

Council of Senior Centers and Services of New York City, Inc.

DFTA Senior Center Concept Paper February 5, 2008

It is important to note that all these changes are taking place within the context of reduced funding for services, about \$15.5 million less:

- The Mayor's Preliminary Budget Plan for FY2009 released on January 24, 2008 included a 3% across-the-board cut to all DFTA programs as of July 1, 2008 (which covers FY08), \$4.1 million.
- An additional 5% cut (covers FY09). DFTA expects agencies to absorb the cuts without impacting services. There is little OTPS or administrative overhead funds already in the budgets. Meeting these fixed costs means funding has to be taken from other parts of the budget.
- The preliminary budget left out City Council funding for core costs such as meals, vans, and rent, a total of \$11.5 million. Funding for the Healthy Initiative was also eliminated. These funds need to be baselined. As a result of these proposed changes to senior centers, there will be unfunded mandates with less money available.

Positive aspects of the draft concept paper -

1. Flexibility of provision of services –
 - a. Can change the operational hours of a center within 250 day service contract
 - b. Broadens accountability beyond meal count only
 - c. Recognizes the important role evidence based chronic care management and wellness programming could play in senior centers
 - d. Allows for offsite programs, senior center without walls concept
 - e. Seeks to evaluate programs in order to demonstrate the health Value of senior centers as individuals age
 - f. Allows case assistance workers to turn on emergency MOW
2. Other public agencies are being brought into the discussion e.g. DOH and HRA.
3. Calls for focus groups of seniors to see what they want at senior centers.

Concerns raised by the draft concept paper –

1. **Senior centers currently provide health and wellness programs:**
 - a. DFTA's concept paper shifts service over to health and wellness programs which is not balanced against other services senior centers provide.
 - b. Although not evidence-based, senior centers are providing health and wellness programs and do collaborate with local medical providers. (Evidence-based refers to already tested programs that provide health benefits for seniors like chronic care management. These programs cost money to implement, evaluate seniors and do data input and analysis. The also take time to bring into the senior centers.)

- b. Current programs and services should be evaluated.
- c. It is questionable how much DFTA understands of what activities and services are already going on at senior centers since the concept paper doesn't acknowledge that any health related services exist when in fact they have for decades.
- d. Broadening programming to develop "senior center without walls" will expand the reach of senior centers into communities. However, resources and regulatory barriers get in the way of bringing this to fruition.

2. Regionalization of senior centers –

- a. DFTA's concept paper discusses the idea of the regionalization of senior centers without giving a definition of what that means. Will services be regionalized as the MOW and case management services are?
- b. Will funding be regionalized? Does this mean some communities will lose funding leading to reduced meals and services?
- c. What will be the funding formula for regionalizing senior centers? What factors will determine the size of the region?
- d. If one part of restructuring senior centers is to bring about economies of scale by going to larger agencies, DFTA should do a cost benefit analysis of the current efficiencies already built into the senior center system. For example, if a senior center kitchen is producing hundreds of congregate and home-delivered meals at a low cost, how much more efficiency while maintaining quality of the meals can be brought about?
- e. RFP'ing out all 325 senior centers simultaneously is too much. Usually, about 60 centers a year are rfp'd out. Does DFTA have the capacity to do all these rfp's so rapidly? How can CBO's respond?
- f. Senior centers have legal liability of leases.
- g. How many senior centers does DFTA plan to close? In which communities do they want to close centers? Seniors, providers, elected officials and other community stakeholders have a right to know.
- h. Seniors tend to go to a center within about a ten block radius of their home especially as they get older.
- i. How will the needs of a diverse elderly population be met? What about immigrant communities?
- j. What happens if a senior center is in the middle of a lease agreement?
- k. There is a danger that smaller, freestanding senior centers will disappear. There may be smaller sponsors that are appropriate for particular communities, especially immigrant communities.
- l. Agencies will have to do multiple RFP's in this time. Can the RFP be streamlined?

3. Explanation of core services needed –

- a. What current services are included in the \$94 million?
- b. The concept paper states that core services (meals, case assistance, or transportation) will "continue to be an important part of congregate services, but will appear in different permutations." What does this mean?
- c. Will DFTA continue to fund vans operated by senior centers or are they looking for some other entity to provide transportation? Is DFTA planning to pull vans from senior centers? Is the funding for vans included in the \$94 million?
- d. Besides case assistance, there is no mention of the importance of social services in senior centers. Many centers provide social services without

case assistance contracts. How will they be able to continue to afford to provide these services? Where will seniors go for assistance – especially seniors whose first language is not English.

- e. No mention of recreational, educational and cultural programs as part of core services, ESL and citizenship classes – to encourage socialization, prevent isolation, and stimulate seniors in positive ways.
- f. How can senior centers “modernize” without an infusion of additional funds, an underpaid workforce, and renovations needs of senior centers? (CSCS has completed a renovation needs survey where 160 of the 325 senior centers responded – everything from making the center more attractive, minor repairs, equipment replacement to major renovations and the need for a new site.)
- g. **Pilot programs should be done first to gather evidence that the proposed changes will work.** Any changes should be phased-in – rapid wholesale change is neither effective nor productive. All 325 senior centers should not be RFPd all at once without knowing the impact on seniors, service providers and communities. Insufficient funding will result in a loss of services.

4. **Definition of senior center participant is changed –**

- a. DFTA proposes to structure senior center programs to provide public health activities designed to “ensure that the City will be prepared to help a new generation of seniors to age healthfully while staying active and engaged.” While a worthy goal, the City needs to provide additional public health dollars to allow centers to realistically provide these programs. What about the current generation of elderly attending the centers?
- b. DFTA is emphasizing to meet the needs of younger elderly – for example, the concept paper states that if most seniors in a community are still working the center should provide “professional and technical development courses or other continuing education classes in the evening”. Offering classes at night for employment training will leave out current senior center participants – many in their late 70’s, 80’s and 90’s who will not come out at night and do not need employment training. This type of training could be done elsewhere where continuing education is offered.
- c. Restructuring is emphasizing services to low income seniors. Senior centers aren’t only for low income people. They are not means tested. Seniors of all income groups need meals, socialization, health related activities, transportation, etc.
- d. Senior centers can’t be all things to all people - How can a center provide public health programs, health and wellness centers, employment training, nutrition, social services, other recreational programs, transportation, etc. – especially with their physical plants needing renovations and insufficient funding.

5. **While moving towards incorporating evidence-based chronic care and wellness programs at senior centers and evaluating them is welcomed,**

the concept paper does not allow for adequate time to incorporate these new programs.

- a. Presenters at DFTA workgroup meetings from outside NYC discussed the need to “nurture” programs into these new programs and that it took 3-4

years to do so. The concept paper does not allow for a process but rather mandates a rapid change without added financial resources.

- b. Capacity for data analysis – Senior centers do not have the staff capacity and technology to do evidence-based programming, ie – interviewing hundreds of seniors, data entry and analysis of performance based outcomes. What does DFTA mean that it would “allow for a more robust system of collecting and analyzing outcomes data”?

6. There is some experience with evidenced-based programs that seniors do not necessarily want to come to these classes or do not come consistently enough to be evaluated.

- a. Have any focus groups been held to ask seniors about shifting senior center program to be heavily on the evidence based wellness side? Seniors attend centers for more than wellness classes.
- b. It creates an imbalance in programming and the purpose of senior centers. Having only these kinds of programs and constantly being interviewed and evaluated may not be fun for seniors. Where is the “free choice” for seniors? This treats all seniors universally as the same.
- c. Senior centers meet a broad range of interests and needs through a variety of programs and services. The concept paper is proposing a one size fits all model which will not work in NYC. It does not leave room and resources for creativity and the capacity to meet emerging needs of seniors.

7. Use the NORC model for flexibility –

- a. NORCs are allowed and encouraged to develop programs that are unique to their development. This flexibility is a recognized value by DFTA.
- b. This value of flexibility needs to be recognized for senior centers in order to meet the needs of their particular community.

8. An uneven playing field is created in this concept of senior centers and divides the service sector –

- a. Middle class vs. poor communities – local resources and fundraising capacity inequitable.
- b. Large vs. small agencies - The concept paper states preference will be given to agencies that can raise more private dollars. Agencies already significantly supplement DFTA funding with private dollars.
- c. Regionalization of funding or services could also leave an uneven playing field between small, medium and large agencies.
- d. Program vs. meals – while seeking to emphasize wellness programs, agencies would have the choice of not providing any meals. Lack of additional funding for wellness programs could push agencies to take funds from meals and set up a situation of “old” model vs. “new” model without the appropriate balance.

9. Meal provision –

- a. Meal levels have been set at levels where some agencies can never meet the number which adds to the “underutilization” rate. While one million unused meals needs to be addressed, the reasons need to be explored in a more nuanced way. For example, if a program is contracted for 180

meals and provides 160 meals, should it be considered an underutilized center?

- b. The one million less meals is within the 10% variance rate (it's 9% unused across the system of 9 million total congregate meals). Also – there's not enough money for the meals, so all the funds are still being used.
- c. Flexibility to mix up the meal provision is needed - to move lunch funds to other meals like breakfast or early dinner.
- d. Senior centers overserving congregate meals are not reimbursed.
- e. The congregate weekend meal program is not mentioned. What is DFTA's plan for this program?

10. Will senior centers with MOW in their current contract will get shortchanged as they will have to refer for emergency MOW without additional staff?

11. A recommendation was made that other city agencies, including DOH, which co-chaired DFTA's workgroup on senior centers, should be allocating funds for evidence-based wellness programs at senior centers in order to add to the funding base to successfully implement these programs.

- a. The concept paper is proposing that senior centers have the responsibility to meet the public health needs of the elderly without an infusion of government funds to do so.
- b. Public health is a government function requiring funding for CBO's to carry out the programs. It appears as though the needs of government are being met by this wholesale change, but not the needs of seniors.

12. There is no new money for tracking these programs, i.e. – interviewing, data entry and analysis – this is an unfunded mandate.

- a. Appropriate staff and technology capacity is necessary.
- b. Time is needed to phase-in all this because if seniors do not show up consistently outcomes cannot be measured.
- c. Recognition needs to be given that if focus groups of seniors are to be held, time is needed. A common focus group tool should be developed.

13. Performance based contracting for senior centers –

- a. PBC doesn't work for senior centers because there are fixed costs which remain the same no matter how many seniors attend on any given day