CSCS

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- *In Memoriam*

United Way Helps Here

July 9, 2007

Commissioner Edwin Mendez-Santiago
New York City Department for the Aging
2 Lafayette Street
New York, New York 10007

Dear Commissioner Mendez,

The Council of Senior Centers and Services (CSCS) is the central organization in New York City representing a broad array of community-based services for the elderly including case management and case assistance programs. CSCS members serve 300,000 older New Yorkers through a gamut of services including multi-services senior centers, congregate and home-delivered meals, transportation, home care, NORCs, adult day services, mental health, housing, and other programs.

The membership of the Council of Senior Centers and Services is in agreement with the Department for the Aging's overarching goal to assist seniors to age in place and, with the 2006 revisions in the Older Americans Act, to make information and access to services easier for seniors and their families. Allowing seniors and family caregivers to take advantage of low-cost programs that have proven to be effective in reducing the risk of disease, disability and injury, and to have flexible service models to help consumers who are at high risk of nursing home placement to remain in their own homes and communities has been part of CSCS's mission for the past 28 years.

On June 15, 2007, CSCS held a meeting of its members that provide case management and case assistance to discuss the Department for the Aging's (DFTA) case management concept paper. There were 50 individuals representing 35 agencies from each of the boroughs at the meeting.

We also agree that case management is key to reaching the goals outlined in the concept paper.   We note that in order to maximize the health prevention aspect of case management and case assistance, the city has a vested interest in ensuring that frail seniors, both homebound and those able to go to senior centers for assistance, and their families, can easily access these services geographically, linguistically and culturally.

The planning necessary to meet the future service needs of services to older New Yorkers must take into account future service recipients as well as currently served individuals, making any change a delicate and complex undertaking.

Increasing investment in case management to contain health care spending:

Evidence-based research has well documented that early intervention with frail elderly individuals through case management significantly saves health care dollars. The city needs to take a comprehensive approach to the structure, funding and workforce issues of case management and case assistance services. Utilizing case assistance as a bridge to case management provides a continuum of service in local communities. Increasing access is prudent policy for the city as there is broader opportunity here to provide both quality case management services to older New Yorkers while containing city health care spending.

We agree that we need to look at performance-based outcomes to demonstrate the effectiveness of case management as a preventive as well as crisis intervention. However, we are concerned that the suggested approach – i.e. restructuring the current system without having studied the current system, may be premature. It may be less costly to continue case assistance/meals-on-wheels in senior centers than moving the individual on to case management in all situations.

A full understanding, through exploration of what the capacity case management agencies need to have to intervene at key moments in the lives of seniors, is essential toward operating a cost efficient and effective system in providing quality services while containing other city expenses. CSCS and its members offer our expertise in engaging in an authentic planning process.

For example, rather than continuing the practice of lean budgeting for case management and case assistance programs, a cost-benefit analysis and study of where and how much public funds could be wisely invested to save on other costs to the city while enhancing the quality of life for seniors should be done. While it may be counter-intuitive to consider investing additional funds, early intervention and ongoing case management have proven to significantly save health care spending. For example, New York State has considered adding a "Medicaid-lite" portion in its Medicaid megawaiver proposal that would allow seniors up to 250% of poverty to be eligible for discrete community-based social services including meals, transportation and adult day services. Research has shown that the larger the opportunity for seniors to receive early lower-cost intervention services, the greater the savings on Medicaid costs. (The megawaiver process is on hold right now.) In addition, maximizing the use of informal community services such as churches, synagogues, co-op boards, block associations, neighborhood watch groups and so on, saves money. As Frank Burns from the Administration on Aging stated at DFTA's recent Summit on the Modernization of Aging Services, "You do not have to give up the 300-400 small towns (as he described NYC) to have a single point of entry system".

Aging services in New York City has grown organically within communities in response to increased demand for services, increased longevity and diversity, and to meet emerging needs of the elderly over time. This will

continue to happen as mission driven nonprofits seek to fill the vacuum any system of services creates as new situations arise. To this degree, aging services has been in constant change over time. Such growth and response should be encouraged and strengthened. New Yorkers are community-oriented; it's how we survive and thrive in such a large and complex city.

Criteria for design of case management system:

The criteria used to design case management will decide the outcome. CSCS recommends the following criteria or principles to include:

- Implementing policy and services to seniors and family caregivers always taking into consideration quality of life concerns. Ensuring easy access to services by seniors and their families. This includes adhering to the practice of self-determination, which requires the capacity and workforce skills to work with seniors individually, which is often a slow process in gaining trust and moving forward with the care plan.
- Designing districts of a functional size to realistically allow for partnerships with medical providers, other formal service providers and informal community resources, etc. and to serve diverse populations. Retaining a local presence in neighborhoods and the importance of walk-ins is critical – we suggest increasing the number of local access points for services.
- Ensuring cultural competency within agencies and service districts to avoid disparities in services. Strengthening the capacity of senior centers to perform case assistance including seniors who can walk in and need assistance with benefits, housing, etc. This is especially important in minority communities and immigrant communities where English is not the first language. Public health studies have shown that the larger a region for providing health care, the larger the health disparities experienced by low-income minority communities. The same could be true for community-based social services.
- Funding adequate agency infrastructure including lower caseloads, higher salaries for case managers, sufficient fixed costs funding, up to date technology, appropriate office space, staff education and training.
- Recognizing the capacity of case management agencies to provide early intervention, which saves health care dollars while providing quality of life and independence for seniors. Building agency capacity to provide care on the level of an individual in a particular community upon hospital discharge, to prevent crises on an ongoing basis, and, if necessary, in times of crisis. Lowering disease and disability rates as stated in the concept paper through increased investment of public dollars in case management and case assistance services.
- Providing sufficient time for agencies to develop workable collaborations in order to provide quality services to seniors along with an understanding of what DFTA means by collaborations.
- Planning should be cognizant of philanthropic funds that currently support case management services and allow for augmentation of government-funded services. Changes in districts and contractors could impact privately raised funds needed to supplement public dollars.

Effectiveness of community-based case management services:

As stated in the CSCS Policy and Practice Case Management paper released May 11, 2007, "For case management services to reach the optimum level of effectiveness, services must be client-focused and easily accessible. Case management must be comprehensive and strengths based, allowing for consumer choice, when feasible. Services need to be neighborhood based and local in order to maximize local resources and access the entire continuum of care, strengthening the ability to forge community partnerships. For a senior or caregiver to have meaningful choice, case management services must be easily accessible. Neighborhood based services allow for accessibility to family members and clients, as well as allowing for optimal outreach to constantly shifting populations. The local case management agency needs to be easily identifiable by older community residents and their family caregivers. The presence of EISEP funded case management agencies have become stabilizing factors in communities throughout the city for older residents and caregivers. This is an especially valuable and necessary asset as we see increases in diversity, poverty and longevity in the older adult population in NYC."

An evaluation of the current case management and case assistance system has not been done and so it is not known what the current system is achieving in performance outcomes. For example, the concept paper emphasizes the importance of close linkages and partnerships between case management agencies and local resources. This is already widely done throughout the city, although has not been tracked by DFTA. These linkages developed over years are at risk of being lost as regions are changed. Time is needed to redevelop these resources while having the capacity to serve seniors currently in need. We recommend a baseline study be done of current performance outcomes so there can be a comparison with any changes made to the case management and case assistance systems.

Importance of access to services and community planning:

If accessibility is the premise of the development of an integrated senior services system with case management as a core function, then reconsideration of the districts outlined in the concept paper is called for.

Authentic planning would include local senior service providers who know the neighborhoods within a borough intimately, as well as other community stakeholders. Rather than list where specific changes can be made in the districts as outlined in the concept paper, CSCS recommends a planning process with City government and community service providers be implemented. Engaging community groups will bring to the table a broad array of expertise, experience and talent from the aging services network citywide. These aging services professionals have built one of the best as well as the largest community-based aging services network in the country and would welcome a mutual planning process. We all have a stake in this network providing high quality services. Including community groups will serve to build trust and more likely lead to buy-in of changes made. Clearly, this cannot take place by August 10th.

On a more specific level, CSCS recommends that the contracts in Brooklyn, with the highest number of seniors of any borough not be reduced by five, as some of the districts are too large in geography and diversity. There are questions in other boroughs as well which need to be discussed further. For

example, in Queens, – there is a highway that separates the proposed district of CB 1&3. The current district of 1&2 is more contiguous. The diversity in 9, 10 & 12 would be difficult to manage due to the widespread diversity of senior populations. There is no overlap of where case management agencies currently serve seniors as stated in the concept paper – programs may be in the same community board, but not the same neighborhoods. People live in neighborhoods, not community boards.

Strengthening the partnerships between case assistance and case management programs while maintaining local access points:
We also recommend that case assistance programs be maintained at senior centers along with their authority to turn on meals-on-wheels. A senior can always be referred to case management as is done now. In speaking with home delivered meal providers who do their own assessments as well as accept referrals from case management agencies, currently the vast majority of referral for meals-on-wheels do not come from case management agencies, but rather from hospitals, family, neighbors and other local organizations – a number as high 80% of referrals coming from outside of case management. Currently, a case assistance agency can provide the home-delivered meal the next day, which is especially important upon hospital discharge. Easy access to meals-on-wheels could well be lost under the proposed system. It is essential that these access points not be lost especially as we move towards a point of entry system intended to increase I&R and access to services. Seniors, some of whom are frail, can walk into a local senior center now and receive case assistance services. We recommend that performance measures be developed for case assistance in order to standardize services. Case assistance was created in parts of the city in a response to the need to begin meals-on-wheels as quickly as possible for frail seniors.

Additionally, the concept paper discusses moving 4000 seniors currently receiving meals-on-wheels through case assistance to case management. It is unclear if the additional $2.1 million to be added into these contracts in FY2009 will be sufficient to incorporate this large number of seniors. The concept paper discusses DFTA wanting to move towards a more comprehensive case management system. If this is done, more seniors will seek services without sufficient infrastructure funding put in place.

Individuals seeking adult day services have to go through a case management assessment and referral to the adult day program before being able to begin the program. Seniors and their families are usually approaching adult day in the middle of crisis. The first person they speak to about the service is critical. Experience has shown that case management agencies often do not adequately refer seniors to adult day and having to go through case management for an assessment delays service. There is concern that a similar situation would be created if case assistance programs could not authorize meals-on-wheels.

Role of case management in community after care following hospital discharge:
We believe that even more savings could be realized through increasing local access points for support to seniors upon hospital discharge. There is a tremendous amount of unrealized potential to capture savings in hospital costs through appropriate discharge planning and community after care.

Optimizing community-based services could be a key component to providing proper care. Some facts about hospital admissions and readmissions nationally are:

- Top 10 conditions are all chronic, requiring at-home care to avoid re-admittance
- 1997-2004 costs per stay up 25% (after-inflation) while length of stay decreased (6.4 days to 5.7 days)
- Emergency Room admittance continues to rise
- Re-admission for same ailment ranged between 31% – 50%
- Re-admission is 24% – 55% more costly than first
- First 2 weeks are very important in recovery
- Proper dietary intake is crucial

A thorough exploration of how the findings of this study could be used to contain hospital costs while providing appropriate community after care to seniors would reap unrealized benefits. Case management and case assistance would be key pieces in this community-based care network. (Senior centers are also well positioned to play a productive role in community after care to elderly individuals upon hospital discharge.)

Transition period for contract changes and collaborations:
Transition of contracts and systems change cannot be done overnight without seniors and family caregivers falling through the cracks. For example, if contracts are changed while bringing 4000 new clients into the case management system, an impact analysis of such a large and complicated change on seniors and their families needs to be done. This also includes taking into account the ending of critically important relationships of case managers and seniors, some of whom have known each other for many years. Additionally, working relationships between case management agencies and local health care providers, churches, synagogues, etc. will change with new regions. Reworking those kinds of relationships takes time. There should be a period of time for transitions to occur in order to protect and appropriately provide for continuity of service for frail, homebound seniors.

For example, during the transition to new home care providers last year, case management agencies were relied upon by DFTA to provide a safety net for seniors who were being served and were falling through the cracks. Who will act as the safety net during a case management transition? We recommend that the impact on seniors of the lack of sufficient time for transition in the home care situation be used to inform any transition that takes place within case management.

Collaborations between agencies as part of an RFP does not happen overnight if done well. Guidance is needed from DFTA as to what kinds of collaborations are appropriate. Additionally, sufficient time needs to be given for appropriate collaborations to be done to ensure the infrastructure for quality service delivery is in place.

We have attached a list of additional concerns in response to the concept paper regarding information that was not included or is unclear.

Recommendations:

- **CSCS is recommending that this process be delayed by at least six months until the next fiscal year, July, 2008 in order to allow for a planning process to take place.**
- Initiate a planning process with community-based agencies.
- Review proposed districts in the concept paper in terms of easy access to services, cultural competency for an increasingly diverse elderly population, and retaining a community-based case management system.
- Strengthen case management by investing more funds in order to save on health care costs through early intervention, crisis management, community after care following a hospital discharge, and ongoing case management supports.
- Develop a plan to address high caseloads, low salaries, lean agency infrastructures and ongoing staff training. A stated goal of the restructuring of case management is to gain administrative savings. Developing and managing a series of partnerships, collaborations and subcontracts will require sufficient administrative overhead costs be funded. An underfunded agency infrastructure can impact quality of services.
- Expand local access points via case management agencies and case assistance programs in senior centers in order to maximize access to services by frail seniors and their family caregivers.
- Do a baseline survey of what linkages case management and case assistance programs currently have so any changes made could be measured and evaluated.
- Develop performance measures for case assistance in order to standardize services.
- Carefully plan and extend the transition period to ensure a safety net is in place for seniors and their families.

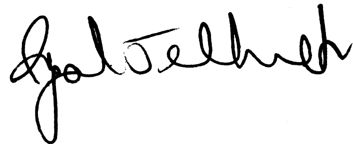
Questions Related to DFTA's Concept Paper

- What is the city's overall vision of aging services?
- What was the criteria used to draw case management boundaries? How will this plan serve seniors better? What is the city's definition of community-based? Is there evidence that bigger regions will provide better access and quality of services?
- What services does the $22 million include? Will case assistance funds remain in the senior centers as they are now?
- Why is the RFP and change of contracts happening in the middle of the fiscal year? It is more difficult to make change in the winter – like case managers meeting with clients who they will no longer be the case manager for. In some cases, case mangers have worked with the same clients for many years – this is a delicate, very personal relationship. Holiday time is particularly an emotionally fragile time for seniors.
- If POE is not due to start for 3-4 years, how can the city know what to plan for now? What will be projected caseload sizes?
- Is the city planning to strengthen the case management system? If so how and what is the timeline? Will case management salaries be

raised? Any other funding invested in strengthening the case management system? If requiring more services by case management, then how will the infrastructure be funded to carry it out? Many case management agencies already work with local hospitals, churches, etc. Can an inventory of existing relationships be done in order to both better understand the extent to which case management agencies are already working with other local resources as well as what working relationships could be lost taking a long time to resurrect?

Thank you for the opportunity to respond to the case management concept paper. We look forward to working with DFTA to ensure that older New Yorkers can age in place in their communities with accessible and affordable services.

Sincerely,



Igal Jellinek
Executive Director