that those attributes that create value for a customer be identified and used to enhance the service delivery. Customer histories are particularly useful in providing detailed information which can be used to further tailor the service experience to meet individual client needs. In fact, Dreachslin (2007) argues that in industries such as healthcare, it makes sense to view the client base as “100 percent diverse.” That is, each individual has special needs and therefore requires individualized service.

Questions for Consideration:

(a) In the Senior Center context, to what extent is customization possible? Desirable?

(b) In what specific ways might services be tailored to a “100 percent diverse” customer base?
One problem in achieving greater service customization is that many organizations reward “conforming” employee behavior (Bowen, 1997). Individuals who follow rules, rather than those who make independent decisions, are viewed as performing their jobs well. Companies need practices and policies that encourage the empowerment required to provide individualized service (Shimko, 1994) and managers, in turn, need to support such initiatives in meaningful ways.

**Question for Consideration:**

(a) *Are senior service providers rewarded for providing individualized service, or for making independent decisions that customize the service experience?*

(b) *What does “adaptive behavior” look like in senior service environments?*

**Employee Characteristics Required to Deliver Quality Service**

As line employees become the center of attention (Kenagy, Berwick, Shore, 1999), managers find that not just anyone is capable of delighting customers (Torres & Kline, 2006; Kelly, 1992). Several authors (Gwinner, Bitner, Brown, Kumar, 2005) have focused on what they term **employee adaptive behavior**. In many instances, this adaptive behavior is required for service customization. Employees must assess each service encounter and determine the customer’s needs, then behave in ways that address the individual’s unique set of service requirements.

Vilnai-Yavetz & Rafaeli (2003) studied adaptive behavior and suggested that it be understood as a skeleton-tissue distinction. Skeleton aspects of service consist of the content and behavior required to complete the encounter. Tissue aspects are the social, individualized behaviors that either enhance or damage the relationship and service experience (for example, nonverbal communication such as facial expressions). Employees
who are able to operate effectively at the tissue level were found to be strong in self-
monitoring, tolerance of ambiguity, and service orientation. The researchers emphasized the
importance of rewarding adaptive behavior. Financial resources are not the primary
requirement in fostering this service orientation, as employees must be intrinsically
motivated to provide consistent adaptive service delivery.

Questions for Consideration:

(a) Is it possible and/or feasible to select employees with strong adaptive behavior for
senior services? What changes would need to be made in current practices or
philosophies?

(b) How might adaptive behavior be rewarded or fostered within a senior services
environment?

Recognizing the importance of front line employees in service delivery, numerous
studies have focused on identifying employees with the “right stuff.” Effective service
providers have been described as resilient, resourceful, empathetic, and creative. One study
of the motivators that influenced the best service employees found that security and justice
needs served as hygiene factors (employees were demotivated in the absence of these
organizational factors) and esteem needs (feeling that their efforts were recognized and
valued) were among the most essential motivators.

When Chang (2006) looked at personality traits of effective service employees, he
determined that friendliness and enthusiasm were prerequisite to high quality service
delivery. In addition, empathy, confidence, responsiveness, and reliability ranked high on
the list of key traits. Similarly, in her research on service encounters Brownell (2006) has
found that effective listening plays an important role in perceptions of customer care.
Service providers whose listening skills are perceived as excellent are rated significantly higher than their co-workers.

**Questions for Consideration:**

(a) **Currently, what are the key personal characteristics of service employees? i.e., what would a profile of the typical service provider look like?**

(b) **What competencies or personal characteristics distinguish excellent service employees in this environment? How are these critical competencies assessed?**

**Managing the Service Environment**

Findings from studies on customer loyalty have stimulated renewed interest in how providers can move beyond simply delivering a service to creating quality **service experiences**. In fact, several theorists suggest that hospitality be defined, as has been discussed, as **Behavior + Experience** (Hemmington, 2007). One element of this experience is influenced by the service provider; the other is determined largely by the environment or context in which the encounter occurs.

The term “**servicescape**” has been used (Pullman & Gross, 2003) to describe the place where service occurs, and research on “place” has become of increasing interest to those who seek to better understand the factors that influence an individual’s perceptions of his or her environment. Components of the experience include sights, sounds, textures, and other similar physical characteristics (Pullman & Gross, 2003; McCole, 2004). All elements contribute in some manner to the affective quality of the setting, and make it memorable. Researchers have found that the sequencing and duration of each attribute also effects the overall service experience.
Questions for Consideration:

(a) What physical elements contribute to the “servicescape” of Senior Centers?

(b) What factors might be reduced or enhanced—sights, sounds, textures, etc.—to create the most positive environment possible?

Evaluating Service Quality

Service is a series of independent episodes, and customer perceptions may well vary across the spectrum during one meal, one enrichment program, or one visit (Dagger & Sweeney, 2007). Determining which “moments of truth,” or contact experiences, are critical and which are less important is a key piece of information. As elusive as it may seem, focusing on the specific service encounter is essential. Simos’ (2007) findings are among those that support the importance of better understanding service episodes. He discovered, for instance, that nearly 70 percent of customers say they would not return to a provider who gave them poor service.

Questions for Consideration:

(a) What are some examples of common service “episodes” in the Senior Center context?

(b) At what point is service most likely to derail? What are the consequences?

While many hospitality organizations emphasize the importance of quality service, far fewer have measurement systems in place to assess the effectiveness of their efforts (Chowdhary & Prakash, 2007; Stumpf, 2007). Perhaps SERVQUAL is the most widely used approach to assessing customer satisfaction. Although this instrument does not capture all quality dimensions, it focuses on five that are felt to be among the most directly related to customer perceptions of service (Saravanan & Rao, 2007). The five qualities measured by the Lodging Quality Index are:
(1) tangibility,
(2) reliability,
(3) responsiveness,
(4) confidence, and
(5) communication.

While not fully operationalized, these indicators provide a starting point for managers looking to improve perceptions of service quality. Service organizations have also been interested in assessing the relative importance of each as it contributes to perceptions of service quality. Since service is often produced and consumed simultaneously, it becomes particularly difficult to isolate aspects of the delivery process (Getty & Getty, 2003).

Similarly, Gomes (2007) and his colleagues found that availability, quality, and efficiency were three aspects of operational effectiveness that customers valued. Bowen (1997) views two distinct aspects of the service experience or what he calls Functional Quality—the process of service delivery, and Technical Quality—the product resulting from the service experience (the meal, room, etc.).

Impediments to service delivery exist at all phases of the service cycle and include such factors as:

1) budgetary constraints,
2) staff attitudes,
3) lack of mentoring and performance feedback, and
4) high customer expectations (Presbury, Fitzgerald, Chapman, 2005).

Identifying the key obstacles to quality service is the first step in working to reduce or eliminate factors that interfere with high performance and customer satisfaction.
Questions for Consideration:

(a) What service dimensions need to be evaluated in senior services?

(b) What systems might be put into place for the assessment of each dimension identified?

(c) What are the major impediments to delivery of the basic services provided by Senior Centers?

(d) What, specifically, might be done to reduce obstacles for each of the central service experiences?
Internal Service: The Service Within

Service within has been defined in a number of ways. One common approach is to recognize every employee as having a “customer.” The premise is that internal customers must be happy in order to provide excellent service to the final customer. Some theorists have gone so far as to propose that the internal customer must come first—that the internal customer service chain needs to be identified and nurtured if organizations are to deliver services successfully (Paraskevas, 2001; Lewis, 1989).

The service within concept also suggests a family metaphor. Researchers have found that making employees feel part of a family or community helps to reduce turnover (Gale, 2007) and promote employee commitment. Spending time together outside of work has numerous benefits and allows employees to see their future as a member of the company. As one company articulates the target philosophy: Play, Make their day, Be there.

Questions for Consideration:

(a) Does the “service within” concept apply to Senior Centers?

(b) What service enhancements might be realized by focusing on service within?

(c) How can Senior Centers foster a family or community spirit among their staff?

(d) What specific changes in employee behavior might be anticipated as a result of these efforts to create a strong community?

In a similar effort, another researcher (Cohen, 1997) suggests that managers might profitably think about service within as putting a WOW into the job for themselves, their employees, and their customers. Cohen talks about the importance of treating employees as
if they will “be around tomorrow.” He suggests that managers learn about each employee, take care of them, and show a sincere interest in their welfare.

In efforts to more precisely define the behaviors that characterize a positive service culture within, researchers (Paraskevas, 2001) have developed an internal service provider behavior framework by asking the employee (the receiver of the service) to describe in detail what someone did to create a positive experience on the job. This provider framework consists of five categories of behavior:

- Professionalism,
- Dependability,
- Conscientiousness,
- Communication, and
- Consideration.

Questions for Consideration:

(a) Would this (or a similar) framework work for providers of senior services?

(b) How might it be adapted? What dimensions would be particularly important?

Other studies (Sun, Aryee, & Law, 2007) have focused on citizenship behavior as an important variable in developing strong cultures of service within. Individuals who establish good will and “do their share” promote a positive service culture. In addition, trustworthiness is seen as an important quality not only in leaders but in line employees as well. Ensuring trustworthiness enables managers to operate in a team environment and, as one study revealed (Bowen & Shoemaker, 1998), customers “trust an organization that trusts its employees.”
Questions for Consideration:
(a) How important is trust in the senior service environment? In what ways must providers demonstrate that they are trustworthy?
(b) What can be done to increase trust at an organizational level?

Creating a Service Culture

The manager-employee relationship has been found to have a significant impact on organizational culture as well (Cowan, 2007). Service organizations today stay competitive and healthy only when their leaders create a culture for success (Macaulay & Clark, 1998). Strong service cultures can be built in many ways, but researchers agree that it requires a commitment to continuous improvement and a view toward the future (Zairi & Whymark, 2000). As one study reports, effective culture leaders develop a picture of the future that is easy to communicate. In addition, they trust their employees and establish a smooth information flow throughout the organization (Kyriakidou & Gore, 2005). In fact, taking a systems perspective (see Box 1) to creating service cultures seems essential to create and maintain service excellence (Testa & Sipe, 2006).

Questions for Consideration:
(a) Would you describe current practices as a “systems approach”?
(b) What would a systems perspective look like in a senior services (Senior Center) context?

When managers were asked to provide words that described strong hospitality cultures, they generated a list that included respect, integrity, pride, trust, commitment, and warmth (Anonymous, 2007). Regardless of the specific nature of the organization, clear values and a vision of the future were essential ingredients (Dreachslin, 2007). If leadership
is a process of influencing others toward a particular goal, then one of the most essential goals is that of a clearly defined, strong and healthy organizational culture. Creating slogans is one common means through which culture can be communicated (Teare, et. al., 2002).

**Questions for Consideration:**

(a) *What words best describe the desirable Senior Center culture?*

(b) *What slogans might be developed that would clearly communicate key values to all employees?*

Zairi & Whymark (2000) have identified four steps to building a culture of continuous improvement. They propose that leaders focus on 1) making the culture visible, 2) implementing service initiatives, and 3) building on success. Goffee & Jones (1998) have described such a culture as characterized by sociability (friendliness) and solidarity (shared goals and tasks). Brownell (1994) termed the supportive environment required for employee empowerment a “Listening environment.”

After clarifying the vision and core values, all employees must be encouraged to participate in the visioning process. Empowerment of the workforce promotes a shared experience and a stronger commitment to the values of the culture. Focus groups, task forces, and other problem solving committees facilitate action learning and involvement (Teare, Ingram, Prestoungrange, Sandelands, 2002).

**Questions for Consideration:**

(a) *What specific action steps can be taken to support or facilitate the dimensions of vision?*

(b) *How might all organizational members be engaged in the visioning process?*

**Promoting Organizational Learning for High Quality Service**
The concept of learning organization has been defined in a number of ways (Ellinger, et. al., 1999; Hawkins, 2005; Henderson & McAdam, 2003; Yeo, 2005). Frahm and Brown (2006) envision an organization where employees work collaboratively to “continually expand their capacity to create the results they desire” (p. 202). Cornett (1998) proposes that learning organizations encourage employees to improve current practices and to challenge what and how things are done, resulting in a continuous improvement process (p. 9). Researchers focus on facilitating the continuous transfer of knowledge from one employee to another, which significantly increases the resources available to solve organizational problems and make effective decisions.

Whatever the specific definition, a learning organization is concerned with the process of gaining, sharing, and utilizing the knowledge accumulated by individuals and transferring it through the organization so that the information becomes a shared resource (Murray, 2002). Once established, a learning organization provides leaders with a solid foundation from which to readily introduce and implement their strategic plans.

**Questions for Consideration:**

(a) **Would you consider your Senior Center a “learning organization”?** What brings you to that conclusion?

(b) **What processes are strong in your Senior Center?** Which need to be further developed or reconsidered?

Because different employees may require different messages, organizational leaders must understand the nature of the workforce and tailor internal communication accordingly. In addition, employees often seek information through channels that are not aligned with those used by senior management to communicate key information (Brownell & Jameson,
Studies have found, for instance, that while managers often communicate through printed material and training programs, employees are more likely to tap into informal channels as they observe their peers and engage in informal conversations to better understand “what is going on.”

**Questions for Consideration:**

(a) **What are the most common channels senior managers use to communicate important messages to employees?**

(b) **What are the most common ways employees seek out information about the organization and their specific roles?**

(c) **Do the responses to the above questions suggest any changes in how managers use communication channels to reach employees? What employee groups may require tailored messages?**

There is no question that organizations with strong learning environments have a clear competitive advantage (Halawi, et. al., 2006; James, 2003; Lustri, et. al., 2007). Knowledge, or collective learning, then becomes one of the organization’s core competencies; it is valuable and non-substitutable. Organizational learning facilitates the change process, increasing the overall adaptability and agility of the organization and enabling it to respond more quickly and smoothly. Further, as knowledge moves through an organization it increases employees’ confidence, reassuring them that things will go well and increasing their self esteem and self efficacy (Henderson & McAdam, 2003). When there is continuous information sharing, every employee becomes a valued resource and feels ownership (Frahm & Brown, 2006; Harung, et. al, 1999).
Yet, as Lucas and Ogilvie (2006) warn, knowledge sharing typically occurs in impulsive and uncoordinated ways. In their view, success in establishing continuous knowledge transfer—the basic process of a learning organization—depends upon employees’ perceptions of one another and the nature of the relationships they establish (Small & Irvine, 2006; Marvin & Cavaleri, 2004). Learning is not something that is done “to” employees. Leaders, no matter how skilled, cannot make employees learn. Rather, learning is a voluntary process dependent upon each individual’s perceptions and subsequent interpretations of organizational messages and activities.

Questions for Consideration:

(a) What could be done to further strengthen employees’ self-efficacy and self-confidence?

(b) What specific changes (organizational, social, economic, other) are taking place that would be facilitated through a strong learning environment?

(c) Do you agree with these statements—that no one can “make” employees learn? What kinds of knowledge are important for senior service providers to have?

(d) How can organizational learning be further encouraged, supported, and sustained?

Brand Management

Promoting service quality and customer satisfaction leads to a strong brand. Branding is important because it is assumed that brands have a longer life and more salient image for both organizational members and the public (Kandampully & Hu, 2007). While managers develop brand concepts, customers develop brand images which create strong messages in their minds about the organization and its services. In addition, customers are
becoming increasingly involved in the branding process. Market surveys have traditionally been the most common approach to helping organizational leaders create a strong brand. Customers’ opinions help target the services to the specific market and often yield surprising findings. “Healthy,” for instance, was found to mean very different things to different market segments (Tanyeri, 2006).

**Questions for Consideration:**

(a) What brand “images” should older people hold of their service providers?

(b) What questions might be asked to ensure that older peoples’ images of the brand are those intended, and that important meanings are shared?

(c) Where are “disconnects” most likely to occur?

McEnally and de Chernatoney (1999) report some unique findings with regard to branding in the hospitality industry. Their studies indicate that there has been a change in branding strategies as the focus has shifted from instrumental to terminal values. Whereas traditionally brands have emphasized values that help customers achieve something desirable—status, or a date, or reduced medical bills—brands today often exemplify terminal values or the desired end state. In other words, organizations are associating themselves with the end states that customers find important—peace, a safe environment, or sustainability.

**Questions for Consideration:**

(a) What are the terminal values that might be associated with senior services?

(b) How could these values best be communicated to clients?
References


Restaurants & Institutions, 117(9), 22.


**Figure 1**

**Transformative Continuum of Service Delivery to Older Adults**

<table>
<thead>
<tr>
<th></th>
<th>Conventional</th>
<th>Transformative Continuum</th>
<th>Responsive/Asset-based</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Older consumers</strong></td>
<td>Clients with service needs</td>
<td>[ ]</td>
<td>Diverse multi-dimensional consumers with social, physical, spiritual, knowledge capitol</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Evolving, dynamic, based on consumer needs and desires</td>
</tr>
<tr>
<td>Services are . . .</td>
<td>Pre-determined, static</td>
<td>[ ]</td>
<td>Are capable, engaged people with ongoing learning needs</td>
</tr>
<tr>
<td>Staff at all levels . .</td>
<td>Receive little ongoing staff development</td>
<td></td>
<td>Can be accessed from many different sources</td>
</tr>
<tr>
<td>Resources . .</td>
<td>Are limited, finite</td>
<td></td>
<td>Descriptive, creative, desirable words including “café” “resources” “action” “wellness” “learning” “independence”</td>
</tr>
<tr>
<td>Language used to describe services include . .</td>
<td>Sometimes includes words like “feeding programs” “illness/disease” “dependence”</td>
<td></td>
<td>An opportunity to evolve and create more responsive programs</td>
</tr>
<tr>
<td>Change is . .</td>
<td>Sometimes seen as a threat to the status quo</td>
<td></td>
<td>A integral element of service delivery and is welcoming, pleasant, stimulating, possibly virtual</td>
</tr>
<tr>
<td>The practice environment is . .</td>
<td>Of limited importance</td>
<td></td>
<td>Adds mutually-satisfying positive value to both groups</td>
</tr>
<tr>
<td>The relationship between staff and consumers . .</td>
<td>Is sometimes uni-dimensional, adds neutral value</td>
<td></td>
<td>Is an ongoing bi-directional conversation between equals who engage in dialogue about needs and services</td>
</tr>
<tr>
<td>Communication between staff and consumers . .</td>
<td>Is mono-directional</td>
<td></td>
<td>Social integration, engagement</td>
</tr>
<tr>
<td>Outcomes can be . .</td>
<td>social isolation</td>
<td></td>
<td>[ ]</td>
</tr>
</tbody>
</table>

* Meador, 2006
Integrated Model of Service Processes

Leaders Facilitate and Assess Service Quality

Individual Level Concerns
- Employee Characteristics
- Service Customization
- Service Environment

Customer Loyalty

Organizational Level Concerns
- Service Within
- Service Culture
- Organizational Learning

Organizational Image/Brand
APPENDIX J  Hospitality Consensus Workshop Recommendations

Hospitality Consensus Conference Brainstorming:

Prioritized Recommendations

1. Organizational Change – 21 votes

- Overcome local barriers by taking the time to educate and change the culture through innovations in leadership
- Change organization through an intentional process
- Introduce niche marketing in order to further innovations

2. Program Implementation – 19 votes

- Adapt senior centers for a changing and diverse demographic:
  - Develop a “tool-kit” for senior center directors to assist with innovations
  - Facilitate a sense of belonging and pride for older people through senior centers
  - Develop new image and programs for a diverse range of ages, including “baby boomers”

3. Valuing Customers: older people (external) and staff (internal) – 12 votes
● Place emphasis on the consumer rating of senior centers, demonstrate responsiveness to customers

● Balance core services to meet customers’ wants and needs

● Develop employee incentives for innovation

● Reward staff at all levels to give them a sense of shared purpose
The Institutional Review Board (IRB) Chair has reviewed this project and has declared the study exempt from the requirements of the human subject protections regulations as described in 45 CFR 46.101(b). The IRB determination of exemption means that:

- **You do not need to submit an application for annual continuing review.**

- **You must carry out the research as proposed in the IRB application**, including obtaining and documenting (signed) informed consent if you have stated in your application that you will do so or if required by the IRB.

- **Any modification of this research should be submitted to the IRB on a Continuing Review and/or Modification form, prior to making any changes**, to determine if the project still meets the Federal criteria for exemption. If it is determined that exemption is no longer warranted, then an IRB proposal will need to be submitted and approved before proceeding with data collection.

Please be sure to use the documents with the IRB approval stamp in your research.

Please note that you must submit all research involving human participants for review by the IRB. **Only the IRB may make the determination of exemption**, even if you conduct a study in the future that is exactly like this study.
The Institutional Review Board (IRB) Chair has reviewed this project and has declared the study exempt from the requirements of the human subject protections regulations as described in 45 CFR 46.101(b). The IRB determination of exemption means that:

- You do not need to submit an application for annual continuing review.

- You must carry out the research as proposed in the IRB application, including obtaining and documenting (signed) informed consent if you have stated in your application that you will do so or if required by the IRB.

- Any modification of this research should be submitted to the IRB on a Continuing Review and/or Modification form, prior to making any changes, to determine if the project still meets the Federal criteria for exemption. If it is determined that exemption is no longer warranted, then an IRB proposal will need to be submitted and approved before proceeding with data collection.

Please be sure to use the documents with the IRB approval stamp in your research.

Please note that you must submit all research involving human participants for review by the IRB. Only the IRB may make the determination of exemption, even if you conduct a study in the future that is exactly like this study.
DATE: April 29, 2008

TO: Rhoda Meador
    105 Lisa Place, Ithaca, NY 14850

CC: Leah Keino
    30C Mackay Hall

FROM: Jan Canny, IRB Administrator
      Office of Research Assurances

TITLE: Appreciative Interviews in Senior Centers

IRB ID: 08-174 Study Review Date: 28 April 2008

The Institutional Review Board (IRB) Chair has reviewed this project and has declared the study exempt from the requirements of the human subject protections regulations as described in 45 CFR 46.101(b). The IRB determination of exemption means that:

- You do not need to submit an application for annual continuing review.

- You must carry out the research as proposed in the IRB application, including obtaining and documenting (signed) informed consent if you have stated in your application that you will do so or if required by the IRB.

- Any modification of this research should be submitted to the IRB on a Continuing Review and/or Modification form, prior to making any changes, to determine if the project still meets the Federal criteria for exemption. If it is determined that exemption is no longer warranted, then an IRB proposal will need to be submitted and approved before proceeding with data collection.

Please be sure to use the documents with the IRB approval stamp in your research.

Please note that you must submit all research involving human participants for review by the IRB. Only the IRB may make the determination of exemption, even if you conduct a study in the future that is exactly like this study.