Public Advocate for the City of New York

Unsolved Case

A Survey of New York City Department-for-the-Aging-Contracted Case Management Services Staff

December 2009

Visit us on the web at www.pubadvocate.nyc.gov or call us at 212-669-7200.

Office of the New York City Public Advocate

Betsy Gotbaum

Public Advocate for the City of New York

PREPARED BY:

Daniel Browne

Director of Policy and Research

Mark Woltman

Deputy Director of Policy and Research

Sabine Dyer

Senior Policy Analyst

EXECUTIVE SUMMARY

In the past two fiscal years, the Department for the Aging (DFTA), which administers services for 1.2 million New Yorkers over the age of 60, has absorbed successive budget cuts, including $16.6 million in 2008.[1] Ninety percent of DFTA's budget goes to contracts with more than 400 community-based nonprofit agencies that provide a range of community-based programs, including three core services—case management, home-delivered meals, and congregate[2] services in senior centers.

Citing an increase in the demand for services due to the aging of the city's population, DFTA launched a modernization initiative to redesign all three of its core services, beginning with case management in April 2008. DFTA characterized the reorganization of the case management system as "preparing for the increasing and changing needs of tomorrow's diverse older population."[3]

DFTA contracts with private agencies to provide home-bound seniors with services such as house-keeping, assistance with bathing or laundry, transportation, and legal aid. These services are coordinated by social work case managers employed by DFTA-funded case management agencies who complete an in-home assessment and authorize needed support services. The 2008 reorganization reduced the number of DFTA-funded case management contracts from 32 to 23 and gave case management agencies exclusive responsibility for authorizing home-delivered meals, previously the purview of community senior centers.

Soon after the new contracts went into effect, providers reported that DFTA's estimates of the number of clients each agency would serve were too low, leaving many agencies with insufficient funding and large numbers of seniors without services.

In August 2009, the Office of the Public Advocate surveyed case managers and case manager supervisors to gain a better understanding of the reorganization's impact on the capacity and quality of the case management system.

Findings:

Caseloads

- Since the reorganization, the average caseload for case managers has increased from 66 to 69 cases, higher than DFTA's target caseload of 65.
- Since the reorganization, the average caseload for supervisors has increased from 401 to 456 cases, far higher than DFTA's target caseload of 325. Forty-six percent of current supervisors also directly manage clients in addition to their supervisor role.

---

[1] Sackman, B., "A Graying NYC Threatened by Cuts and Consolidations," *New York Nonprofit Press*, April 2009. See: http://www.nynp.biz/index.php/points-of-view/738-a-graying-nyc-threatened-by-cuts-and-consolidations

[2] The Department for the Aging, (DFTA) refers to programs at senior centers as "senior congregate activities."

[3] DFTA, *Letter to Community Stakeholders*, Case Management Concept Paper, May 25, 2007, p.1

- A majority of supervisors do not consider DFTA's standard of 65 cases per case manager a manageable caseload. Nearly two-thirds do not consider DFTA's standard of 325 cases per supervisor manageable.

Case Management Capacity

- Since the reorganization, the majority of supervisors report an increase in new requests for services.
- Since the reorganization, homebound seniors' average wait time from service request to assessment has increased by one week to a total of five weeks. Seniors' wait time for home-delivered meals, from request to start of service, currently averages 6.2 weeks for regular meals and 6.9 weeks for kosher meals.
- Since the reorganization, homebound seniors' average wait time from initial assessment to receiving assistance with travel to medical appointments has more than doubled from nearly two and a half weeks to more than five weeks.
- Since the reorganization, case manager turnover has significantly increased.
- Since the reorganization, problems related to DFTA's data processing system have continued despite frequent complaints to DFTA from case management staff.

Case Management Quality

- The majority of veteran case management staff does not believe that the reorganization has improved the quality of case management services.
- More than three quarters of current case managers are not able to reach out to seniors in the community to proactively identify seniors at risk of nursing home placement.
- Since the reorganization, the percentage of case managers who always or frequently have to reduce or delay client services and other responsibilities to cope with their workload has risen significantly.

Recommendations:

The New York State Office for the Aging Should:

Consider New Funding Sources Such as an Income Tax Check-Off for the Expanded In-home Services for the Elderly Program (EISEP).

The New York City Department for the Aging Should:

Reduce Caseloads by:

- Funding agencies to a level that ensures their ability to hire sufficient case managers and supervisors.
- Determining a lower standard caseload, including a case mix variable for clients requiring frequent visits or complex service arrangements.

Improve Case Management Capacity by:

- Transitioning the current Provider Data System (PDS) to a secure, web-based system that allows remote and user-friendly entry and exchange of client data.

Improve Case Management Quality by:

- Providing case managers with greater access to benefits and entitlement resources by expanding training opportunities and creating a case management resource website.

- Providing logistical support and incentives to increase outreach efforts to identify at-risk seniors.

Update:
On Tuesday, September 29, 2009, the City Council's Committee on Aging held a hearing on the state of DFTA's redesigned case management program. DFTA acknowledged "challenges in the period after the transition," including "waitlists due to higher than anticipated caseloads." DFTA reported that it had evaluated existing caseloads and that "both caseload sizes and funding per client varied significantly among our providers across the system."[4]

In response to the evaluation, DFTA decided to "fine-tune the amount of funding received by each provider based on community need,[5] by reducing funding for two case management agencies and shifting the resources to five others.[6] This reallocation of resources, however, does not take new client volume into account.

In its September 29th testimony, DFTA also announced that home-delivered meals providers would be allowed to conduct intake, determine meal eligibility, and authorize meal service for 120 days without referral to case management organizations[7]—a policy similar to the system of "self-assessment" that existed before the reorganization. Once the 120 days have passed, home-delivered meals clients must be referred to case management agencies, which must give them a case management assessment within 10 days.

While the Office of the Public Advocate applauds DFTA for taking steps to ensure that seniors gets the services they need in as timely a manner as possible, it remains concerned that resources in the case management system are insufficient to provide all clients with timely, high-quality services and increase capacity for the future. The fact that clients face longer average wait times to receive services than before the redesign suggests that the city may need to rethink its strategy for meeting the needs of its growing and diversifying senior population. Without additional funding, it is unclear how DFTA proposes to address the fact that the average caseload system-wide is higher than what providers have collectively contracted for.

[4] DFTA Commissioner Barrios-Paoli, Testimony, Sept. 29, 2009, p.3. It should be noted that variation in funding per client was built into DFTA's original contract awards. The dollar per client ratio (based on estimated client numbers) varied from $1,306.41 to $1,035.79 per client, depending on the contract. Reimbursement for one unit of service varied from $36.85 to $61.59 per unit, depending on the contract.
[5] DFTA Commissioner Barrios-Paoli, Testimony, Sept. 29, 2009, p.3.
[6] DFTA Commissioner Barrios-Paoli, Testimony, Sept. 29, 2009, p.3.
[7] Memo from Commissioner Barrios-Paoli to Home Delivered Meal Providers and Case Management Agencies on Home Delivered Meal Authorization, Dated September 28, 2009.

INTRODUCTION

Since Fiscal Year (FY) 2004, the Bloomberg administration has proposed and implemented large-scale budget reductions[8] that have required agencies to cut staff and services or generate savings by cutting administrative costs and providing services at lower costs.[9] In the past two fiscal years, the Department for the Aging (DFTA), which administers services for 1.2 million New Yorkers over the age of 60, has absorbed successive budget cuts, including $16.6 million in 2008.[10]

Ninety percent of DFTA's budget goes to contracts with more than 400 community-based nonprofit agencies to provide three core services—case management, home-delivered meals, and congregate services in senior centers—as well as a range of other services to seniors and their caregivers. Citing an increase in the demand for services due to the aging of the city's population, DFTA launched a modernization initiative to redesign all three of its core services, beginning with case management in April 2008.[11]

DFTA contracts with private agencies to provide home-bound seniors the services they need in order to stay in their homes, rather than receiving institutional care. In addition to home-delivered meals, services include home and personal care, such as house-keeping and assistance with bathing or laundry. Before home care services are provided to a senior, a social work case manager employed by a DFTA-funded case management agency must conduct an in-home assessment and authorize homecare services, provided by specialized organizations also funded by DFTA. Case managers also link seniors to a range of other services provided in the community, including transportation and legal aid.

DFTA argued that the case management system needed to be redesigned "in anticipation of growing case management needs."[12] The crux of the redesign was that service areas would be redrawn so that no more than one case management contract would serve each community district.[13] The redesign resulted in larger geographic areas served by a smaller number of providers. The consolidation reduced the number of DFTA-funded case management contracts from 32 to 23.[14] DFTA characterized the reorganization of the case management system as "preparing for the increasing and changing needs of tomorrow's diverse older population."[15] In addition, DFTA gave case management agencies exclusive responsibility for authorizing home-delivered meals, previously the

---

[8] Gotham Gazette, "Mayor Bloomberg's 2004 Budget," April 2003. See: http://www.gothamgazette.com/article/issueoftheweek/20030421/200/357#jump

[9] Office of Management and Budget (OMB), *Executive Budget Fiscal Year 2004*, April 2003, p. 150. See: http://www.nyc.gov/html/omb/downloads/pdf/mm4_03.pdf

[10] Sackman, B., "A Graying NYC Threatened by Cuts and Consolidations," *New York Nonprofit Press*, April 2009.

[11] DFTA, "DFTA Launches Aging Services Modernization to Address Senior Needs of Today and Tomorrow," Press release January 22, 2008, See: http:// www.nyc.gov/html/dfta/downloads.pdf/pr_release/press_012208.pdf.

[12] DFTA, *Concept Paper for the Provision of Case Management Services to the Elderly*, May 25, 2007, p.1.

[13] DFTA, *Concept Paper for the Provision of Case Management Services to the Elderly*, May 25, 2007, p.1.

[14] DFTA, *Concept Paper for the Provision of Case Management Services to the Elderly*, May 25, 2007, p.1.

[15] DFTA, *Letter to Community Stakeholders*, Case Management Concept Paper, May 25, 2007, p.1

purview of community senior centers, in order to ensure that all seniors requesting home-delivered meals would receive a comprehensive assessment of their needs.[16]

Soon after the new contracts went into effect, providers reported that DFTA's estimates of the number of clients each agency would serve were too low, leaving many agencies with insufficient funding and large numbers of seniors without services. Despite these problems, DFTA proceeded to redesign its two other core services, home-delivered meals and congregate[17] service at senior centers. In spring of 2009, contracts for home-delivered meals were consolidated along the same line as case management contracts. However, the Request for Proposals (RFP)[18] for the senior center redesign was withdrawn after extensive advocacy efforts and a change in DFTA leadership.[19]

With public and media attention focused on the home-delivered meals and senior center redesigns, the problems with the new case management system remained largely unexamined and unsolved by DFTA for more than a year. DFTA has recently begun to evaluate case management agencies' caseloads and announced its intention to redistribute funding so that allotments will more closely match contract agencies' actual caseloads.

In August 2009, the Office of the Public Advocate surveyed case managers and case management supervisors to gain a better understanding of the reorganization's impact on the capacity and quality of the case management system. The following findings and recommendations are the result of this survey.

BACKGROUND

New York City's Aging Population

Three trends are changing New York State's senior population: an overall aging of the population due to longer life-spans;[20] the aging of the baby boomer generation, in

[16] DFTA, *Request for Proposals for Case Management Programs for Older Adults*, October 12, 2007, p.3.
[17] DFTA refers to programs at senior centers as "senior congregate activities." Historically, funding for congregate activities at senior centers has been directed primarily to the provision of weekday lunch service at senior centers.
[18] An RFP is a formal request to submit a bid, in this case for service contracts with the city. All mayoral agencies are required by the New York City Charter to follow procurement protocols established by the Procurement Policy Board and the City Council. For the city's procurement rules, including contracts for services see: http://www.nyc.gov/html/mocs/ppb/downloads/pdf/rulescompleteApril2007.pdf
[19] The City of New York, Office of the Mayor, "Deputy Mayor Gibbs, Speaker Quinn and Aging Commissioner Designee Barrios-Paoli announce plans to re-evaluate strategy to modernize senior centers." *Press Release*, December 19, 2008.
[20] From 1900 through 1902, life expectancy for a 65-year-old in the US was 12 years; by 2005, life expectancy for this age group had increased to 18.7 years. The proportion of the U.S. population age 65 and over more than tripled from 1900 (4.1percent) through 2000 (12.4 percent), and will constitute 20 percent of the U.S. population by 2030. See: National Center for Health Statistics, "Health Characteristics of Adults Aged 55 Years and Over: United States, 2004-2007," *National Health Statistics Reports*, No. 16, July 8, 2009.

particular; and growing cultural diversity among seniors, including an increase in the minority and lesbian, gay, bisexual and transgender (LGBT) senior populations.[21]

By 2015, New York City's 60-plus population is expected to grow at a rate significantly faster than in the state as a whole (29.4 percent vs. 25.8 percent). The number of New York City residents over the age of 65 will grow by 21 percent in the same timeframe, an increase of nearly 200,000. By comparison, the city's overall population is expected to grow by only 9 percent.[22] By 2015, at least 20,000 more city residents will have reached or surpassed age 85. In addition, the city will see a pronounced increase in the number of seniors living with disabilities.[23] Almost 43 percent of adults age 80 and over have physical limitations, and about 27 percent of adults in this age group have three or more physical limitations.[24]

The growing proportion of minorities among the city's senior population presents additional challenges. For example, 34 percent of African Americans age 60 to 69 have one or more physical limitation, compared to 24 percent of whites age 60 to 69.[25] In 2005, nearly 48 percent of New Yorkers 65 and older were members of minority groups, compared to 43 percent in 2000 and 35 percent in 1990.[26] Between 2000 and 2005, the city's over-65 black population increased by 10 percent, the Hispanic population by 22 percent, and the Asian population by 36 percent.[27]

Compared to the national average, seniors in New York City are more likely to live alone and to be divorced, separated, widowed, or unmarried in the first place.[28] Certain populations within the city are even less likely to have a close family caregiver. Because of their longer average life span, senior women are often widowed. First generation immigrants to New York City may experience old age far removed from friends and family. Seventy-five percent of LGBT seniors live alone, 90 percent have no children, and 80 percent age as single persons without a life partner or significant other.[29]

---

[21] Council of Senior Centers & Services of NYC (CSCS), *No Time to Wait: The Case for Long-Term Care Reform*, January 2009, p.29.

[22] CSCS, *No Time to Wait*, 2009, p. 29. For the year 2030, the New York City's Department of Planning projects that the percentage of the city's residents aged 60 and over will reach 20 percent of the total population—an increase of 581,000 (or, 46 percent) since the year 2005. See: DFTA, Letter to "Community Stakeholders" attached to *Concept Paper for the Provision of Case Management Services for the Elderly*, May 25, 2007. By 2030, the number of seniors aged 85 and over is predicted to increase by 31,000 (25 percent) to 153,000. See: DFTA, Letter to Community Stakeholders, May 25, 2007.[22]

[23] CSCS, *No Time to Wait*, 2009. p.28.

[24] National Center for Health Statistics (NCHS), "Aging Differently: Physical Limitations Among Adults Aged 50 years and Over: United States, 2001-2007," *NCHS Data Brief*, No. 20, July 2009, p.1.

[25] NCHS, "Aging Differently", *NCHS Data Brief*, No. 20, 2009 p.2.

[26] DFTA, Annual Plan Summary April 1, 2008-March 31, 2009, September 2007, p. 9.

[27] DFTA, Annual Plan Summary April 1, 2008-March 31, 2009, September 2007, p. 9

[28] Walker, J., Herbitter, C., *Aging in the Shadows: Social Isolation Among Seniors in New York City.*, United Neighborhood Houses (UNH), 2005.

[29] Chambers, C.L., Hollibaugh, A., Gilberto, P., Kaelber, T., Berman, D., *No Need to Fear, No Need to Hide. A Training Program about Inclusion and Understanding of Lesbian, Gay, Bisexual and Transgender Elders for Long-Term Care and Assisted Living Facilities*, 2004.

When confronted with the frailty of old age, most seniors prefer the dignity of remaining in their homes and of living as independently as possible in a familiar community. In a national survey conducted in 2000 on behalf of AARP,[30] 89 percent of respondents age 55 and older agreed that they would like to remain in their current residence for as long as possible.[31]

This preference of seniors to "age in place" is matched by the mission of the Older Americans Act[32] to protect the dignity and independence of older adults, as well as the Supreme Court's ground-breaking 1999 Olmstead decision,[33] which privileged community-based over institutionalized care. In addition, the increasing realization that home care services are less costly for government payers than institutionalized care[34] has encouraged policy makers at all levels of government to pursue more socially integrated, community-based models of care.

Case Management Services in New York City

As public policy has shifted from a model of institutional care for seniors in nursing homes to a continuum of support services enabling seniors to age in place, case management has become a core service designed to help seniors live independently in their communities.

At its most basic, case management is "[a] procedure to plan, seek, and monitor services from different social agencies and staff on behalf of a client."[35] In the spectrum of social work practices, "case management is a highly individualized approach that considers the unique aspects of the person and at the same time provides a holistic orientation that

[30] Formerly "American Association of Retired Persons," the organization was renamed "AARP" in 1999 to reflect a broader focus. AARP is a membership organizations for all persons 50 years and older and does not require its members to be retired.
[31] AARP, *Fixing to Stay: A National Survey of Housing and Home Modification Issues*, May 2000.
[32] Congress passed the Older Americans Act (OAA) in 1965 in response to concern by policymakers about a lack of community social services for older persons. The original legislation established authority for grants to states for community planning and social services, research and development projects, and personnel training in the field of aging. The law also established the Administration on Aging (AoA) to administer the newly created grant programs and to serve as the federal focal point on matters concerning older persons. The OAA was reauthorized in 2006. See US Department of Health and Human Services. Administration on Aging at: http://www.aoa.gov/AOARoot/AoA_Programs/OAA/index.aspx
[33]"Olmstead—In 1999 the United States Supreme Court decided the Olmstead case, interpreting Title II of the Americans with Disabilities Act (ADA) to require that persons with disabilities be supported in the 'most integrated setting.' The Court specified that community-based care was to be the norm and institutional care be considered only after community-based care was ruled out." CSCS, *No Time to Wait*, 2009, p.22.
[34] In 1995, the New York State Office for the Aging compared seniors who used New York State's Expanded Services for the Elderly Program (EISEP) and Medicaid clients and found that seniors who used home-based care through EISEP used significantly less publicly supported service than the Medicaid clients despite similar functional deficits. The key finding showed that EISEP clients cost the government 20 percent (one fifth) less than the Medicaid client. See: NYSOFA, *Aging Network Case Management Study* (ANCM Study), 1995, in: CSCS, *No Time to Wait*, 2009.
[35] Barker, *The Social Work Dictionary*, 2003, in: Yagoda, 2004, p.1.

views all aspects of the client system, including the client family, friends, their situation, and their environment."[36]

New York City has a long tradition of community-based, case management services for New Yorkers of all ages provided by multi-service non-profit organizations going back to the settlement houses of the late 19th century.[37] For more than a decade[38], New York City has helped fund Supportive Service Programs (SSPs) in Naturally Occurring Retirement Communities (NORCs)—a case management model for New York City buildings and neighborhoods with a high density of seniors aging in place.[39] Senior centers and senior service organizations across the city also offer a variety of privately and publicly funded case management and case assistance services, such as benefits and entitlement counseling.

For Medicaid-eligible seniors, New York City's Human Resources Administration (HRA) provides medical home health services, as well as non-medical home and personal care services through its Community Alternative Systems Agency (CASA) offices.[40] However, unless seniors receive Medicaid services through a specialized Managed Care Organization, the burden to organize Medicaid services lies with the client and their representatives. CASA does not provide case management services.

For seniors who are not eligible for Medicaid, non-medical home care services, including case management, are provided in New York State through the Expanded In-Home Services for the Elderly Program (EISEP).[41] EISEP is designed to help seniors age 60 and older who need assistance with everyday activities such as dressing, bathing, shopping, and cooking but want to remain at home and are not eligible for Medicaid. According to an analysis by the Independent Budget Office, the program served 24, 379 New York City seniors in 2007.[42]

Unlike Medicaid, EISEP is not an entitlement program. EISEP services are determined by state budget appropriations rather than need. Each county is required to match 25 percent of their state EISEP allocation.[43] In New York City, EISEP services are administered by DFTA. DFTA also uses a portion of the Community Services for the

---

[36] Yagoda, L., "Case Management With Older Adults: A Social Work Perspective," *Practice Update Aging*, National Association of Social Workers, May 2004, p. 1.
[37] United Neighborhood Houses, *Settlement House History*. See: http://www.unhny.org/about/settlement.cfm
[38] New York State has contributed to New York City NORC-SSPs since 1992. Since 1999, the New York City Council has provided discretionary funding to support existing and create new NORC-SSPs in New York City.
[39] Vladeck, F., *A Good Place to Grow Old: New York's Model for NORC Supportive Service Programs*, 2004.
[40] Medicaid Personal Care and Home Attendant Program in NYC, see: http://www.wnylc.net/pb/docs/CASAlist12-04.pdf
[41] NewYork State Department of Health, Expanded In-home Services for the Elderly (EISEP). See: http://www.health.state.ny.us/health_care/medicaid/program/longterm/expand.htm.
[42] New York City Independent Budget Office (IBO), Home Care for Seniors: Trends In Service Levels and Costs," *Fiscal Brief* January 2008, p.2.
[43] IBO, Home Care for Seniors," *Fiscal Brief* January 2008, p.2.

Elderly Program (CSE) grant, provided by the state to maximize seniors' independence, to fund home care services.[44]

EISEP requires clients to share the costs of home care services received according to a sliding income scale.[45] Clients who receive case management but not home care services are exempt from cost sharing, as are clients with monthly incomes below 150 percent of the federal poverty level[46] ($16,245 annual income for one-person household in 2009).[47] According to the Independent Budget Office (IBO), roughly a quarter of seniors in New York City receiving home care services are required to cover some or all of the costs of the services provided.

Before home care services are provided to a senior, a social work case manager employed by a DFTA-funded case management agency must conduct an in-home assessment and authorize the services. Once authorized by a case manager, home care services are provided by organizations also funded through EISEP. Home care services include assistance with personal care, including bathing, dressing, grooming, toileting, walking and eating, as well as assistance with house-keeping, including dusting and vacuuming, light cleaning of the kitchen, bedroom and bathroom, shopping or other essential errands, laundering, ironing and mending, and light meal preparation.[48] Case managers are also responsible for "turning on" additional in-home services including home-delivered meals and connecting clients with financial benefit and entitlement programs and with other medical and non-medical services available in the community, including mental health services and caregiver services.

During the initial in-home visit to interview and assess a new client, case managers are expected to complete an exhaustive assessment, including:

> [A]n evaluation of physical health, functional abilities, mental status, nutritional status, informal supports, other social supports and economic status—not just the need for a particular service—and an evaluation of interests (i.e. social, cultural, familial, religious), life accomplishments, strengths, and quality of life wishes that might have an impact on care planning. As part of this assessment, the contractor would collect and document information on the client's finances.[49]

The financial assessment is intended to determine whether clients are enrolled or eligible for government benefit programs. Because new clients may have reservations about sharing information about their finances, health, and social life, case managers often need to visit them and establish a relationship before a comprehensive assessment is possible.

---

[44] IBO, Home Care for Seniors," *Fiscal Brief* January 2008, p.1.
[45] New York State Department of Health (DOH), EISEP. See:
http://www.health.state.ny.us/health_care/medicaid/program/longterm/expand.htm.
[46] IBO, "Home Care for Seniors," *Fiscal Brief* January 2008, p.2.
[47]Poverty Guidelines for Older American Act, updated February 2009. See:
http://www.aging.ca.gov/aaa/guidance/2009_Poverty_Guidelines.pdf
[48] DFTA, District Resource Statement, Fiscal and Service Reports for Fiscal Years 2007 and 2008, p.v
[49] DFTA, *RFP Case Management*, Section III "Scope of Services," p.5

After the interview, case managers travel to their main office, to input information into DFTA's Provider Data System (PDS). For each client, case managers fill out a series of standard forms in PDS as well as a case summary, including demographic information, health history, prescriptions, and other information.

Following the completed assessment, case managers develop a "Comprehensive Service Plan," or "care plan," authorize and connect clients with the services they need, and provide on-going monitoring of service delivery.[50] Case managers are expected to coordinate with caregivers and with other professionals involved with the client, including physicians, attorneys, and mental health workers.

DFTA's Service Reorganization

Bronx Home-Delivered Meals Pilot

In FY 2004, DFTA developed a plan for providing home-delivered meals at lower service costs.[51] Through the Request for Proposal (RFP) process, DFTA implemented a pilot program called "Senior Options" in the Bronx, which consolidated 17 different community provider contracts into three large contracts[52] awarded to two contractors.[53] The pilot required the contractors to provide a predetermined proportion of their clients with twice weekly frozen meals instead of daily hot meal delivery.[54]

The contracts were for approximately 2,300 home-delivered meals clients[55] in the Bronx at a cost of $5 per meal[56] instead of the previous average cost of $6.96.[57] Seniors, service providers, community advocates, and many elected officials, including the Public

[50] DFTA, *RFP Case Management, ,*Section III "Scope of Services," p.5.
[51] The IBO identified the Mayor's FY 2004 cost-cutting initiative as the impetus for DFTA's efforts to lower the cost of providing home-delivered meals. IBO, "Progress Report: The Mayor's Social Services Streamlining Plan," Inside the Budget, No. 142, p.1. However, then-DFTA Commissioner Mendez stated that the goal of the pilot was to create a system that could serve more seniors in the future and enable DFTA to reinvest all savings back into the program. See: Commissioner Mendez-Santiago's testimony at the New York State Assembly hearing on "Ensuring that Seniors Retain Access to Essential supports During the Aging Services Modernization Initiative in new York City," *Transcript*, p. 76
[52] KPMG, *New York City Department for the Aging. Evaluation of the Senior Options Pilot Program,* March 8, 2007, p. 3
[53] DFTA received six proposals of which only two complied with the requirements of the RFP. See: KPMG report, p. 14. Mid-Bronx Senior Citizen Council, Inc. ("Mid-Bronx") received one contract for delivering 173,639 meals and Regional Aid for Interim Needs, Inc. ("RAIN") received the other two contracts for a total of 357,004 meals. See: KPMG, *Evaluation,* 2007, p.9.
[54] The original RFP required 40 percent hot meals and 60 percent frozen meals. The ratio was later changed to 70 percent hot meals and 30 percent frozen meals, with DFTA stating the ratio was not mandatory and could fluctuate. See: IBO, Letter to the Human Services Council, Feb 4, 2008 (Fn 4). In the first year of the pilot, 42 percent of Bronx clients received frozen meals. See: IBO, Progress Report, *Inside the Budget*, No. 142, October 27, 2005. p.3.
[55] KPMG, *Evaluation*, 2007, p.21.
[56] Originally, DFTA proposed a per meal cost of $4. After considerable concern, the RFP established a fixed per meal cost of $5. See: KPMG, *Evaluation*, 2007, p.13.
[57] IBO, Letter to Chris Winward Read, Human Services Council, February 4, 2008. See: http://cscs-ny.org/files/Bronx_pilot_letter_Final020408_ibo.org

Advocate, strongly opposed the pilot and raised concerns about the quality of the food and the impact of eliminating daily visits to many seniors.[58]

Before the 2004 consolidation, many of the sixteen community-based service providers, including senior centers providing home-delivered and congregate meals, were multi-service agencies, able to "check in" informally with seniors during their daily delivery and follow up with additional services as needed. Under the pilot, however, all meals were provided by a single for-profit food service company[59] and delivered to seniors by two large-scale contractors, preventing drivers, who now had tighter delivery schedules, from informally checking in with clients.

DFTA's Modernization Initiative

In 2008, DFTA officially launched an initiative to modernize its three core services— case management, home-delivered meals, and congregate services— in three phases beginning with a redesigned case management system in April of 2008. The case management redesign is discussed in greater detail below.

A year later, DFTA expanded the Bronx pilot program for home-delivered meals by consolidating 97 home delivered meals contracts into 20 city-wide.[60] The consolidation was phased in borough by borough.[61] Newspaper reports and constituent complaints to elected officials' offices indicated that seniors in Queens did not receive their meals for days after the transition, received them early in the morning or late in the day, or received non-kosher meals instead of the kosher meals they requested.[62] DFTA reacted to the Queens delivery problems by restructuring contracts and transferring responsibilities for clients in a couple of community districts to a different agency.[63]

A concept paper issued in January, 2008, indicated that DFTA also planned to reorganize all 329 senior centers in a single RFP process, requiring centers to demonstrate their ability to provide health- and wellness-based programs and conduct data analysis of outcomes and program effectiveness. Meal service was to be more flexible, encouraging senior centers to consider alternatives to midday hot lunch service, such as healthy

---

[58] Office of the Public Advocate (OPA), Releases and Statements, *Gotbaum Calls for City to Keep Its Hands Off Food Programs for Homebound Elderly*, March 9, 2003. OPA, Releases and Statements, *Meals on Wheels Seniors Get Taken for a Ride. Statement from Public Advocate Betsy Gotbaum on Service Changes to Bronx Meals on Wheels Program*, October 4, 2004. OPA, Releases and Statements, *Gotbaum Blasts DFTA Meals on Wheels Delivery of Unsafe Food to Bronx Seniors. Repeats Call for Cancellation of Pilot Program, Fearing Unsafe Delivery Methods and Spoiled Meals*, November 16, 2004.

[59] Whitson's, based in Long Island. One of the contractors started out handling catering responsibilities itself, but eventually switched to Whitson's. See: KPMG, *Evaluation*, 2007, p. 15.

[60] DFTA, Office of the Chief Contracting Officer, *Request for Proposals for Home-Delivered Meals*, May 1, 2008, p.5.

[61] New York Nonprofit Press, "Bumpy Expansion of DFTA Meals Model Leads to Contract Adjustments," February 11, 2009. See: http://www.nynp.biz/index.php/breaking-news/384-bumpy-expansion-of-dfta-meals-model-leads-to-contract-adjustments

[62] New York Post, "Snafu Hits Wheel Meals," February 4, 2008. See: http://www.nypost.com/p/news/regional/snafu_hits_wheel_meals_W6dZLhRSCAyHqzEk0zMMxN

[63] NY Nonprofit Press, "Bumpy Expansion," February 11, 2009.

cooking classes.[64] The concept paper also invited comments on the idea that DFTA would distribute funding based on "regions." While the details of the regional model were not explained, advocates and elected officials, including the Public Advocate, expressed concern that some smaller senior centers would be unable to meet the terms of the RFP and would be forced to close.[65]

The actual RFP, released in November 2008, sought proposals for two different senior center models—"neighborhood centers" with budgets up to $500,000 that would add basic health and wellness activities to the traditional senior center approach and "senior hubs" with budgets up to $1,000,000 that would offer more complex health and wellness programming, as well as computer labs, employment assistance, arts and cultural events, and recreational trips.[66] The programming requirements as well as the option in the RFP of awarding as few as 240 contracts[67] made the closure of some smaller senior centers a virtual certainty. The RFP was withdrawn after extensive advocacy efforts and a leadership change at DFTA.[68] DFTA is expected to re-issue a revised RFP for senior centers in the near future.

Case Management RFP

In 2007, DFTA released a concept paper describing a citywide RFP for Case Management Services for Older Adults[69] and invited community stakeholders to comment. DFTA delayed the release of the RFP after many stakeholders expressed concerns; however, when the RFP was released in October, 2007, all the proposed elements described in the original concept paper remained mostly unchanged. New contracts were awarded in January 2008, with new contract services set to begin on April 1, 2008. Existing contracts were set to expire by June 20, 2008, leaving a transition period for incoming and outgoing providers.

The redesign of case management services was based on two primary goals. First, cost efficiencies were to be achieved by the same principle of contract consolidation applied to the Bronx home delivered meals pilot and subsequently to home-delivered meals citywide. The case management RFP consolidated 32 existing contracts with case management agencies serving 14,000 clients into 23 contracts.[70] DFTA argued in its concept paper that reducing the number of contracts and assigning agencies larger, non-

[64] DFTA, *Concept Paper for the Senior Congregate Activities RFP*, p.1.
[65] Comments by New York City Public Advocate Betsy Gotbaum on The Department for the Aging Concept Paper for Senior Congregate Activities Request for Proposals, March 13, 2008. See: http://pubadvocate.nyc.gov/policy/documents/seniorcenterredesigncommentsedit.pdf
[66] Okebiyi, M., "DFTA Releases Senior Center RFP; Council Will Oppose Implementation," See: http://aapci.org/news/publish/seniors/DFTA_Releases_Senior_Center_RFP.shtml
[67] The RFP anticipated contracts for 225 to 310 neighborhood centers and 15 to 25 senior hubs. See: http://aapci.org/news/publish/seniors/DFTA_Releases_Senior_Center_RFP.shtml
[68] NYC The Office of the Mayor, "Deputy Mayor Gibbs, Speaker Quinn and Aging Commissioner Designee Barrios-Paoli Announce Plans to Re-Evaluate Strategy to Modernize Senior Centers," Press Release December 19, 2008.
[69] DFTA, *Concept Paper for the Provision of Case Management Services to the Elderly*, May 25, 2007
[70] DFTA, Office of the Agency Chief Contracting Officer, *Request for Proposals for Case Management Programs for Older Adults*, October 12, 2007, p.3.

overlapping service areas of roughly equal size would lead to cost efficiencies but did not explain how exactly consolidation would produce savings.[71] Service areas, according to DFTA, were redrawn specifically "in anticipation of growing case management needs."[72]

Second, case management agencies would become exclusively responsible for authorizing home-delivered meals services. The Senior Options pilot program for home-delivered meals in the Bronx had eliminated seniors' daily contact with neighborhood-based providers, who had taken responsibility for connecting them with additional services as needed. In anticipation of the expansion of the Senior Options model citywide, DFTA decided that the responsibility for assessing the needs of home-delivered meals clients should be shifted to the case management agencies.[73]

Moreover, seniors requesting home-delivered meal service would first have to undergo a comprehensive case management assessment, with exceptions made only for five days of emergency meals. Any request for meal service for longer than five days, even temporary service—for example, after a hospital stay—would require a full assessment. This new rule would ensure that at-risk seniors receive necessary services but would also create a barrier to timely home-delivered meals.

In addition, the RFP included new responsibilities designed to improve the quality of case management services for a diverse population and to increase outreach to seniors at risk for nursing home placement, including "frequent visitors to the emergency room post-hospital and post-rehabilitation discharges."[74]

The RFP also stated that[75] "DFTA believes that a caseload of 65 is a manageable one for a caseworker"[76] and that agencies should maintain a ratio of "no more than five case managers per supervisor."[77] Prior to the reorganization, DFTA had not set a standard caseload. In November 2007, DFTA administrators testified before the City Council that 65 cases per case manager was a goal, not a current average. In fact, DFTA did not provide a system-wide caseload average in its testimony, stating that, while there was no waiting list for case management services at that time,[78] case managers had a wide range of caseloads, from 40 to 120 clients, depending on the agency.[79] In effect, the only reason

---

[71] DFTA, "Letter to Community Stakeholders," *Concept Paper for the Provision of Case Management Services to the Elderly*

[72] DFTA, *Concept Paper for the Provision of Case Management Services to the Elderly*, May 25, 2007

[73] Testimony of Commissioner Edwin Mendez Santiago, Assembly Hearing, April 18, 2008, Transcript p. 94

[74] DFTA, *RFP Case Management*, Section III "Scope of Services," 2007, p.6.

[75] For a comprehensive list of all services required in the RFP, please see RFP.pp.5-6.

[76] DFTA, *RFP Case Management*, 2007, p.9.

[77] DFTA, *RFP Case Management*, 2007, p.8. The RFP also allows for the Director of the Program to supervise case managers. (p.8)

[78] "There currently isn't a waiting list." Testimony by Karen Shaffer, DFTA Assistant Commissioner for Long-term Care, Transcript of the Minutes of the Committee on Aging, November 16, 2007, p.21.

[79] "Actually there isn't [an average of 65 cases per case workers]. That's the goal. Right now there is a wide variation, it goes from 40 to 120 per case worker, depending on who is holding the contract." Testimony by Julie Friesen, DFTA Assistant Commissioner for Management and Budget, Transcript of the Minutes of the Committee on Aging, November 16, 2007, p.22.

DFTA offered for setting a uniform 65-cases-per-case manager standard was its intention to bring "parity" to case management agency caseloads.[80] However, in May 2007, prior to the reorganization, the Council for Senior Centers and Services for New York (CSCS) noted that, due to an increase in state EISEP funding in 2007, the average caseload per case manager had been lowered to "around 65."[81]

Case Management Redesign Implementation

During the three-month transition period between April 1, 2008 and July 1, 2008,[82] the 23 agencies that received DFTA contracts under the new RFP began serving their new, larger service areas and accepting client records from outgoing providers, whose contractual obligations officially ended on June 30, 2008. In addition to case management clients served by the previous case management providers, DFTA added 4,000 seniors citywide receiving home-delivered meals,[83] all of whom now required a comprehensive case management assessment.[84]

Soon after the new case management contracts went into effect in April 2008, providers reported that DFTA's estimates of the number of clients each agency would serve were far lower than actual caseloads. DFTA's records for existing home-delivered meals clients also proved inaccurate, adding even more uncounted clients to case management agencies' rosters. Moreover, the requirement that all new clients requesting home-delivered meals receive a full case management assessment increased the number of daily service requests fielded by contract agencies.

This combination of factors created a situation in which case management agencies had far more clients requiring assessment than they contracted for, forcing them to increase caseloads for case managers and supervisors, wait-list clients, or both. The need to meet tight contract deadlines for assessments compelled case managers to prioritize assessment over care planning and follow-up, creating long waits for services.

Case managers encountered other problems, as well. While a number of case management agencies had DFTA contracts before the reorganization, some providers were assigned entirely new catchment areas and different communities under their new

---

[80] "Right now there is a wide variation, it goes from 40 to 120 per case worker, depending on who is holding the contract[…] so we want to bring some parity to that." Testimony by Julie Friesen, DFTA Assistant Commissioner for Management and Budget, Transcript of the Minutes of the Committee on Aging, November 16, 2007, p.22.

[81] CSCS, "*Community-Based Case Management. Policy and Practice*," May 11, 2007, p.3. See: http://www.cscs-ny.org/actionalerts/casemanagement07.shtml

[82] DFTA, *RFP Case Management*, 2007, p.3.

[83] DFTA refers to clients who received only home-delivered meals prior to the reorganization as "self-assessed," suggesting that they evaluated their own need for meals and contacted a local provider accordingly.

[84] DFTA expected its new case management contractors not only to determine whether these clients needed any services in addition to home-delivered meals but also whether they met all eligibility criteria for home-delivered meals in the first place. If a client was deemed ineligible, case managers would be expected to proceed with an "involuntary termination" of the clients' meal delivery. Information based on informal interview with case management staff.

contracts.[85] The lack of familiarity with their new communities in some cases caused distrust among clients who were hesitant to accept new services from unfamiliar case managers.[86]

In addition, DFTA indicated that case managers would be expected to terminate home meal delivery for new clients already receiving the service if, in the course of a full assessment, they determined that the client did not meet all qualifications. In addition to evaluating whether meals clients meet all programmatic eligibility criteria such as being over 60, homebound, and unable to prepare meals,[87] case managers would also be expected to terminate meal service if clients did not "cooperate with program requirements (i.e. permitting a case manager to visit)" or if the client received "at least 20 hours of homecare through Medicaid, DFTA, or private-pay plans."[88] This expectation that case managers would be responsible for "involuntary terminations"[89] of home delivered meal service put additional strain on their relationships with new clients.

In December 2008, Commissioner Mendez-Santiago resigned and was replaced by Commissioner Lilliam Barrios-Paoli.[90] This change in leadership had a number of positive effects, including the administration's withdrawal of the senior center RFP.[91] DFTA has recently begun to evaluate agencies' caseloads and announced its intention to redistribute the funding so that allotments more closely match contract agencies' actual caseloads, but as the redesigned case management system enters its second year, agencies are still too overwhelmed with initial assessments to focus on improving the quality of services.

[85] For example, the Brooklyn-based provider Heights and Hill previously served clients mainly in Brooklyn Heights. Under the new contract, the agency became responsible for a catchment area extending to East Flatbush. Similarly, the Manhattan-based provider Lenox Hill previously served the Upper East Side, from E14th Street to East 96th Street. Under its current contract, Lenox Hill serves Community Districts 8 and 11, from East 59th street to East 143rd street.

[86] Based on informal conversation between Office of the Public Advocate policy analyst and case manager supervisor, who requested to remain anonymous.

[87] In order to receive home-delivered meals, clients have to be age 60 or over, unable to attend congregate meal sites unattended; homebound and incapacitated due to accident, illness, or physical or mental frailty; isolated due to lack of family, friend or neighbor support; and unable to prepare meals because of lack of facilities, inability to shop or cook, inability to safely prepare meals or lack of knowledge or skill to prepare meals. See: DFTA, "Terminating Home Delivered meal (HDLM) Service," *Memo from DFTA Assistant Commissioner Karen Shaffer to Case Management Agencies*, October 8, 2009, p.1

[88] DFTA, "Terminating Home Delivered meal (HDLM) Service," *Memo from DFTA Assistant Commissioner Karen Shaffer to Case Management Agencies*, October 8, 2009, p. 3.

[89] DFTA, "Terminating Home Delivered meal (HDLM) Service," *Memo from DFTA Assistant Commissioner Karen Shaffer to Case Management Agencies*, October 8, 2009, p. 1.

[90] New York Non-Profit Press, *Lilliam Barrios-Paoli New DFTA Commissioner*, Wednesday, December 17, 2008. See: http://www.nynp.biz/index.php/breaking-news/201-barrios-paoli-new-dfta-commissioner

[91] The City of New York, Office of the Mayor, "Deputy Mayor Gibbs, Speaker Quinn and Aging Commissioner Designee Barrios-Paoli announce plans to re-evaluate strategy to modernize senior centers." *Press Release*, December 19, 2008.

METHODOLOGY

Between July 1, 2009 and August 9, 2009, the Office of the Public Advocate surveyed case managers and case manager supervisors currently employed by DFTA-funded senior case management agencies. The survey[92] was designed to examine the impact of the spring 2008 reorganization on the quality of DFTA-funded senior case management services and the capacity of DFTA-funded case management agencies.

The Office of the Public Advocate e-mailed links to the online survey to the executive or program directors of all 23 DFTA-contracted case management agencies in the five boroughs for distribution to the approximately 290 case managers and 58 case management supervisors currently employed[93] under DFTA contracts. Survey responses were anonymous and did not indicate agency affiliation. Case managers had until August 9, 2009 to respond to the survey.

Based on their answers to two screening questions, the survey automatically directed respondents to one of four subsections of the survey designated for veteran case managers, new case managers, veteran supervisors, or new supervisors respectively. Respondents were considered veterans if they were employed by a DFTA-funded case management agency prior to January 2008 (i.e. prior to the reorganization). Respondents were considered new if they had been hired by a DFTA-funded case management agency after January 2008 (i.e. during or after the reorganization).

In order to create a baseline for comparison, veteran staff were asked additional questions referring to the time period prior to the reorganization. For findings referring to the current state of the case management system, responses from all case managers and/or supervisors, veteran and new, were combined.

The Office of the Public Advocate received 103 completed surveys,[94] a response rate of nearly 30 percent (29.6 percent). The Office of the Public Advocate received an additional eight (2.3 percent) incomplete[95] surveys. Incomplete surveys were not used in the following findings.

[92] See http://www.pubadvocate.nyc.gov/pages/reports.html

[93] Case manager numbers are based on estimated client numbers in agency contracts divided by 65—the DFTA standard for caseloads. Supervisor numbers are based on the estimated client numbers in agency contracts divided by 325—the DFTA standard of one supervisor for every five case managers. Actual staff numbers may vary due to ongoing staff turnover, but for most agencies match contract numbers.

[94] These respondents answered all screening questions. Some of these respondents skipped some of the subsequent questions asked in their survey section.

[95] These respondents did not answer all the screening questions.

FINDINGS[96]

The Office of the Public Advocate received 103 completed surveys from case managers and case manager supervisors currently employed under DFTA contracts.

Respondents by Position:

- Sixty-five respondents (63.1 percent) are veteran (24.3 percent) or new (38.8 percent) case managers.
- Thirty-eight respondents (36.9 percent) are veteran (17.5 percent) or new (19.4 percent) supervisors.

Respondents by Borough:

- Eight respondents (7.8 percent) are case managers (3) or supervisors (5) in the Bronx.
- Seventeen respondents (16.5 percent) are case managers (7) or supervisors (10) in Brooklyn.
- Forty-seven respondents (45.6 percent) are case managers (34) or supervisors (13) in Manhattan.
- Twenty-four respondents are case managers (16) or supervisors (8) in Queens.
- Seven respondents (6.8 percent) are case managers (5) or supervisors (2) in Staten Island.

Caseloads

Since the reorganization, the average caseload for case managers has increased from 66 to 69 cases, higher than DFTA's target caseload of 65.

- Prior to the reorganization, the average caseload for case managers[97] was 65.9 cases per case manager; 90 cases was the highest reported caseload.
- Currently, case managers'[98] average caseload is 69.3 cases per case manager; 125 cases is the highest reported caseload.
- A majority (54.5 percent) of supervisors[99] do not consider DFTA's standard of 65 cases per case manager a manageable caseload.

"Clients have various case management needs; housing, entitlements and benefits, abuse, financial management and grant assistance, on-going advocacy and home care needs. Most recently there is a need for legal services and pooled income trusts given Medicaid options. With a case load of 65, many case managers do not have adequate time to provide the appropriate oversight and intervention required to provide comprehensive services to needy frail seniors."

[96] In addition to the findings below, representative quotations from responses to the survey's open-ended have been included in text boxes accompanying the main text.

[97] 39 of 43 veteran case managers and supervisors answered this question. Veteran case managers were asked about their own caseloads prior to the reorganization. Veteran supervisors were asked about the average caseload of case managers they supervised prior to the reorganization.

[98] 95 of 103 current case managers and supervisors answered this question. Case managers were asked about their own current caseload. Supervisors were asked about the average caseload of case managers they currently supervise.

[99] 33 of 38 current supervisors answered this question.

- Since the reorganization became effective (since April 2008), 79.2 percent of case managers[100] have participated in evaluating "self-assessed" home-delivered meals clients.
- Of those case managers who have participated in evaluating "self-assessed" home-delivered meals clients,[101] 72.2 percent believe that these additional evaluations make it impossible to meet all of DFTA's standards and deadlines.
- Sixty-two percent of case managers[102] believe that the need to give home-delivered meals clients who request meals for more than five days a comprehensive case management assessment has contributed to longer wait times for assessments.

"There is more work to do than there are hours in the work week. I find myself taking work home, not taking my lunch break and still not finding enough time to finish it all."

Since the reorganization, the average caseload for supervisors has increased from 401 to 456 cases, far higher than DFTA's target caseload of 325. In addition, 46 percent of current supervisors also directly manage clients in addition to their supervisor role.

- Prior to the reorganization, the average number of case managers overseen by each supervisor [103] was 5.7 case managers per supervisor, with an average total of 401.2 cases[104] overseen.
- Currently, the average number of case managers overseen by each supervisor[105] is 6.1 case managers per supervisor, with an average total of 456.4 cases[106] overseen.
- Forty-six percent of supervisors[107] directly manage clients in addition to their supervisor role. Among those respondents,[108] the average number of clients directly supervised is 18.

"As a highly motivated and dedicated MSW Case Management Supervisor with several years of Case Management experience, and excellent organizational, managerial, and time management skills, I find that, even though I put in an average of 50-55 hours per week (I'm only paid for 35), it is still impossible to come even remotely close to doing the entire job. Between my own home visits, writing up assessments, case noting, Worker Log, supervising, reviewing cases, office/phone coverage, clerical tasks (we have NO clerical or administrative help), orientation, teaching, training, coaching, overseeing, following up (and helping staff follow-up) on DOZENS of No-Answers, emergency/problem situations, referrals, collateral contacts, coordinating with providers, fielding complaints for home-delivered meals, fielding HUGE NUMBERS of complaints for home care services, DFTA and agency-required paperwork, meeting (or trying to meet) the myriad 'nit-picky' DFTA and agency regulations and 'deadlines,' there are days when I literally have no time to eat."

[100] 48 of 65 current case managers answered this question.
[101] 36 of 38 current case managers who said they had participated in evaluating "self-assessed" clients answered this question.
[102] 47 or 65 current case managers answered this question.
[103] 16 of 18 veteran supervisors answered this question.
[104] The average total number of cases overseen prior to the reorganization was calculated by multiplying the average number of case managers per supervisor prior to the reorganization (5.69) with the average number of cases handled by case managers prior to the reorganization (65.87) plus the average number of cases directly handled by supervisors prior to the reorganization (26.43).
[105] 32 of 38 current supervisors answered this question.
[106] 33 of 38 current supervisors answered this question.
[107] 37 of 38 current supervisors answered this question.
[108] 17 of 17 current supervisors who answered that they also managed clients directly answered this question.

- Nearly two thirds (62.1 percent) of supervisors[109] do not consider DFTA's standard of 325 cases (5 case managers with 65 cases each) per supervisor a manageable caseload.

Case Management Capacity

Since the reorganization, the majority of supervisors report an increase in new requests for services.

- Sixty-three percent of veteran supervisors[110] say that intake volume has increased since the reorganization. Six percent say the intake volume has stayed the same, and 31.3 percent say the intake volume has decreased.

Since the reorganization, homebound seniors' average wait time from intake to initial assessment has increased by one week to a total of five weeks.

- Prior to the reorganization, homebound clients waited an average of 4.1 weeks from intake to assessment.[111]
- Currently, homebound clients wait an average of 5.0 weeks from intake to assessment. [112]
- Due to additional the wait time for assessments, homebound clients currently wait an average total of 6.2 weeks from initial request to receiving regular home-delivered meals [113] and 6.9 weeks for kosher home-delivered meals. [114]

Since the reorganization, homebound seniors' average waiting time from initial assessment to receiving assistance with travel to medical appointments has more than doubled.

- Prior to the reorganization, homebound clients waited an average of 2.4 weeks from assessment to receiving assistance with travel to medical appointments from the Access-A-Ride program or community-based programs. [115]
- Currently, homebound clients wait an average of 5.2 weeks from assessment to receiving assistance with travel to medical appointments from the Access-A-Ride program or community-based programs. [116]

Since the reorganization, staff turnover among case managers has significantly increased.

- Sixty-three percent of veteran supervisors[117] say that case manager turnover has increased since the

[109] 29 of 38 current supervisors answered this question.
[110] 16 of 18 veteran supervisors answered this question.
[111] 16 of 18 veteran supervisors answered this question. The question was only asked of supervisors because supervisors are responsible for assigning clients to case managers in the period between intake and initial assessment.
[112] 25 of 38 current supervisors w answered this question.
[113] 73 of 103 current case managers and supervisors answered this question.
[114] 72 of 103 current case managers and supervisors answered this question.
[115] 29 of 43 veteran case managers and veteran supervisors answered this question.
[116] 68 of 103 current case managers and supervisors answered this question.

reorganization. Thirty-one percent say it has stayed the same, and only 6.3 percent say that it has decreased.

- Thirty-eight percent of veteran supervisors[118] say that supervisor turnover has increased since the reorganization. Fifty-six percent say it has stayed the same, and only 6.3 percent say that it has decreased.

"The direct result of all this is that even the best case management staff are leaving in droves, and those who stay are understandably disgusted and burned out, which in turn causes a truly dangerous situation for our very frail and vulnerable clients. It is only a matter of time before something tragic occurs."

Since the reorganization, problems related to DFTA's data processing system have continued despite frequent complaints to DFTA from case management staff.

- Ninety-four percent of veteran supervisors[119] say that, since the reorganization, data problems related to DFTA technology increased or stayed the same. Only six percent of respondents said problems decreased.

"The information data system (PDS) can seriously delay referrals and information collection because of its constant glitches and erasing of previously inputted information. I am storing information in a word document and then transferring into PDS which doubles the work load. Then the information will store one way and print another."

Case Management Quality

The majority of veteran case management staff does not believe that the reorganization has improved the quality of case management services.

- Seventy-four percent of veteran case managers and supervisors[120] either disagree (35 percent) or neither agree nor disagree (39 percent) that it is easier since the reorganization for seniors to access linguistically and culturally appropriate services. Only twenty-six percent of respondents agree.
- Seventy-four percent of veteran case managers and supervisors[121] either disagree (26 percent) or neither agree nor disagree (48 percent) that it is easier since the reorganization for seniors to access preventive case management (i.e. proactive, comprehensive service plans rather than crisis-driven interventions). Only twenty-six percent of respondents agree.

"The needs of the clients are becoming greater and greater due to the economy. Due to the heavy case loads the time spent with each client is less frequent and it is impossible to really assist clients completely and thoroughly."

- Sixty-four percent of veteran case manager and supervisors[122] disagree (26 percent) or neither agree nor disagree (39 percent) that it is easier since the reorganization to connect seniors with resources in their community. Only thirty-six percent of respondents agree.

---

[117] 16 of 18 veteran supervisors answered this question.
[118] 16 of 18 veteran supervisors answered this question
[119] 16 of 18 veteran supervisors answered this question.
[120] 31 of 43 veteran case managers and supervisors answered this question.
[121] 31 of 43 veteran case managers and supervisors answered this question.
[122] 31 of 43 veteran case managers and supervisors answered this question.

More than three quarters of current case managers are not able to reach out to seniors in the community to encourage aging in place.

- Seventy-seven percent of respondents[123] say they currently do not have the time and/or contacts in the community to proactively identify older adults most at risk for nursing home placement, such as frequent visitors to the ER.

Since the reorganization, the percentage of case managers who always or frequently have to reduce or delay client services and other responsibilities to cope with their workload has risen significantly.

- Since the reorganization, the percentage of respondents[124] who always or frequently have to shorten the time spent with clients during visits has increased from 5.9 percent to 25 percent.
- Since the reorganization, the percentage of respondents[125] who always or frequently have to reduce the frequency of visits or delay visits to long-term clients has increased from 12.5 percent to 16.7 percent.
- Since the reorganization, the percentage of respondents[126] who always or frequently have to delay entering case notes into the Provider Data System (PDS) has increased from 5.9 percent to 14.6 percent.
- Since the reorganization, the percentage of respondents[127] who always or frequently have to delay follow-up, such as writing a care plan or filling out benefit/entitlement applications after an assessment has increased from 0 to 16.7 percent.
- Since the reorganization, the percentage of respondents[128] who always or frequently have to reduce the time spent carrying out care plans, such as linking clients to specific services or monitoring service delivery has increased from 0 to 12.5 percent.
- Since the reorganization, the percentage of respondents[129] who always or frequently have to reduce the time spent helping clients with complex problems, such as mental health or housing issues has increased from 0 to 18.8 percent.
- Since the reorganization, the percentage of respondents[130] who always or frequently have to reduce case consultations with other professionals (physicians,

[123] 47 of 65 current case managers answered this question.
[124] 17 of 25 veteran case managers answered this question for the time period prior to the reorganization; 48 of 65 current case managers who took the survey answered this question for the present.
[125] 16 of 25 veteran case managers answered this question for the time period prior to the reorganization; 48 of 65 current case managers answered this question for the present.
[126] 17 of 25 veteran case managers answered this question for the time period prior to the reorganization; 48 of 65 current case managers answered this question for the present.
[127] 17 of 25 veteran case managers answered this question for the time period prior to the reorganization; 48 of 65 current case managers answered this question for the present.
[128] 17 of 25 veteran case managers answered this question for the time period prior to the reorganization; 48 of 65 current case managers answered this question for the present.
[129] 17 of 25 veteran case managers answered this question for the time period prior to the reorganization; 48 of 65 current case managers answered this question for the present.
[130] 17 of 25 veteran case managers answered this question for the time period prior to the reorganization; 48 of 65 current case managers answered this question for the present.

mental health workers, attorneys) or caregivers has increased from 0 to 20.8 percent.

RECOMMENDATIONS

In addition to the recent efforts made by DFTA to evaluate agencies' caseloads and redistribute funding so that allotments more closely match contract agencies' actual caseloads, the Public Advocate makes the following recommendations to increase the case management system's capacity and improve the quality of its services.

The New York State Office for the Aging Should:

Consider New Funding Sources Such as an Income Tax Check-Off for the Expanded In-home Services for the Elderly Program (EISEP)
In a national survey, the vast majority of seniors said that they preferred to "age in place," that is to remain in their homes and live as independently as possible in a familiar community. Moreover, home care services are less costly for government payers than institutionalized care. However, EISEP, which provides home care services to New York seniors, is not an entitlement program, and its services are determined by budget appropriations rather than need.

Homebound seniors should not have to wait for home care services because EISEP lacks funding for sufficient numbers of case managers to assess clients. Securing additional funding for core senior services such as case management and home care should be a priority of all levels of government. Advocates have suggested that New York State consider an option on its income tax form that would allow taxpayers to designate a contribution specifically for senior services.

The New York City Department for the Aging Should:

Reduce Caseloads by:

Funding Agencies to a Level that Ensures Their Ability to Hire Sufficient Case Managers and Supervisors
The Public Advocate's survey shows that current caseloads are approaching 70 cases per case manager—exceeding DFTA's own standard. This average caseload is a conservative measure because it does not take into account seniors who are currently on wait lists for assessment. According to informal interviews with case management supervisors, some agencies have chosen to maintain standard caseloads in favor of longer waiting lists. Without additional funding, it is not clear how DFTA proposes to lower average caseloads.

"In order to prevent dangerous and potentially TRAGIC circumstances from happening to our most vulnerable citizens, the city MUST: add enough case managers to ensure that caseloads are NO MORE than 60-65 per Case Manager."

Determining a Lower Standard Caseload, Including a Case Mix Variable for Clients Requiring Frequent Visits or Complex Service Arrangements.
While actual client numbers and caseloads have exceeded DFTA's estimates, the funding it provides its contract agencies is based on a formula of one case manager for every 65 clients. The majority of survey respondents disagrees with DFTA's assessment that 65 cases is a manageable caseload for case managers and supervisors, who are expected to oversee five case managers each. Responses to the Public Advocate's survey suggest that a standard of 65 cases per case manager is too high to provide comprehensive quality case management for frail seniors with complex service needs.

In order to both lower caseloads and increase the quality of case management, DFTA should base funding levels on lower standard caseloads. According to National Association of Social Workers' standards for social work case management, "caseload standards should be based on "the breadth and complexity of client problems or services, and the length and duration of case mix."[131]

"In order to establish a helping relationship with clients, completely screen them for all eligible entitlements and benefits, follow up with client concerns regarding many different issues, connect with client's family or support system, make timely home visits and frequent contact with clients and maintain appropriate paperwork while meeting deadlines, case workers would require less than 65 cases. A more manageable number in order for case workers to complete their duties would be 58."

In determining a more manageable standard for case managers, DFTA should consider a case manager's case mix, including the number of new clients and the number of clients requiring frequent visits and/or complex service arrangements, for example for financial management, mental health services, or assistance with housing issues. DFTA also needs to ensure that its caseload standard is low enough to allow supervisors to provide appropriate oversight, in addition to their management and training responsibilities.

Improve Case Management Capacity by:

Transitioning the Current Provider Data System (PDS) to A Secure, Web-based System that Allows Remote and User-Friendly Entry and Exchange of Client Data
Case managers and supervisors at various agencies reported that record-keeping requirements are overwhelming in large part due to redundancies in data entry requirements in PDS and frequent system glitches that delay entry and erase information. Given the increase in requests for services and DFTA's emphasis on performance evaluation, a secure, interactive, and reliable system is essential to improving case management services. Fixing system glitches and building capacity should precede any further reorganization of services.

"PDS data entry is a cumbersome process. The PDS has many repetitive fields that waste valuable time where I could be assisting clients. For example, "Health Conditions," "Current Problems" – both areas require that you list exactly the same thing!"

"The city should fix the PDS system or use a different system to input information."

[131] National Association of Social Workers, *NASW Standards for Social Work Case Management*, June 1992, See: http://www.socialworkers.org/practice/standards/sw_case_mgmt.asp#9

Improve Case Management Quality by:

Providing Case Managers with Better Access to Benefits and Entitlements Resources by Expanding Training Opportunities and Creating a Case Management Website

In the open-ended section of the survey, a number of case managers reported that they are not prepared to provide sound benefit and entitlement counseling and that existing trainings are often inaccessible to them. DFTA should provide standard Medicaid and city benefit training for all case management staff as well as regular updates and create a website for case management staff that would allow password-protected access to DFTA announcements, forms, changes in policy and resources for case managers.[132]

"I also feel that case managers should be trained in Medicaid and city benefits in a more effective manner other than our individual agency's trying to get someone to come in and 'brief' us on entitlements and benefits."

Providing Logistical Support and Incentives to Increase Outreach Efforts to Identify At-Risk Seniors

Increasing outreach efforts by case management agencies to identify seniors at risk of nursing home placement has been a stated goal of DFTA's reorganization. However, the increase in caseloads has had the opposite effect, leaving case managers scarcely enough time and resources to deal with existing clients, let alone reach out to additional seniors in need of services. DFTA should provide logistical support and financial incentives for case management agencies' efforts to cooperate with hospital and nursing home personnel in identifying seniors in need of support services after discharge.

[132] A survey respondent suggested that DFTA could explore the Community Service Society's subscription based "PBRC Manual" as a model. See: http://pbrcmanual.cssny.org/.

UPDATE

On Tuesday, September 29, 2009, the City Council's Committee on Aging held a hearing to update council members and the public on the state of DFTA's redesigned case management program.

Commissioner Paoli restated the goals of the reorganization as "designating the case manager as the gatekeeper for all of the Department's in-home services; providing more holistic assessments of client need in order to link clients to a broader-range of benefits and services; establishing distinct service areas with clearer boundaries; and creating a stronger link between the case management and home delivered meals systems." [133]

When DFTA announced its plan to redesign case management in 2007, it argued that it needed to consolidate resources and service areas "in anticipation of growing case management needs."[134] Its RFP for the redesign released later that year estimated that the system would serve 18,729 clients. According to DFTA's most recent client data, this estimate has proved roughly accurate. As of September, 2009, approximately 18 months after the start of the redesign, DFTA-funded case management agencies were serving 19,216 clients citywide.[135] This number is only slightly higher (487 clients, or, on average, 21 additional clients per agency) than the number estimated in the RFP.[136]

In late July and early August of 2009, case management staff responding to the Public Advocate's survey reported an average caseload of 69 clients per case manager with a maximum caseload of 125. In its September 29th testimony, DFTA reported a similar current average caseload—72 clients per case manager—but a much lower maximum caseload of 88.[137]

DFTA acknowledged "challenges in the period after the transition," including "waitlists due to higher than anticipated caseloads." DFTA attributed the problems to "issues with capturing accurate data and a higher than anticipated demand for case management

---

[133] DFTA Commissioner Lilliam Barrios-Paoli, "An Update to the Modernization of DFTA's Case Management Services," Testimony before the NYC City Council Committee on Aging, September 29, 2009, p.1-2.

[134] DFTA, *Concept Paper for the Provision of Case Management Services to the Elderly*, May 25, 2007, p.1.

[135] DFTA Commissioner Barrios-Paoli, Testimony, Sept. 29, 2009, p.1.

[136] The Case Management RFP (Appendix A) estimated 18,729 clients. (As per Section II – Summary of RFP: 14,000 current clients plus 4,000 home-delivered meals clients). See: DFTA, Request for Proposal for Case Management Programs for Older Adults, October 12, 2007.

[137] DFTA also testified that the average caseload prior to the reorganization was 85 with a maximum case load of 106. However, DFTA did not indicate when caseloads were recorded. The average caseload of veteran case management staff responding to the Public Advocate's survey prior to January 2008 was 66 with a maximum caseload of 95. This result closely matches information published by CSCS in 2007. According to CSCS, caseloads had dropped from an average of 90 to an average of 65 in the year prior to the reorganization in response to increased state funding for the EISEP program. See: Council of Senior Centers and Services of New York City, Inc., "*Community-Based Case Management. Policy and Practice*, May 11, 2007, p.3. See: http://www.cscs-ny.org/actionalerts/casemanagement07.shtml

services in their geographic region," as well as a backlog resulting from the need to assess all home-delivered meal clients. DFTA stated that the agency considered the backlog "to be temporary in nature."[138]

DFTA reported that the agency evaluated existing caseloads after "caseloads had stabilized and the contracts had now been in place for some time"[139] The agency found that "a few providers continued to carry higher than anticipated caseloads" and that "both caseload sizes and funding per client varied significantly among our providers across the system."[140]

In response to the evaluation, DFTA decided to "fine-tune the amount of funding received by each provider based on community need."[141] Using two indicators, the "average caseload of providers" and "the dollar resources allocated to particular regions relative to the number of people living below 150 percent of the poverty level," DFTA reduced funding for two case management agencies and shifted the resources to five others.[142] DFTA suggests that the reallocation, or "right-sizing," will allow agencies to hire additional staff and reduce their caseloads.

This reallocation of resources, however, does not take new client volume into account. Moreover, by taking resources away from some agencies in order to correct problems at others, DFTA may be forcing these agencies to increase caseloads or wait times themselves or, alternatively, to maintain their current level of service without appropriate reimbursement. Without additional funding, it is unclear how DFTA can address the fact that the average caseload system-wide is higher than what providers have collectively contracted for.

In its September 29th testimony, DFTA also announced an additional fundamental change in the system. Effective as of the 29th, DFTA authorized home-delivered meals providers, including subcontractors, to conduct intake, determine meal eligibility, and authorize meal service for 120 days without referral to case management organizations—unless the client has an apparent emergency need for case management services.[143] In other words, clients would now be able to receive home-delivered meal service before receiving a full case management assessment—a policy similar to the system of "self-assessment" that existed before the reorganization. Once the 120 days have passed, home-delivered meals clients must be referred to case management agencies, which must give them a case management assessment within 10 days.

---

[138] DFTA Commissioner Barrios-Paoli, Testimony, Sept. 29, 2009, p.2.
[139] Paoli, DFTA Commissioner Barrios-Paoli, Testimony, Sept. 29, 2009 p.3.
[140] DFTA Commissioner Barrios-Paoli, Testimony, Sept. 29, 2009, p.3. It should be noted that variation in funding per client was built into DFTA's original contract awards. The dollar per client ratio (based on estimated client numbers) varied from $1,306.41 to $1,035.79 per client, depending on the contract. Reimbursement for one unit of service varied from $36.85 to $61.59 per unit, depending on the contract
[141] DFTA Commissioner Barrios-Paoli, Testimony, Sept. 29, 2009, p.3.
[142] DFTA Commissioner Barrios-Paoli, Testimony, Sept. 29, 2009, p.3.
[143] Memo from Commissioner Barrios-Paoli to Home Delivered Meal Providers and Case Management Agencies on Home Delivered Meal Authorization, Dated September 28, 2009.

According to Commissioner Barrios-Paoli, this action was taken primarily in order to help home-delivered meal providers meet their contract targets and thus avoid financial penalties written into their contracts. More importantly, however, it allows seniors to receive meals while waiting to be assessed for additional services. Seniors who need home-delivered meals only for a temporary period of time should be able to do so without relying on the overburdened case management system.

Taking requests for home-delivered meals off the plate of case management agencies may also temporarily ease wait times for case management assessments and services. However, all home-delivered meals clients will still eventually become the responsibility of case management agencies. Moreover, allowing seniors to receive home-delivered meals without getting a full assessment first may encourage more requests for meals and ultimately increase the number of assessments. Therefore, it is possible that in the long-term the new policy will actually increase the burden on case management agencies, particularly those that have experienced budget cuts and those that already struggle with large caseloads and wait lists. In some areas, home-delivered meals providers' maximum client capacity may exceed case management agencies' maximum client capacity.

While the Office of the Public Advocate applauds DFTA for taking steps to ensure that seniors gets the services they need in as timely a manner as possible, it remains concerned that resources in the case management system are insufficient to provide all clients with timely, high-quality services and increase capacity for the future. The fact that clients face longer average wait times to receive services than before the redesign suggests that the city may need to rethink its strategy for meeting the needs of its growing and diversifying senior population.