NYC Senior Centers: Visioning the Future

2010

Table of Contents

Introduction

Background

Since the founding of the nation's first senior center in 1943 in the Bronx, senior centers in New York City have evolved into a complex and varied system that includes 281 full-time centers and 20 part-time centers offering a range of programs. Many of NYC's older adults rely on the centers and other aspects of the City's network of aging services and social service programs for their basic needs, to maintain their health and independence, and to mitigate the effects of social isolation. While many older New Yorkers enjoy and rely on senior centers, many others are either unaware of what they have to offer, choose not to participate or are unable participate. Moreover, research increasingly suggests that today and tomorrow's seniors may have different expectations and needs than those that guided the development of the current system.

Working to creatively build on the strengths of the existing system is especially difficult during times of fiscal constraint. However, the New York City Department for the Aging (DFTA) has repeatedly expressed a commitment to working with providers and other stakeholders to enhance the system to address services gaps, improve the integration of multiple services, and better meet the needs of New York's growing population of older adults. In 2009, the Mayor announced his commitment to secure new public and private funding for innovation grants for up to 50 senior centers. This, along with ongoing interest in improving the existing service network, provided an opportunity to investigate how New York's system of senior centers could better meet the needs of older New Yorkers.

In 2009, DFTA, under the leadership of Commissioner Lilliam Barrios-Paoli, began a broadly based consultative process to study the needs of New York City's older adults and the senior centers that serve them. At the request of DFTA and with funding from The New York Community Trust, The New York Academy of Medicine (NYAM) helped coordinate and facilitate this effort. Founded in 1847, NYAM has a long history as a neutral convener of stakeholders and in providing a solid, evidence-base for policy and programmatic decisions. As such, NYAM was uniquely positioned to solicit input from a range of stakeholders and service providers and to collect and analyze data on need, available resources, as well as innovative models of delivering senior services. This report is the end product of that effort.

In reading this report, it is important to understand that it is not a comprehensive needs assessment of older adults in NYC, nor is it an evaluation of the current system. Instead, it is based on the following underlying premises:

- Senior centers are a lynchpin of aging services in NYC
- There is strong support for senior centers, and they should continue
- Like many urban residents, older New Yorkers are often very neighborhood-focused and prefer to spend most of their time in the immediate vicinity of their homes

- Neighborhoods in NYC and the people who live within them are highly differentiated with a range of populations, needs and resources
- Neighborhood centers can and should be the foundation of aging services
- Stakeholders, senior center directors, older adults and others have consistently acknowledged that resources for senior centers are currently inadequate
- In this constrained environment, it is even more important to prioritize and to build networks – linking to other centers and to other resources

Within these premises, we examine how current centers can be improved to better meet the needs of older adults they are currently serving and how they can be improved to attract and address the needs of other older adults. Only a fraction of older adults use senior centers (exact estimates vary), and evidence to be presented below suggests others would benefit from them. Since the Mayor has pledged new resources for innovation and new senior center models, this report identifies what the needs of older adults are and ways in which these resources may be best used to address those needs.

There are several questions this report aims to address that were raised throughout the consultative process:

- What are the needs of older adults in NYC?
- How are those needs met by existing resources outside of senior centers?
- How do current senior centers address these needs?
- What is the evidence of senior center effectiveness in meeting those needs?
- Are there changes that would help senior centers address needs better?

To answer these questions, this report begins with a description of older New Yorkers and their needs, including the needs of special populations. One strong theme that emerged from our conversations with stakeholders was the need for senior centers to better integrate and link to existing aging services and to the rich resources of the City. We next provide a brief overview of other resources upon which older New Yorkers can draw. We then discuss the core functions of senior centers that were identified through our review of the literature and refined by our meetings with stakeholders. Drawing on our research on innovative models of senior centers, we provide several examples of creative strategies for meeting those core functions. We conclude with a synthesis of our key findings and their implications for the NYC senior center network.

A number of organizations concurrently examined issues of senior centers, their staffs, and their participants from their own perspectives (or those of their members), and they have generously shared their findings with NYAM. This report synthesizes the data from these and other sources, as described below. We are particularly indebted to the Brookdale Center for Healthy Aging and Longevity, the Council of Senior Center Services, , the New York City Department of Health and Mental Hygiene, the Planning Unit at the Department for the Aging as well as all of the stakeholders, senior center directors and older adults who graciously shared their time, ideas, and opinions.

Data Collection Methods & Sources:

Review of the Literature

NYAM staff conducted review of the literature to identify information about the needs of older New Yorkers and effective senior center models and programs. This review included searches of the peer-reviewed literature across several disciplines, including gerontology, health, public health, and sociology. In addition, we conducted a search of the grey literature (publications, like white paper and reports, not controlled by commercial publishers).

Review of Model Senior Centers

In addition to identifying model senior center programs through our review of the literature, we also did extensive online, in-person, and phone research to find innovative models of senior center programs in New York, elsewhere in the United States, and around the world. We began with existing reviews of senior centers, such as the National Institute on Senior Centers' New Models of Senior Centers Task Force Report and a report by the California Commission on Aging. We identified other models by reviewing conference abstracts from national and international aging meetings and through networks of aging experts. Our goal for this report was to incorporate examples of programs which had good evidence of effectiveness and/or which were particularly creative and relevant in how they addressed needs and problems of NYC older adults and senior centers.

Consultations with Key Stakeholders

To ensure that the needs, ideas, and concerns of stakeholders were taken into account, NYAM and DFTA convened a group of approximately 70 aging service providers, policy makers and experts. This group met four times over several months; membership included advocacy groups, service providers, policy makers, representatives from other city agencies, philanthropists, researchers, and older adults. The group was deliberately composed to include multiple sectors, including people currently involved in senior centers as well as those who have never worked with them. NYAM and DFTA provided some background information and data to the group, but the meetings were focused primarily on learning from the stakeholders their concerns about and their vision for the future of NYC senior centers. In addition to the large group meetings, staff from NYAM had several individual meetings and solicited and reviewed written comments from a number of specific stakeholders.

Consultations with Senior Center Directors

The DFTA arranged a series of five meetings—one in each borough—with the directors of existing senior centers. Meetings were attended by Commissioner Barrios-Paoli, elected officials and several dozen directors, who led the direction of the conversation and openly shared their concerns. NYAM staff attended each of these meetings and took extensive notes on the issues and concerns voiced by this important constituency.

In addition, the Council of Senior Center Services (CSCS) conducted a survey of 155 senior center directors and provided the findings from that survey to NYAM. The survey was printed and faxed or mailed to the more than 200 senior center members of CSCS. Additionally, the survey was posted on Survey Monkey and requests for participation were mailed via email to all members of CSCS. Of the 155 senior center directors and administrators contacted, 94 returned paper surveys and 61 completed themonline. CSCS also conducted a focus group with senior center directors and administrators. More information about the CSCS study is available at www.cscs-ny.org.

Age-friendly New York City

In 2007 and 2008, NYAM conducted a comprehensive assessment about how well the City was meeting the needs of older New Yorkers. This assessment, included a series of consultations with experts, but was primarily focused on hearing from older New Yorkers themselves. Through a series of community forums, focus groups, and individual interviews, NYAM consulted with more than 1500 older New Yorkers. The results of this assessment were published in the Fall of 2008 in *Toward an Age-friendly New York City: A Findings Report*. For this current report, we went back to our primary data from that project and analyzed specific comments about the senior center network and about the kinds of services and programs that older New Yorkers want that could potentially be provided by senior centers.

The Council of Senior Centers and Services (CSCS) Survey and Focus Groups

In addition to its survey of senior center directors, CSCS conducted a survey of 3,663 seniors. The survey was made available in English, Spanish, Cantonese, Mandarin and Korean. These surveys were printed and distributed to participants at over 200 senior centers in New York City. Extensive effort was made to circulate the survey among older adults who do not attend centers, including working with several partners to conduct outreach and posting it online. Of the respondents, 3,249 attended senior centers and 414 did not. This survey, while not a representative sample[1], provides important and unprecedented insight into the kinds of services and programs that seniors enjoy and would like to see more of. It also provides important information about some of the barriers to participating in senior center activities. CSCS also conducted eight focus groups with older adults. Four focus groups were held with senior center participants (Caucasian, Asian, African American and Hispanic older adults respectively); three focus groups were held with non-senior center participants (Asian Indian, Hispanic and Caucasian older adults respectively); and one focus group was held with non senior center participating gay, bisexual and lesbian older adults. More information about the CSCS methods and a copy of the report are available at www.cscs-ny.org.

[1] A representative sample is a research term for a sample population that was chosen because it accurately reflects the characteristics of the population as a whole. A non-representative sample still provides powerful information, but results cannot be generalized to an entire population. CSCS's study is not representative but it is the largest study we are aware of involving senior center users and non users in NYC.

The Brookdale Health Indicators Project (HIP)

The Brookdale Center for Healthy Aging and Longevity (Brookdale), in collaboration with the New York City Department for the Aging, developed and conducted a health status survey of a sample of 483 seniors designed to be representative of all senior center users. The primary objective of this study was to investigate the health status, including functional status, mental and physical health status and co-morbidities, utilization patterns, and behaviors of older adults attending New York City senior centers. Validated measures and instruments were incorporated into a face-to-face interview. It also has helpful demographic, social isolation and social support information. More information about the Brookdale study is available at www.brookdale.org.

The New York City Department for the Aging (DFTA) Survey

DFTA created a survey concerning the nature of seniors' participation in centers and the importance of different services and activities to them. The sample was constructed to reflect the demographics of older adults in senior centers citywide and to ensure that the sample paralleled the overall network of centers in terms of borough distribution and of large versus small centers. DFTA program officers administered the survey to older adults who were at each selected center on the day of data collection. The final sample included 2,375 users in 33 senior centers, and the demographics of respondents are representative of senior center users at the city wide level.

The New York City Department of Health and Mental Hygiene (NYCDOHMH) data

NYCDOHMH collects a wide array of data on health-related topics. For this report, we drew upon three different data sets: 1) the Community Health Survey (CHS), a representative sample of all New York City residents; 2) the record of vital statistics; and 3) the Statewide Planning and Research Cooperative System (SPARCS) data , which collects information on all discharges from hospitals, including patient characteristics, diagnoses and treatments, services, and charges for every hospital discharge, ambulatory surgery patient, and emergency department admission in New York State. These data were used to indicate unmet need for primary health services, using an adaptation of the "ambulatory care sensitive conditions" construct developed by John Billings for adults of all ages and in wide use for this purpose in NYC and New York State (See for example, Billings *et al.*, 1996).

American Community Survey (ACS)

For this report, DFTA prepared an analysis of the American Community Survey 2005-2007 3-year estimates with breakdowns by borough and by NYC's community districts. The American Community Survey, which is conducted by the U.S. Census Bureau, is a representative sample of the entire population. These data included demographic information, income, immigration status, race/ethnicity, education, and primary languages spoken.

Description of older adults in New York City

Demographics[2, 3]

New York City's older population is growing and growing older. More than 1.3 million people, or 16% of New York City's inhabitants, are currently over 60 years old. It is expected that by 2030, this age group will increase by nearly 500,000 to 1.8 million people, out numbering school-aged children for the first time in history.

Older adults are distributed similarly to the overall population throughout the city, with Queens and Brooklyn, the city's most populous boroughs, each having approximately 30% of NYC's seniors. Manhattan, the next largest borough, has 20% of the city's seniors, the Bronx has 14%, and Staten Island has just 6%. Older adults are, however, clustered in particular neighborhoods within boroughs (See Table 1 "Basic Demographics" and Map 1 - "Number of Adults Age 65 and Over by Census Tract, NYC").

Like the city as a whole, New York's older adults are a diverse group. They speak an estimated 170 languages, and 44% are foreign born. While the vast majority of those who were born in another country (93.5%) have lived in the United States for more than 10 years, only 56% of all NYC's seniors report using English as their primary language. Nineteen percent speak primarily Spanish. Five percent use Chinese, 4% use Russian, and 4% Italian. French Creole, French, and Greek, along with a multitude of other languages, make up the balance.

Many of NYC's immigrant populations are gathered into small pockets throughout the city. Of all the Chinese language speakers aged 60 and over living in New York City (nearly 61,000), 18.5% live in Manhattan Community District 3 (Chinatown/Lower East Side), and 11.5% live in Queens Community District 7 (Flushing/ Willets Point). Nine point one percent of all Spanish speakers aged 60 and over[4] live in Manhattan Community District 12 (Washington Heights/Inwood). Twenty-seven percent of all Russian speakers aged 60 and over live in Brooklyn Community District 13 (Coney Island/Brighton Beach). Seventeen point two percent of French Creole speakers in the City live in Brooklyn Community District 18, which includes Canarsie, Flatlands and Marine Park.

Another way to examine distribution is to see whether a language other than English dominates a neighborhood, and this is sometimes the case. For example, 21.2% of all elders living in Brooklyn Community District 11 (Bensonhurst) speak Italian—17.0% of aged

---

[2] Except as noted otherwise, the source of all data in this section is DFTA's analysis of the 2005-2007 American Community Survey (ACS) 3-year estimates.

[3] "Older adults" refers to people over the age of 60 when data comes from the ACS and in general in this report, because it is the age DFTA uses to determine eligibility for senior centers. Several other data sources use the age 65 as a cut-off point, as that is the age when people become eligible for federal benefits like Medicare and Social Security.

[4] ACS data put the total of those aged 60 and over in New York City who use Spanish as their language in the home at nearly 250,000.

Italian-speakers citywide—and 11.9% of Bronx Community District 11's (Pelham Parkway and Morris Park) elders speak Italian. Some neighborhoods are dominated by Spanish: 62.5% of all those aged 60 and up in Brooklyn Community District 4 (Bushwick) speak Spanish, and 77.8% of elders in Bronx Community Districts 1 & 2 (South Bronx) speak Spanish in their homes. Brooklyn Community District 8 (Crown Heights/Prospect Heights) is the city's Community District with the highest percentage of English-speakers in its population aged 60 and up: 86.4%. This means that even in this district, 13.6% of the older population uses a language other than English in the home. Speaking a primary language other than English does not necessarily mean that English language proficiency is poor, but it can indicate where ethnic enclaves are located and where there might be large groups of older adults who share a culture. (See Map 2 – "Percent of NYC Population Aged 60 and up Who Do Not Speak English Well by Community Districts")[5]

Across the city, about 46% of those aged 60 and over identify as white. Twenty-one point one percent identify as black; 19.5% identify as Hispanic; and 9.1% identify as Asian/Pacific Islander. Older adults of these self-identified racial groups are clustered in certain boroughs and neighborhoods across the city. Of the city's senior population who identify as black, Brooklyn has 41.8%; Queens has 24.9%; the Bronx 18.7%; Manhattan 13.4%; and Staten Island 1.2%. Of those who identify as Hispanic, the Bronx, Brooklyn, Manhattan and Queens share relatively equal percentages. Of those who identify as white, almost 34% live in Brooklyn, while just 8% live in the Bronx. And while the Bronx has just 5.1% of those who identify as Asian/Pacific Islander, Queens has 48.1% of New York City's seniors who identify with that group. Brooklyn Community District 16 (Brownsville) and four community districts in the Bronx hold a percentage of whites so small that it is statistically zero percent.

As far as religious adherence, according to the Association of Statisticians of American Religious Bodies (ASARB), NYC counties are more religious than any other in the state, supporting what senior participants in the Age-friendly assessment said, that religion is an important social support, value system and promoter of health as people age. Staten Island, the least populous borough, was the most religious with 75% of the total population participating in a religious congregation. Manhattan followed with 70%, Brooklyn with 64%, the Bronx with 56% and Queens with 48%. These numbers do not include historically African American denominations, and the study leaders estimate that numbers of congregants could be as much as 30% higher in Brooklyn and the Bronx when those churches are included, making those the most religious boroughs.[6] The numbers also do not include older adults who are spiritual or religious but do not participate in a congregation.

---

[5] Language(s) spoken in the home are questions in the American Community Survey.

[6] In 2000, the ASARB gathered information from 149 religious denominations to measure the number of congregations and the number of adherents in within their membership. Congregational "adherents" include all full members, their children, and others who regularly attend services or participate in the congregation.

To look at education levels, approximately one-third of New York seniors (36.5%) have some schooling beyond a high school diploma. Manhattan has one of the most educated senior populations in the country, with 40% holding a bachelor's degree, which is nearly double the national average. Despite this, stakeholders' accounts and statistics show that a large portion of the city's population of older adults does not understand basic written English instructions. According to the U.S. Department of Education, Queens has the lowest literacy rate in the city, with 46% of adults of all ages lacking basic prose English literacy skills. This is followed by the Bronx (41%), Brooklyn (37%), Manhattan (25%) and Staten Island (14%).[7] NYC's older adults have a range of work histories, which in turn affect their current income level and assets, their access to benefits, their lifestyle and interests, their social and community connections and their overall health. Some had careers spanning decades. Others worked jobs on and off or worked in the underground economy. Statewide, 17% of those age 65 and older continue to work at least part time. In the greater NYC area, 73% of older adults over 60 receive social security benefits, which is less than the 80% national average.[8] In the same region, only 37% receive private retirement income of some kind, also less than the 46% national average.

Stakeholders and senior center directors emphasized over and over that poverty among older adults is overwhelming in many of the city's neighborhoods and permeates even the wealthiest community districts. Statistics support stakeholders' observations. According to the ACS, nearly 18% of those aged 60 and over in the city live at or under the federal poverty line, which in 2009 was defined as $10,830 of annual income for a single-person. When the expenses and benefits particular to New York City are used to calculate poverty, the number of those aged 65 and over living in poverty becomes nearly 32%.[9]

Every community district has at least 2,000 older adults living in poverty, but the concentration of poverty ranges widely across the city's neighborhoods. Large concentrations of older adults living in poverty are particularly present in the Bronx, Brooklyn and Manhattan. The Greenpoint-Williamsburg area of Brooklyn has the highest percentage of older adults living in poverty in the city (63%). The eastern most community district of Queens, which includes Queens Village and borders Long Island, has the lowest percentage of older adults living in poverty (16%). (See Map 3 – "Total Age 65+ at 100% CEO Poverty by Community District")

---

[7] These percentages are strongly connected to the percentage of non-English language speakers living in each borough, but also include native English speakers who are illiterate as well as adults who speak a language other than English but are unable to read or write.

[8] The "greater NYC area" referred to in this report is the ACS NY-NJ Metropolitan District, which includes all New York City counties as well as Putnam, Westchester, Rockland, Bergen and Hudson counties—in short, the greater NYC area, excluding Long Island.

[9] The NYC CEO poverty calculations adjust for income from benefit programs such as Earned Income Tax Credit, food stamps, housing support; and subtracts for expenditures such as medical out-of-pocket expenses, food, clothing, shelter, utilities, tax liabilities as well as work-related expenditures, such as transportation costs and childcare. These are calculated at the rates paid in New York City rather than on national averages, taking into account local differences such as housing costs, and it uses ACS data in its calculation. In 2008, the CEO poverty line for a single-person household is $12,114.

Health and Mental Health Outcomes

As people age, they develop new and more severe health problems, and existing chronic health conditions often become more difficult to manage. Stakeholders said, and other data confirm, that the prevalence of severe health problems and chronic health conditions is also not evenly distributed throughout the city, with the burden falling on neighborhoods with the highest levels of poverty. Poverty is both an underlying cause and an effect of the disproportionate distribution of health problems and disabilities. Data indicate a high need for community-base prevention for older adults. According to the CHS, 38% of older New Yorkers are overweight and 22% are obese (See Map 4 - "Prevalence of Obesity Among Adults Age 65 and older"). In addition, 9.7% of older men and 8.2% of women smoke, and 65.9% of participants in the Brookdale HIP study said they never engage in at least moderate physical activities (See Map 5 – "Prevalence of Current Smokers Among Adults Age 65 and older"). All these behaviors are strongly associated with chronic health conditions, including heart disease, diabetes, cancer, and arthritis. In addition, the CHS found that 17% of older adults in NYC are socially isolated, which has been shown to be a risk for lower general health, mental health issues, and failure to get care for chronic conditions (See Map 6 – "Prevalence of Social Isolation Among Adults Age 65 and older"). Overall, 36% of those aged 60 and over living in the greater NYC area experience a disability of some kind. Twenty percent are frail—meaning they have difficulty caring for themselves or leaving their homes unaided.

Chronic Conditions

NYC's Community Health Survey (CHS) found 56% of those aged 65 and over have diagnosed hypertension, the major underlying cause of strokes and heart attacks.[10] The rate of diagnosed hypertension among blacks was 10 percentage points higher than any other ethnic group. Rates of diagnosed hypertension also vary widely between neighborhoods. For example, 39% have been diagnosed with hypertension in the Upper East Side and Gramercy as compared to 70% in the South Bronx, Northeast Bronx, Bed-Stuy-Crown Heights, and East New York (See Map 7 – "Hypertension by UHF Neighborhood, NYC").[11]

The CHS also found that 23% of seniors over age 65 have been diagnosed with diabetes, which is a significant portion of the population, but on par with the national average. Twenty-six percent of men are diagnosed as diabetic and 21% of women. Only 17% of

[10] These percentages are limited to diagnosed conditions self-reported in the CHS phone survey. They do not capture conditions likely to exist but that remain undiagnosed because of insufficient access to health and medical care. While Medicare and Medicaid give older adults greater access to health services than their younger cohorts, rates undiagnosed disease or insufficient access to or utilization of primary and preventive health care remains a problem, as evidenced by the data on preventable hospitalizations that follows.

[11] Different data sources use different geographic units to define neighborhoods. ACS uses NYC Community Districts. The health data included here is broken down, collected and analyzed using the United Hospital Fund (UHF)'s 42 neighborhoods, as shown in the maps in the Appendix.

those identified as white are diabetic, whereas 31% of blacks and 32% of Hispanics over 65 have been so diagnosed. Diabetes is also more prevalent in poorer communities. The Upper East Side and Gramercy, for example, report a diabetes rate of only 8%, but the South Bronx reports a diabetes diagnosis rate of 42% (See Map 8 – "Diabetes by UHF Neighborhood, NYC").

These high rates of chronic conditions are especially worrisome since data indicate that many older adults are not accessing primary care and preventive services. Citywide, CHS data show that nearly 12% of New York City's population aged 65 and older do not have a regular primary care provider, a key to preventative health care.[12] Twenty-six percent of Hispanics do not have one. CHS found that overall 6.1% of those aged 65 and older did not get needed medical care in the last 12 months. Additionally, those 65 and older experience a high rate of preventable hospitalizations. The statewide Planning and Research Cooperative System (SPARCS) data reveal that during 2006, total preventable hospitalizations in this population were 69,832, or 70.5 per 1000 seniors, with 1.15 women hospitalized for every man.[13]

Sensory Impairments

Vision loss is widespread in the aging population, but no population-based data on prevalence in NYC are available to the authors of this report. Most blind adults lose their sight during adulthood from disease, in particular age-related eye diseases such as glaucoma, cataracts, age-related macular degeneration and diabetic retinopathy. Partial, progressive vision loss, which affects far more people than blindness does, often also has a substantial impact on daily activities and well-being. Across the country, 18% of people over age 70 have a vision impairment, and 92%, almost the entire population, use corrective lenses. (CDC, 2006; Heine & Browning, 2002; Maylahn & Melnik, 2008; Prevent Blindness in America, 2008; Zuckerman, 2004).

Since preventing vision loss is most achievable through early intervention, services to promote vision care are imperative. Not all are getting this care. Among those living in New York State in 2006, 36.7% of those aged 60-69 had not visited an eye care professional during the last year (Maylahn & Melnik, 2008). The Brookdale HIP research found that 70.1% of those participating in NYC senior centers reported having an eye exam within last year. Another 17.1% had one within the last two years.

Hearing loss is widespread and often unidentified and untreated among older adults. The most relevant and startling data come from the Center for Hearing and Communication,

[12] This figure combines those who said they had no primary care provider and those who use emergency rooms as their primary care provider.

[13] "Preventable hospitalizations" refers to admittance overnight to the hospital for conditions that generally require hospitalization only when preventative care is neglected. This includes hospitalizations due to diabetes, perforated appendix, chronic obstructive pulmonary disease, hypertension, congestive heart failure, urinary tract infections, angina symptoms without a procedure, adult asthma and falls (See also Billings *et al.,* 1996).

which conducted a mobile senior hearing program from 2000-2004 under the auspices of DFTA. During the four years that the program operated directly under DFTA, almost 3200 seniors received hearing screenings. Of those screened, none had had a previous test and none had hearing aids, but about 62% failed the screening. Among those who failed, almost 1000 seniors received complete audiological evaluations. Results showed that about 72% of those actually had a hearing loss that required treatment, including 450 seniors who had a bilateral mild to moderate hearing loss, meaning that they miss as much as 50% of what is said in a group setting, in restaurants, meetings, and 180 seniors had more severe hearing loss.[14]

Campbell, *et al.* (1999) found that those with hearing or vision impairment, or both, face more limited activity, poorer health, and greater isolation in every category evaluated compared to their unimpaired cohorts. Those with sensory impairments are also more likely to live in poverty, to suffer from depression and to have other physical health issues.

Mental Health

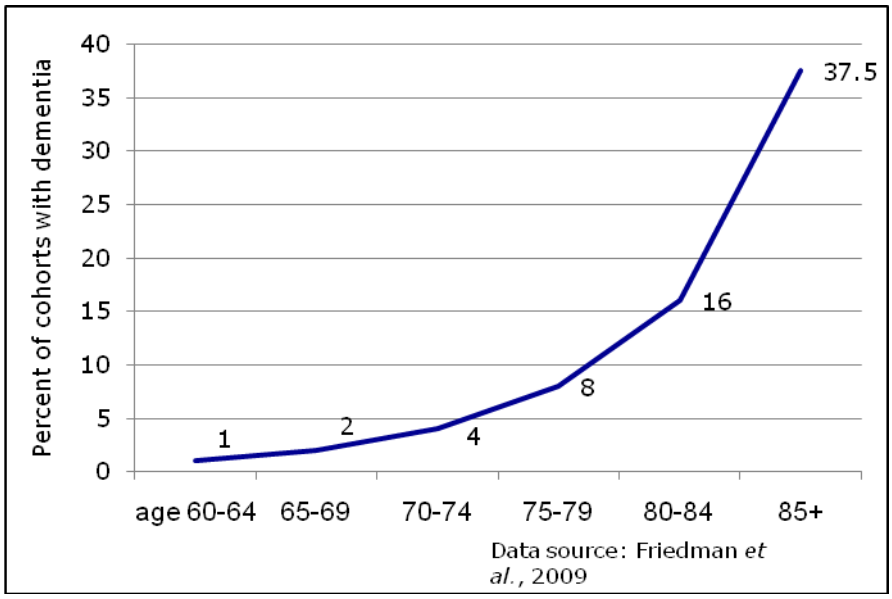
The State's Office of Mental Health estimates that one in five of NYC adults aged 55 and over experience a mental disorder of some kind, mirroring the national average estimated by the U.S. Surgeon General (HHS, 1999).[15] From 2000 to 2030, the number of adults over 65 in New York State with mental disorders is expected to increase by 50% from about 500,000 to 775,000, both because the population is growing and because the population itself and the environment are changing (HHS, 1999).

Dementia is a tremendous concern for older adults, with prevalence of dementia doubling every five years after age 60, until it is nearly 40% for those aged 85 and over. With Alzheimer's disease specifically, an estimated 50% of those diagnosed also show serious depressive symptoms and 30% of those diagnosed have anxieties, including generalized anxiety, fear of leaving home or of changes in routine, and suspiciousness, sometimes to the point of paranoia (Friedman, Kennedy & Williams, 2009).

[14] The remaining 28% either had normal hearing and failed the screening due to language difficulties taking the screening and/or had minimal hearing loss for which treatment was not recommended.

[15] This figure represents one-year prevalence rates and does not include "minor" depression.

Figure 3 – Prevalence of dementia over age 60



As with the general population, depression is the most highly diagnosed mental health disease affecting older adults. NYC's Community Health Survey (CHS) found more than 13% of those aged 65 and over were diagnosed with a depression at some point in their life.[16] The Brookdale HIP survey also included questions to capture current symptoms of depression and found nearly 25% of their respondents experienced mild to moderate symptoms of depression.

These self-reported outcomes differ by location, gender and ethnic background. Differences are influenced by both a groups' relative familiarity and comfort with identifying mental health disorders, the acceptability of seeking help for these disorders, and actual differences in the prevalence of mental health disorders in the various populations. For example, with the exception of those living in Manhattan, those who self-identified as black report consistently lower rates of depression (diagnosed depression rate: 6%; mild to moderate depressive symptoms: 19%; severe depressive symptoms: 2%). According information obtained from the state's Office of Mental Health by the Citywide Mental Health Coalition for the Black Elderly, less than one percent of black individuals over 65 use public mental health services. The coalition deems this a drastic under-representation of actual mental illness in the population, especially given that blacks are more likely to live alone, live in poverty, have greater familial responsibility than their white counterparts and contend with discrimination (Citywide Mental Health Coalition for the Black Elderly, 2008). A 2003 study conducted by the Asian American Federation of New York and the Brookdale Center for Healthy Aging and Longevity found that while Asian American older adults in NYC tend to have larger and geographically closer support systems, they are more likely to suffer from mental illness than the general population. Reasons posited include that there

[16] Survey question: "Have you ever been told by a doctor, nurse or other health professional that you have depression?"

is still a greater cultural gap between elders and children and because the majority of the population is unable to read and write in English (Asian American Federation of New York City, 2003).

In the case of depression, both CHS and Brookdale HIP found the ethnic group with the highest rates of diagnosed depression to be Hispanics (20% and 21% respectively). Across ethnic groups, women are 50% more likely than men to have been diagnosed with depression.

A two-year randomized study of 808 older adults conducted by the New York Academy of Medicine (NYAM) found that the socioeconomic characteristics of a neighborhood affect how depression manifests itself in individuals. The study found that a neighborhood's "affluence" protected adults over age 51 against the worsening of depressive symptoms and that "disadvantaged" neighborhoods were a marginal indicator of worsening symptoms (Beard *et al.*, 2009).
Depression is also a factor in the rate of suicide for older adults, which in 2001-2005 in the United States, was nearly 50% higher than in the general population (14.8 deaths from suicide per 100,000 among those aged 65 and older). Men are far more at risk than women: 31.1 per 100,000 for men over 65 as opposed to the rate of 3.9 for women. (Friedman *et al.*, 2009; HHS, 1999). In New York State, between 2000 and 2006, white and Asian/Pacific Islander men over age 60, committed suicide at more than double the rate of the general population (NCHS 2010).

Underserved Populations

While each person has a unique combination of attributes and there is wide variability within the following groups; these groups were repeatedly identified by older adults, service providers and other stakeholders as benefiting from particular consideration in planning. These include several groups described above: immigrants, those with sensory impairments, those with mental illness and those with low-levels of literacy. Lesbian, gay, bisexual and transgender adults have historically not been counted as special needs populations and are therefore statistically difficult to describe, but they also have clear special needs.

Immigrants

As already stated, nearly 44% of those aged 60 and older in New York City are foreign born. Although the majority of this group have lived in the United States for more than 10 years, some retain attributes that make them more vulnerable and their needs different from their nonimmigrant counterparts. Key factors that cause differences in need include cultural perspective, language differences, geographic distance from community and family and limited access to benefits, services and opportunities, depending on immigration status.

Access to many government services and benefits requires permanent residency, and sometimes, citizenship, and some of NYC's older immigrants do not fall into either of these categories. For example, Gray et al. (2006) estimate that that 16 to 20% of New York City

residents aged 65 and older lack Social Security or Medicare coverage. Some are in this category because they did not work in the United States long enough to qualify for these benefits, and others worked "off the books" or in the informal sector. Gray et al. found that only after immigrants had lived in the United States for 50 years were they as likely as native citizens to report receiving Social Security income. This is particularly concerning for Asian American older adults in NYC, nearly all of whom came to the United States in middle or late-middle age, according to the Asian American Federation of New York/Brookdale study.

Older adults participating in the Age-friendly NYC community forums repeated what researchers have found: older immigrants especially feel that they are not well-informed and do not understand social welfare and public services here, especially when they do not understand English. Others commented that information and activities must become more accessible to a wider group of older people by making them available in various languages and through the use of translators.

Evidence also shows that a lack of cultural competency among healthcare providers negatively impacts health outcomes. Barriers to effective communication outside of language include differences in personal expectations due to societal roles such as gender or class, differences in what is considered acceptable behavior—for example, when and how it is acceptable to ask for help—differences in what matters are discussed with those outside of the family or with persons of the opposite sex, differences in the terms and images used to describe symptoms or needs, and the like. Communication barriers such as these inhibit effective provision of services. Additionally, many immigrants have what was available and possible in their home country as their frame of reference for what is available and possible here, which can create another barrier to access (Bentancourt et al., 2003; Holland & Courtney, 1998, Ku & Flores, 2005; Menjívar & Salcido, 2002; Nuyen Ngo-Metzger, 2003; Tsai & Lopez, 1998).

Speaking a language other than the one used by the dominant culture affects social inclusion. NYC's elderly immigrants speak of being treated with disrespect in shops and on the streets because of language differences. They report not always feeling confident, comfortable or welcomed. On the other hand, older immigrants who live in established immigrant neighborhoods report feeling respected and included in these communities, and many choose to rarely travel outside neighborhood boundaries. Some who do not live in these neighborhoods (often because of housing costs) travel back to these communities regularly as a way of remaining engaged and included. In addition to maintaining a sense of belonging and connectedness, these neighborhoods increase ease of daily tasks. Shopkeepers in immigrant neighborhoods speak the language of and cater to the tastes of those who live there (NYAM 2008a, 2008b; NYC, 2009). Planning to meet the needs of older immigrants is complicated by the fact that not all immigrants live in immigrant enclaves. Some senior centers are serving older adults in neighborhoods with more than a dozen language groups, with different holidays and a range of other cultural norms. The implications of these strengths for provision of services in senior centers will be discussed in the "Synthesis of Key Findings with Implications for Service Delivery" section of this report.

Sensory Impairments

As described above, an estimated 18% of people over age 70 in the United States have a vision impairment. The Center for Hearing and Communication found that among older adults they screened in NYC, about 62% failed the screening. Of those, 72% actually had a hearing loss that required treatment. Despite these high numbers, many of those with sensory impairments are undiagnosed, and those who are diagnosed do not have access or do not use services available to them.

Services that help those experiencing sensory loss to adapt to this loss and to maintain a high quality of life include those from orientation and mobility specialists. These teach people with visual impairments how to travel safely inside and outside of their homes. Vision Rehabilitation Therapists (VRTs) teach adaptive techniques to help with accomplishing daily tasks, including use of adaptive technologies. Occupational therapists also teach people with vision loss and other disabilities how to efficiently accomplish activities of daily living.. Despite this, a 1994-5 randomized survey of non-institutionalized adults in the United States found that only 13% of blind adults received vocational rehabilitation at any point, 11% received physical therapy within the year, and only 3% got occupational therapy (Zuckerman, 2004).

Similarly disconcerting is that none of those who failed the Center for Hearing and Communication's hearing test had had a previous hearing test or hearing aids. According to the Center for Hearing and Communication, the symptoms of untreated hearing loss are often indistinguishable from that of early cognitive dementia. Most senior centers are not equipped with wide-area assistive listening devices, and most of the seniors with hearing loss do not have hearing aids. The Center for Hearing and Communication says this means that many, if not most, of the seniors who attend programs that include group meetings and/or lectures simply are not hearing them.

Mental Illness

As previously stated, it is estimated that one in five of NYC older adults has a mental illness of some kind. What is troublesome is that the U.S. Department of Health and Human Services estimates that only 22% of older adults with mental illness receive treatment from mental health professionals, an indicator that the majority of mental health conditions go undiagnosed. [17] Mental health care is particularly under-utilized by NYC's ethnic minority communities, especially the black population, as described above. Different ethnic and racial groups' may experience barriers to accessing mental health services based on stigma, cultural preferences and religious belief.

The Geriatric Mental Health Alliance of New York (GMHANYC) recommends the following ways to improve services aimed at seniors with mental health and cognitive disorders:

[17] U.S. Department of Health and Human Services, Older Adults and Mental Health: Issues and Opportunities (Rockville, Maryland: 2001)

improve access by making services affordable and culturally competent and by integrating them into the community, using senior centers as a point of information and referral; improve the quality of mental health care, integrating it in to general health and aging care; increase cultural competence to meet the special needs of immigrant communities; provide family support; prevent severe dysfunction; and promote positive aging (GMHANYC, 2008).

Literacy and Technological Literacy

As previously stated, 36% of all adults in New York City lack basic prose literacy skills, according to the U.S. Department for Education. Queens has the lowest literacy level, with 46% of adults lacking basic English literacy skills, then the Bronx with 41%, Brooklyn with 37%, Manhattan with 25% and Staten Island with 14%. While some agencies have made information and applications for benefits and services more accessible and easier to read, this work remains far from complete.

Professor of Education Edward B. Fry began writing about readability in 1968. Since then, efforts have grown to make government and institutional documents and forms more accessible to those unfamiliar with their contents or with low comprehension of written English. Federal government employees sponsor PlainLanguage.gov, with the goal of "improving communication from the federal government to the public." The pharmaceutical company Pfizer has a Clear Health Communication Initiative. New York City created the 311 system in which information and access to help is available regardless of an ability to read.[18] However, our research suggests that many seniors still do not have access to the information they need to live healthy, productive lives.

Similarly, older adults have limited access to and understanding of computers and the Internet, compared to younger generations. According to the Administration on Aging, fewer than half (45%) of seniors over 65 and 27% of seniors over 75 are using computers compared to 78% of people 50-54, 87% of those 30-34, and 93% of 12-17 year olds. In addition to lagging behind in adopting these technologies, older adults report having fewer skills and are less confident in their abilities to use computers than younger cohorts. According to Older Adults Technology Services (OATS), only 5% of senior-headed households in NYCHA have internet access (a rate 12 times lower than younger NYCHA households). Many stakeholders felt that the lack of computer ownership and training are critical obstacles for seniors, given that essential life activities such as social engagement, health care, finances and commerce, and workforce development are all increasingly mediated through technology.

Lesbian, Gay, Bisexual, and Transgender (LGBT)

A March 2010 report authored by the Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders (SAGE) outlines three broad reasons LGBT older adults' have different needs than their heterosexual peers: first, is the stigma associated with lesbian, gay, bisexual and transgender identities, particularly among the elderly; second is their

[18] Information is also available in a myriad of languages.

generally greater reliance on friends or community members rather than biological families, who evidence shows are more likely to assist with long term care, and third is their unequal treatment under laws, programs and services, which prioritize legal and biological family.[19]

LGBT older adults are less likely than their heterosexual contemporaries to have children and more likely to live alone, increasing their need for social support outside of their biological family (Pearlberg, 2004). According to research conducted for SAGE by the Brookdale Center for Healthy Aging and Longevity in 1999, up to 75% of LGBT older adults live alone (compared to 33% of the general population). About 90% of LGBT older adults have no children (compared to 20% of the general older adult population). And 20% of LGBT older adults indicated that they have no one on whom to call in times of crisis, a percentage 10 times higher than in the general population.

LGBT older adults often need particular help with end-of-life planning, wills, and legal matters. Families of choice and partners often have no legal standing in healthcare or inheritance without specific legal arrangements. LGBT older adults are not eligible for a long list of benefits granted to heterosexual peers including: spousal and survivor benefits under social security, spousal impoverishment protections under Medicaid, spousal inheritance of tax-qualified retirement plans and employee sponsored pensions, exemptions from estate taxes for surviving spouses and veterans' benefits given to heterosexual spouses. Same-sex couples also face a number of legal and attitudinal barriers in planning for maintenance of housing, assisted living or long-term care, especially institutional care, where their partnerships may be unrecognized or even prohibited.

The comment most often offered by stakeholders is that LGBT seniors continue to perceive and experience discrimination, which serves as a barrier to health and social services and to social support. As recent as 1994, a study conducted by The Lesbian and Gay Aging Issues Network of the American Society on Aging found that over 50% of senior centers in New York state reported that LGBT seniors would not be welcome at area senior centers if their orientation were in known. For at least part of their life, for most LGBT seniors, their choice of sexual partners was illegal, and the authorities, as well as friends and family, were and are often derisive. This history makes it less likely LGBT seniors will turn to the authorities when they are abused or experience hate crimes. LGBT elders continue to face discrimination and verbal abuse from other seniors, family members and even from those who provide elder care, including physicians. On the whole, LBGT people living in New York experience higher rates of depression and other mental health concerns, lower use of healthcare, and are less likely to have a regular source of primary care than the general population. For NYC's LGBT seniors, social isolation is a pressing problem. The need for culturally competent health, mental health and social service providers is acute (Frazer, 2009; NYAM, 2008a; NYC, 2009; Pearlberg, 2004).

[19] LGBT of color also tend to face greater levels of stigma, and therefore, have more acute needs.

Existing services and resources available to older adults

In keeping with the perspective that it is most productive to consider senior centers in the frame of other resources in the city, in the following section, we describe current and possible roles of existing resources that help maximize the strengths of the population. We include public services and benefits provided by federal, state and city government, with a focus on NYC, along with a description of NYC's wealth of assets and infrastructure, both public and private, on which older adults rely to have a high quality of life. These resources also help to address the significant challenges of poverty, risk for social isolation, poor physical and mental health, which are prevalent among older adults in NYC.

New York City is the largest city in the country, in both size and population. It is often considered the financial, media, cultural, and international capital of the United States and has historically been the welcome gate to millions of immigrants from across the world. As such, the city has an enormous base of resources available for its citizens. The city's strong neighborhoods, social support system, health care system, cultural, educational and religious institutions, non-profit organizations, philanthropies, businesses, parks and transportation system create the potential for NYC to be an ideal place to age.

NYC is one of 35 cities in the world that is participating in the World Health Organization's (WHO) Age-friendly Cities program, a process in which cities assess their current friendliness toward the aging population and develop a plan to improve the environment based on the information from older adults themselves. [20] The eight domains that the WHO program established as essential urban resources for older adults worldwide are housing, transportation, community support and health services, communication and information, outdoor spaces and buildings, social participation, respect and social inclusion, and civic participation and employment. Results from NYC's assessment, including those from community forums, focus groups, interviews, feedback forms and expert roundtables are helpful in describing how the city's characteristics affect people as they age.

The stakeholders, senior center directors and older adults themselves throughout this consultation process felt that senior centers that were able to connect to and take advantage of outside resources, were able to provide a much richer array of benefits and services than those that did not. The riches that NYC has to offer can be difficult for many older adults to access. Senior centers can play a critical role in helping to identify the resources that are available and ensuring that older New Yorkers are linked to them. Since many of these resources are part of large governmental systems that do not cover all older adults and often do not work together, senior centers can also make connections between them and to them so that individuals that need access to them have support. Senior centers

[20] NYC's participation took the form of a joint initiative between the New York City Mayor's Office and City Council and the New York Academy of Medicine (NYAM). These worked together to identify ways to increase the age-friendliness of New York City. More information about the initiative is available at http://www.agefriendlynyc.org.

can also play key roles as advocates and in helping older adults advocate for greater inclusion and access to all that the City has to offer.

Neighborhoods and Housing

Many of the older adults who participated in the Age-friendly NYC assessment indicated that the main characteristics of urban living, high density housing and highly differentiated neighborhoods, are both an asset and challenge for them as they age. On one hand, many seniors said that dense living, whether in large apartment complexes, small apartment buildings or on blocks of single-family homes, creates natural communities, where younger generations and peers look after each other and serve as informal caregivers. These naturally occurring support systems were most frequently spoken about by older adults living in public housing and poorer neighborhoods. Participants, particularly those from immigrant communities, also emphasized the value of living in a community with neighbors and business owners who speak the same language as they do and come from the same cultural background. Many reported traveling to neighborhoods where people from their background are concentrated because they feel most comfortable there.

On the other side, some older adults said that they live in buildings with a transient population and the businesses they used to visit have closed. The economic and cultural make-up of their neighborhoods has shifted. They may have raised their children in an area, but now they know few people and feel isolated or unsafe. They have watched their family and friends move away or die and feel disconnected from the community. These perspectives were particularly prevalent in neighborhoods that had seen major economic improvements in recent years, but were expressed by some in most communities.

What complicates this experience is that NYC has some of the most expensive housing in the country, and many of the housing situations of older adults are shaped by a complex web of rent stabilization and control guidelines and public housing programs. While forty-eight percent of NYC's elderly own their homes (a higher percentage than the general population), among those who rent, 50% are protected by either rent control or rent exemption. Often, older adults living in rent controlled or stabilized housing or in publicly-funded housing have restrictions on if, when and where they can move. Those who are renting on the open market must contend with rent increases and the overall high cost of housing in NYC, which may also restrict where they can live.

Another issue raised by older adults and experts is the vulnerability of older adults to landlords who want them to move in order to profit from higher paying tenants. Finally, some older adults are living in sub-standard housing situations. The New York City Housing and Vacancy Survey describes one quarter of those in the poorest neighborhoods as living in unsafe conditions, unfit for human habitation (Gusmano & Rodwin, 2007).

One of the greatest assets to the poorest of NYC's older adults are government-subsidized and government-run housing units—some specifically for the elderly, some open to anyone. Categories include adult homes, which provide long-term residential care, including personal care and meals; public housing built and managed by New York City

Housing Authority (NYCHA), which include 42 developments designed for the elderly; Mitchell-Lama housing; U.S. Department of Housing and Urban Development (HUD) funded Section 202 housing for low-income seniors, with 170 projects in NYC; and the federally-funded Section 8 Housing Choice Voucher Program. Section 8 vouchers provide funds directly to landlords to subsidize a portion of rent costs for low-income individuals and families. Conditions in these buildings vary widely, from new construction to buildings which are in dire need of repairs.

Outside of housing specifically for older adults, NYC is home to many naturally occurring retirement communities, or NORCs. These are apartment buildings, complexes or small neighborhoods that have developed over time as areas where significant populations of older adults live. A NORC is a unique housing model, which began in NYC in 1986, was formalized in 1999, and allows older adults to live in the community, or age in place, rather than in an institutional setting by bringing shared social, health, personal care and other services into the community.[21] According to the United Hospital Fund, there are 43 NORC programs in NYC. Of those, 29 are funded by DFTA and another 10 are funded through the NYC City Council. Many NORCs also receive private contributions. As part of the Age-friendly NYC initiative, DFTA will collaborate with NORCs across the city and seek funding opportunities to support existing and new communities.

Also to help older adults remain in their homes is New York State's Home Energy Assistance Program (HEAP). HEAP provides funds to help those aged 60 and older with low incomes to pay rising home heating expenses. HEAP programs, which are administered through the city, include the Weatherization Referral and Packaging Program (WRAP), which helps homeowners aged 60 and older to weatherize their homes as a way of reducing energy consumption and heating expense.

Also funded by the state, the Senior Citizen Homeowners' Exemption (SCHE) and School Tax Relief Program (STAR) reduces real estate taxes for property owners aged 65 and older. The Real Property Tax credit offers homeowners and renters with one family member over aged 65 a refundable income tax credit of up to $375 per year. Household income must be under $18,000 per year and rent must be less than $450 per month. For homeowners, the market value of the property must be less than $85,000.

The City also has a number of initiatives aimed at making housing more affordable for low-income families in general and for seniors in particular. The Senior Citizen Rent Increase Exemption (SCRIE) prevents some or all rent increases for those aged 62 and older whose incomes are less than $29,000 per year. The Home Improvement Program (HIP) of the NYC Department of Housing Preservation and Development (HPD) works with private banks to provide home improvement loans at reduced rates to small homeowners. Another HPD program, the Senior Citizen Home Assistance Program (SCHAP), offers home improvement loans at reduced rates to those aged 60 and over with low to moderate incomes.

[21] For more information on NYC's NORCs, see http://www.norcblueprint.org/faq.

Initiatives that the City began as part of the Age-friendly NYC project include a program to provide free air conditioners to at-risk older adults, a partnership between the Department of Consumer Affairs and DFTA to develop best practices for home contractors when working with older adults, newly created eviction prevention services and the promotion of new housing models that support aging in place.

Public Pension and Income Support

The most wide-reaching program supporting older adults is the federal Social Security system. In the NYC metro area, 73% of older adults receive some social security income, averaging $14,877 a year.[22]

Social Security retirement benefits are only available to older adults over the age of 62 who paid into the Social Security trust fund for at least 10 years. Income must have been earned and reported using a valid social security number, and spouses of wage earners are entitled to reduced benefits. Social Security Disability (SSDI) is available to those who were working but who become permanently disabled, with previous work requirements varying by age. At full retirement age, SSDI converts to social security retirement benefits. Supplemental Security Income (SSI) is available to people of all ages who are disabled but do not qualify for SSDI and to most older adults who have not met the requirements for social security and have less than $2,000 in cash, bank accounts, stocks or bonds. Undocumented immigrants are ineligible.

Unemployment benefits are available to those who have lost their job at no fault of their own, who meet certain work requirements and who are able to work and seeking work. The 2005-2007 ACS data (gathered before the current economic downturn) put unemployment rate in the greater NYC area at 1.1% for adults 60 and over. The Fiscal Policy Institute reported that in 2008 the fastest growing age group of those receiving unemployment insurance was older workers between age 60 to 64, a 46% increase over one year (Fiscal Policy Institute, 2008).

The New York State Safety Net Program administered through NYC's HRA helps older adults with less than $3,000 in resources with temporary cash assistance. The cash grant includes a portion for shelter, energy assistance grants and additional money to assist with expenses.

Health Care

NYC's health care system is a leader in the world, and older adults frequently cite it as an essential resource and reason to live in NYC. Care ranges from acute care delivered in hospitals and care delivered by primary care physicians, specialists and out-patient clinics to long-term care delivered in homes, assisted-living facilities and nursing homes. This includes the New York City Health and Hospitals Corporation (HHC) which is the largest

[22] The census defines the NYC metro area as NYC counties along with Putnam, Westchester, Rockland Bergen & Hudson counties, in short, the greater NYC area, but not Long Island.

municipal hospital and health care system in the country, serving 1.3 million New Yorkers every year, including 450,000 people who are uninsured.

Some of the biggest challenges for individuals being treated within the current health system include affordability, care coordination, and linkage between the various health and social services needed to meet his (or her) multiple needs.

To pay for health care, 15% of all people in New York state, including many of NYC's older adults, are covered by Medicare, a health-insurance program run by the federal government but financed through wage-based taxation. Access is limited to those 65 and older and those who are permanently disabled. Because eligibility for Medicare requires payment of taxes into the system, following the same guidelines as Social Security, thousands of older New Yorkers do not receive this benefit.

Medicaid, a federally-mandated program with cost sharing across all three levels of government in New York, serves as subsidized health insurance for those with low incomes, including some older adults who do not qualify for Medicare and those who have Medicare but need additional support. In New York State, Medicaid eligibility for a single individual who is blind, disabled or aged 65 and older is restricted to those with incomes of $9,200 per year or below.

In New York City, many older adults do not receive either Medicare or Medicaid. Gray *et al.* (2006) estimate that that 16 to 20% of NYC residents aged 65 and older do not have Medicare or Social Security. Others are either not eligible for Medicaid or are eligible but are not enrolled.

Many New Yorkers still struggle to afford health care if they do not qualify for these programs. Those who do qualify also struggle, trying to cover the cost of health care not covered by insurance.

On the state level, the New York State Partnership for Long-Term Care combines long-term care insurance with Medicaid Extended Coverage, which helps New Yorkers protect some or all of their assets if the long-term care that they need exceeds the period covered by private insurance. The State also administers the New York Prescription Saver Card program, which covers some prescription drug costs for those with low incomes aged 50 to 65.

On the city level, the Human Resources Administration serves more than 83,000 city residents through its community-based long-term care programs, which provide coordinated medical, nursing and rehabilitative care to people in the home rather than in an institution. The City also administers Elder Pharmaceutical Insurance Coverage (EPIC) which pays for more than half the cost of prescription drugs for low-income individuals aged 65 and over who do not participate in Medicaid.

DFTA has a Health Insurance Information Counseling and Assistance Program that performs outreach to older adults, caregivers and health professionals to ensure that older adults are aware of and understand their health insurance options.

Food

Throughout NYC, affordability and access to healthy food are major issues of concern. High prices, a small number of supermarkets in poorer neighborhoods and a shortage of fresh fruits and vegetables are problems for the entire population. Older adults bring an additional set of challenges to buying, preparing and eating in a healthy way. Many older adults are on fixed incomes, have mobility impairments that affect shopping and cooking, have dietary restrictions, are living alone for the first time in their lives, are socially isolated and are living in neighborhoods where stores they used to frequent have gone out of business or are replaced.

To help people of all ages living in poverty (including older adults), the federal government administers the Supplement Nutrition Assistance Program (SNAP), commonly called Food Stamps. Eligibility determinations have a number of contingencies, with special rules for those aged 60 and older. Generally, gross income cannot exceed 130% of the federal poverty line, or in 2010, $1174 per month for a single-person household. The maximum monthly allotment for a single-person household is $200.[23]

Food stamp recipients receive an Electronic Benefits Transfer card with their allotment amount credited to the card. This card is presented to participating merchants to be used toward the purchase of qualifying food items. To assist older adults in applying for and recertifiying their food stamps, the city's HRA makes it possible to do both processes over the phone. HRA is also launching an initiative through age-friendly NYC to reach out to older adults enrolled in SCRIE and encourage them to apply for food stamps.

Several of the Mayor's 59 Age-friendly NYC initiatives provide new resources to food, including the NYC green cart program, which issues 1,000 new permits for vendors to sell fresh fruits and vegetables in neighborhoods where availability is limited, and the expansion of a program to use school buses to transport older adults to supermarkets when they are not transporting children.

Greenmarket, a program run by the Council on the Environment of NYC (a privately funded non-profit organization) has more than 40 markets where farmers, fishers and bakers directly sell to city residents. In recent years, more markets have opened in poorer neighborhoods and with the help of the City Council, 24 markets now accept food stamps. Demand is high, as evidenced by the doubling of purchases made with food stamps between 2008 and 2009.[24]

---

[23] The amount of a food stamp allotment is calculated by multiplying the household's net monthly income by 0.3 and then subtracting this result from the maximum allotment for the household size (USDA, 2010).

[24] Source: http://www.cenyc.org/node/806.

For those older adults who have difficulty shopping or cooking or who are homebound, the city administers meal delivery programs to their homes. Meals are culturally appropriate, meet dietary restrictions and are either hot meals delivered daily or frozen meals delivered twice a week, depending on the older adults preference and level of functioning. More than 17,000 older homebound adults currently receive meals under this program. However, no current estimate exists of how many older adults meet the criteria for home-delivered meals but do not receive them. (Such an estimate is beyond the scope of this report.)

NYC also has emergency food providers including the Food Bank for New York, which supplies food to pantries, soup kitchens, senior centers and youth programs at over 1,000 locations, and City Harvest, which rescues food that would otherwise go to waste and distributes it to similar programs. The New York City Coalition Against Hunger's 2008 Annual Hunger Survey showed that emergency food programs report widespread and increasing use by older adults.

Public Spaces

Participants in the Age-friendly forums and stakeholders emphasized that NYC's transportation system is one of the most important resources the city provides. The city contains North America's largest transportation system, serving more than 7.4 million daily through its network of buses and subways (NYC, 2009). Fares are reduced by 50% for those aged 65 and over. The lack of elevators or escalators in many subway stations make the bus system more accessible to the disabled and frail, and this network is extensive, reaching into most corners of the city. Obstacles such as distance to stops, isolated neighborhoods, are negatives. Access-A-Ride specifically addresses the transportation needs of people with disabilities, offering door-to-door transit, often using a vehicle designed to accommodate wheel chairs.[25] For those older adults who have cars, a dearth of parking in general, a dearth of parking near homes and businesses, and strong parking regulations are also a problem.

NYC neighborhoods also have a highly organized system of sidewalks, crosswalks and traffic signals, which makes walking the most common mode of transportation within neighborhoods. However, the Age-friendly NYC reports remind us that barriers such as uneven sidewalks, litter, crowding and lack of benches and safe crossings are a problem for the frail and disabled in some neighborhoods.

The City's Department of Parks and Recreation oversees 5,000 individual properties covering 29,000 acres or 14% of NYC. Parks, beaches, waterfront, community gardens and walking paths are tremendous assets to older adults, as places of recreation, relaxation, communal gathering and environments that promote physical and mental health in areas that otherwise have almost no grass to walk on or trees to sit under. While a major resource, parks are unevenly distributed throughout the city, many are difficult for those

[25] During various Age-friendly forums, the poor quality of service through Access-A-Ride was noted frequently. Non appearance, long waits, rough rides, rude drivers, and drop off and pick up far from one's destination were among the repeated complaints.

with physical disabilities to travel to, to enter and to use, and most were designed with a focus on youth. The Parks department is currently working on an agency-wide transition plan to make all aspects of its parks, beaches and recreation centers more accessible to people with disabilities and has established a committee to advise them on Americans with Disability Acts issues. The Mayor has also set a policy goal that all New Yorkers should live within a 10 minute-walk to a park.

All of NYC's public and private spaces and buildings are protected by the largest police, fire and emergency service departments in the country. This public safety system is a tremendous asset to the city's older adults who are often targets of crime and are more likely to live alone, have limited mobility, and greater health needs.

Educational, Religious and Cultural Institutions

The New York City Public Library has 89 locations throughout the Bronx, Manhattan and Staten Island. The Brooklyn Public Library has 65 locations, and the Queens Public Library has 64 locations. All three systems provide free and open access to their physical and electronic collections and information, which include millions of items. For example, all three systems offer free access to Internet-connected computers, have books by mail programs for those who are homebound, have materials for the visually impaired and hearing impaired and offer assistive technologies. They also host public events and programs designed for older adults and hosts classes in technology, literacy and English for speakers of other languages. In response to the growing aging population, all three systems have launched special programs and outreach campaigns for older adults.

The city is also home to an outstanding public city university system, the largest urban public university in the country (City University of New York, CUNY), with 23 colleges and institutions and 30 libraries across the five boroughs. At CUNY's six community colleges, study is tuition-free for senior citizens. At their four-year colleges, seniors may audit classes on a space-available basis for $70 per semester.[26] NYC is also home to dozens of technical schools, language schools, art schools and the campuses of several major private universities including New York University, Columbia University and Fordham University. Universities are not only places to study but provide major physical facilities in communities; have their own cultural centers, libraries, gyms and sporting events; have research capabilities; and create alumni communities. One of the main initiatives of the Age-friendly project is to investigate how universities can become stronger community partners for older adults.

The City is also home to the national headquarters of several major religious denominations and hundreds of religiously based non-profit organizations. From grand cathedrals, synagogues and mosques to neighborhood churches and storefront prayer groups to religiously-based non-profit organizations, NYC seniors report that spiritual and

[26] For more information on this program, see http://www1.cuny.edu/portal_ur/news/cuny_matters/2002_october/lifespan.html.

religious communities provide a social support system, natural mental health promotion, and in some cases assistance with daily life activities and obstacles. In 2000, the Association of Statisticians of American Religious Bodies (ASARB) gathered information from 149 religious denominations and found that there are more than 3,000 congregations city-wide with 959 in Brooklyn, 882 in Queens, 665 in Manhattan, 426 in the Bronx and 156 in Staten Island.[27]

NYC is also home to hundreds of cultural institutions, ranging from some of the world's most famous museums, theaters and orchestras to neighborhood galleries and small performing groups. Cost, accessibility and language differences are barriers for many older adults, but many institutions have free days for the general population, and in general, offer discounts for seniors, arrange performances or programming for older adults, offer programming in different languages and run outreach in the community. Often, the only barrier is that seniors do not know what is offered or how to access it. The Museum of Modern Art, for example, has programs for older adults with Alzheimer's disease and their caregivers, those who are homebound, and those with hearing or vision impairments. It also has free wheelchairs for visitors and offers several free days every year for seniors.[28] The Brooklyn Academy of Music (BAM) has a free monthly senior cinema series.[29] At the Pregones Theater in the Bronx, where many of the performances are in Spanish, tickets are 30% off for seniors and 50% off for those who live in neighboring zip codes.[30] Similarly, New York sports teams, which have played an important role in the life of many seniors for their entire lives, offer senior discounts, seating and assistive listening devices for those with disabilities.

In some ways, every street, business and facility in NYC is a resource for older adults, just as it is for the general population. The city's gyms, movie theaters, restaurants, retail stores, bars, newspapers, green markets, nail salons, barber shops, delivery services, stoops and sidewalk domino tables all benefit from and contribute to the lives of older New Yorkers. The problem is that barriers to access are often greater for older people. Stakeholders, older adults and senior center directors all expressed a desire to better learn about, connect to, share, refer and use these resources to serve NYC's older adults.

[27] These numbers are lower than reality because they do not include historically African-American denominations.

[28] For more information on this program, see http://www.moma.org/learn/programs/access#access_homebound.

[29] For more information on this program, see http://www.bam.org/view.aspx?pid=1614.

[30] For more information on this program, see http://www.pregones.org/tickets.html.

Senior Centers and their Core Functions

Introduction to DFTA & Senior Centers

NYC Department for the Aging (DFTA)

In 1965, Congress enacted the Older Americans Act (OAA), which established the federal Administration on Aging (AoA) and state agencies on aging to address the social services needs of older adults. The AoA's mission is to help older adults maintain maximum independence in their homes and communities and to promote a continuum of care for the most vulnerable elderly. The AoA distributes money through 56 state agencies and 655 area agencies on aging. The largest percentage of money goes to fund nutrition services for older adults throughout the country (National Policy Forum, 2009).

Previous to the OAA, The New York City Department for the Aging (DFTA) was only city-funded and was called the NYC Office for the Aging. With the passing of the OAA, DFTA became the Area Agency on Aging (AAA) for NYC that receives AoA funds. DFTA acts as both a federal and municipal entity, addressing the needs of older adults in NYC.

DFTA serves and represents older adults in the largest city in the country and is the largest AAA in the country. In this capacity, the Department sees itself as representing the concerns of urban centers on a national scale and advocates on legislative, regulatory, and socio-economic issues that affect older adults (DFTA, 2005).

Among the 39 Mayoral agencies in New York City government, DFTA is the lead agency to address public policy and service issues regarding the elderly. DFTA falls under the purview of the Deputy Mayor for Health and Human Services. DFTA contracts with hundreds of community-based agencies to provide senior services throughout the five boroughs and also runs several of its own programs. Its most far-reaching services delivered through these agencies are case management, home delivered meals and senior centers.

The case management program currently serves 20,000 people, providing in-home comprehensive assessments of physical, mental health and home care needs as well as coordination and monitoring of services for frail and home-bound older adults. Case managers connect older adults to services they need to age in place where appropriate, including entitlements and in-home services, such as home care. Home-delivered meals, as mentioned previously, are provided for 17,000 NYC older adults in the case management program who have difficulty shopping or cooking or who are homebound. Meals are culturally appropriate, meet dietary restrictions and are either hot meals delivered daily or frozen meals delivered twice a week, depending on the older adult's preference and level of functioning.

DFTA also directly offers a number of programs aimed at improving well-being and quality of life for seniors, many of which are offered through DFTA-sponsored senior centers. These include senior employment services, personal care aide training, foster grandparent program, grandparent resource center, Alzheimer's and care givers resource center, intergenerational programs, health promotion services and insurance information programs. The city also supports adult day care programs, bereavement support groups, caregiver services, home health care agencies, Naturally Occurring Retirement Communities (NORCs)[31] and job and volunteer placement services.

Description of the Existing Senior Centers

Senior centers are a key element of NYC's efforts to address the needs of its older population, as physical places where seniors can go for support, engagement and basic needs. DFTA sponsors 301 senior centers citywide, 20 of which function part time. There are other senior services programs that could be called senior centers, or centers for seniors in a broad sense (e.g., VISIONS at Selis Manor, NYCHA sponsored senior centers), but for the purpose of this report the definition of a senior center is one that DFTA funds. (See "List of DFTA-funded Senior Centers" in the Appendix.)

DFTA-funded centers exist in a range of physical settings from public housing to church basements to freestanding modern buildings. They are operated by larger multipurpose organizations, by religious organizations and as small non-profit organizations with single purpose boards. Some were founded before DFTA existed, others have begun over the past decade. While there is a wide variation in the size of centers, what programs and services they offer, what population they serve, how they link to outside resources and what resources they have, at the core of every center is a congregate meal and a knowledgeable, committed and passionate staff.

Because many of NYC's senior centers receive federal, state and city funding, they are subject to rules from each of these sources. Federal mandates require centers to offer health, social, supportive and recreation services; activities geared toward disease prevention and health promotion; information on public benefits available to seniors; opportunities for clients to contribute toward the cost of senior center services; and services to low-income minority individuals.[32][33]

Centers must provide at least one meal five days per week, and each meal must include one-third of the federally-mandated "dietary reference." Meals must also meet New York State nutrition requirements and New York City Food Standards. Which days and times meals are to be offered is not specified. New York State requires centers to provide six

[31] See the list of identified NORCs in New York City in the Appendix.

[32] Federal Regulation, Title 45: Public Welfare, Subpart D—Service Requirements, Part 1321—Grants to State and Community Programs on Aging, §1321.65 Responsibilities of service providers under area plans (d).

[33] The National Council on Aging's National Institute of Senior Centers (NCOA/NISC) also has set standards for senior center certification but, to our knowledge, only two NYC centers have applied and been accredited.

nutrition education presentations per year, and New York City requires centers to hold two presentations on elder abuse prevention and awareness per year. Individual centers may receive funding from multiple other public and private sources, each of whom define their own programmatic and contractual requirements. The city also relies on senior centers for dissemination of information and as congregate centers in emergency situations.

DFTA senior centers serve on average 28,000 meals per day, approximately 250 days per year. Because records are focused on meal service, current data on senior center use are limited. However, several recent studies shed light on who is using senior centers and what their preferences are. These include a recent Council of Senior Centers and Services of NYC, Inc. (CSCS) survey of more than 3,000 participants, the Brookdale Center for Healthy Aging and Longevity's Health Indicators Project (HIP) and a recent DFTA participant poll of 2,375 users citywide. While it is not the purpose of this document to estimate numbers of persons who would benefit from the services senior centers provide, there are obviously a very large number (over a million) of older adults in NYC who do not receive either a congregate or home delivered meal. Given high rates of poverty, isolation and disability it seems reasonable to assume more would benefit from these services than currently receive them.

Another significant current information gap is data providing a systematic understanding of the effect of senior centers on those who participate. However, one exciting development identified during stakeholder consultations is that there is growing, local and national interest in formally defining the functions of senior centers and in identifying feasible methods to document the outcomes centers produce. In NYC, the United Hospitals Fund is considering expanding its 75-item Healthy Indicators questionnaire, which measures the long-term impact of NORCs on their communities, to include senior centers. CSCS organized a committee to developed outcome indicators, and Brookdale is developing a menu of outcome measures focused on physical and mental health from which centers will be able to choose what they will track. Senior center directors who attended the borough-level forums expressed an interest in assessment tools that focus not only on health indicators but on indicators that capture the whole experience of a person and the impact of the many functions centers serve. DFTA is reviewing these and intends further work on developing outcome indicators. (For further discussion, see the section Synthesis of Key Findings with Implications for Service Delivery).

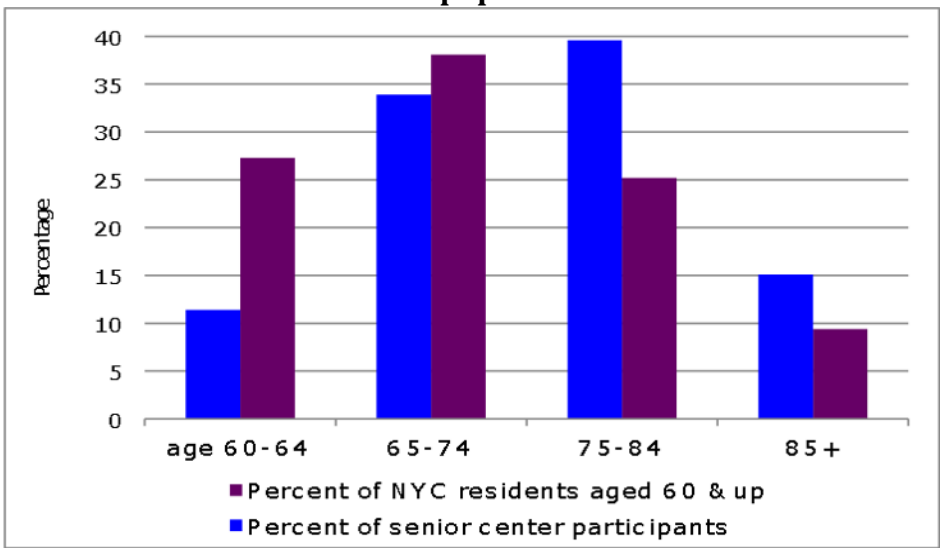
Description of Senior Center Users

The Brookdale HIP survey paints a picture of the demographic characteristics and health status of senior center participants. This survey of a representative sample of senior center participants found the average age of participants to be nearly 76 years, much older than the citywide average (See Figure 2). Most striking is that senior center participants are much poorer than the general population: 75% of senior center participants have incomes of less than $20,000 per year.[34] Also, far more center participants smoke. Nineteen percent of Brookdale HIP survey respondents said they currently smoke as compared to the

[34] Thirty-nine percent of NYC residents aged 60 and older have incomes at twice the federal poverty line, but as stated, 75% of senior center participants have very limited incomes of less than $20,000 per year.

citywide figure average of 9%. Increased age, lower education levels, higher poverty levels, and tobacco use are all strongly related to poorer health outcomes.

Figure 2 - Age of senior center participants compared to general NYC population



Similar to the Brookdale HIP, the DFTA 2009 senior center survey of a representative sample of senior center participants found that senior center participants are poorer than the overall older adult population. The DFTA survey found that 63% of participants reported making less than $1,214 in monthly income, including 42% who make less than $903 a month.[35] The DFTA survey also found that 51% of survey participants live alone, as compared to 30% of the general population over age 60.

All three studies found that the majority of senior center users who are at a center on one day are likely to be there on additional days of the week. More than a third of the 3,000 senior center users who participated in the CSCS survey said that they come to the center daily. Close to another third said they use the center at least 2-3 times per week. The DFTA survey found that 83% of older adults said they visit a senior center at least three to four times a week.

The DFTA survey confirmed the importance of centers being located in neighborhoods, near older adults' homes. The survey found that 51% of participants walk to the center, 24% take the bus and 11% take the subway. Just 10% drive a car or carpool, and 8% use Access-A-Ride. All three surveys were limited to senior center users (in the case of CSCS a sample of non-participants was also surveyed) and therefore can not be used to predict characteristics or preferences of the larger number of older adults who would benefit from senior centers, but do not currently participate.

[35] Numbers did not include the 20% of participants who opted not to answer that question.

Core Functions

Conversations with key stakeholders, focus groups of service providers, meetings with senior center directors, the comments of NYC's older adults, and surveys of all these groups to learn what senior centers currently do as well as what they thought centers ought to be in the future identified core functions of service centers, A group of stakeholders (See List of Stakeholders in the Appendix) refined this list of functions at four meetings sponsored by DFTA and NYAM over the past year.

The five functions of senior centers identified as critical and core are:

1) **Providing opportunities for social engagement**
2) **Providing a link to public services and benefits**
3) **Providing a link to community resources**
4) **Providing nutritional support**
5) **Promoting health, mental health and healthy behaviors**

Most center programs aim to address more than one of these functions at a time. For example, programs that link seniors to volunteering opportunities provide opportunities for social engagement, promote mental health and offer a link to community resources. Programs that help enroll older adults in Medicaid provide a link to public services and benefits and promote health and healthy behaviors. The existing congregate meal system offers nutritional support and provides opportunities for social engagement.

Stakeholders articulated that these core functions can be met through a spectrum of service delivery options including **providing consumer information only**, **providing screening and referral**, **providing a direct service** and **performing advocacy to change policies that affect all older adults, not just direct participants**. Because resources are limited, every center makes choices about what strategy it will employ. Stakeholders and senior center directors understood that these strategies have distinct advantages and disadvantages: provision of information only is the least costly and requires the least time and skill of center staff. Age-friendly NYC participants cited senior centers as an important source of information; however, data from other settings suggest information provision alone is inadequate to facilitate access. Screening and referral is a more skill and time intensive modality, which is still only effective if referrals are adequately supported (based on the participants' level of need). Linkage to community resources requires knowledge and skills from staff that may be different from current job requirements but that have the potential to benefit more elders than just center participants because these community resources may become more "age-friendly" through increased, systematic use by seniors. Obviously direct provision of services is the most resource intensive for the center (unless these are provided by a partner organization), but this has the highest penetration for center participants and may be more effective than the other strategies mentioned.

Providing opportunities for social engagement

Evidence substantiates the negative impact of social isolation on health and well-being. The World Health Organization finds that social isolation is strongly associated with poorer chances of surviving a heart attack, increased rates of disability, increased rates of addiction, generally poorer health, and higher rates premature death (WHO, 2003). The risk of social isolation is great for many of NYC's seniors. As mentioned earlier, more than 30% of those aged 60 and above live alone, with nearly 17% of seniors at particular risk of social isolation.[36] The Brookdale HIP survey of senior center participants found that nearly 25% have contact with family members less than once per week, and 19% communicate with friends less than once a week. A significant theme among elderly respondents participating in the Age-friendly NYC research was people feeling excluded and vulnerable.[37] (See Map 7 – Prevalence of Social Isolation Among Adults Age 65 and Older.)

Conversations with center directors and participants reinforce these findings. A summary finding of a recent CSCS focus group of participants is that senior centers serve as the only source of social interaction for many participants. The CSCS survey found that 60% of those who responded lived alone. The DFTA survey found that 51% lived alone. This means that those who come to senior centers are at even greater risk for social isolation than the general population. Gusmano and Rodwin (2007) found that elders need more than just services. They need companionship and a sense of connection to the community. Senior centers can offer a place of safety and security—a place to foster connections.

Further supporting this, those who answered the CSCS survey reported the highest rates of participation in center programs that involve social activities.[38] Therapeutic arts was reported as the most attended (75% of respondents), and at least 40% of respondents reported participating in dancing, bingo, movies, and trips. Twenty-three percent said they attended cultural events organized by the center. The DFTA survey found that congregate meals and spending time with friends were the most popular reasons for visiting the center, 72% and 71%, respectively.

By reducing social isolation and providing a regular place for social engagement, senior centers are also a wonderful resource for caregivers who need to work, need a respite or are searching for ways to improve the life of an older adult. As one stakeholder suggested, senior centers are just as important for the quality of life of younger generations, who often simultaneously care for children and for parents or older relatives at the same time.

Finally, a topic that arose over and over at the Age-friendly NYC forums and roundtables is that seniors are not just in need of help, but many are in a position to help to others. This benefits the community and the older adults. Seniors can become advocates and advise

[36] Interestingly, only 19% of Asian American older adults live alone in NYC, according to a 2003 report by the Asian American Federation of New York.

[37] As part of the Age-friendly NYC initiative, NYAM held a series of community forums, focus group and one-on-one interviews, and expert roundtables during 2007 and 2008.

[38] This refers to programs other than meals.

lawmakers and administrators developing policy and programs aimed at seniors so that these programs and policies more effectively meet their needs. Centers can also serve as conduits for formal and informal volunteering activities, linking up those willing with those in need.[39] While helping other elders is important, the skills and experience of seniors also offer a resource to those younger as well. Seniors are interested in donating their time in this way. Eighteen percent of CSCS respondents said they engaged in volunteer activities, and another 11% said that they would do so if the opportunity was made available. The DFTA study found that 37% of participants are active volunteers. Age-friendly NYC respondents encouraged exploring ways to match the needs of the city with the skills of retirees. Many experts, stakeholders, senior center directors and older adults agree that seniors' skills are an under-utilized resource.

Providing a link to public services and benefits

Gaining access to the public benefits and services available to NYC's older adults requires knowing how to navigate a complex system of eligibilities, agencies, and forms, as well as the persistence and know-how necessary to untangle the inevitable bureaucratic complications. Some systems require in-person visits further complicating access, particularly for those with mobility or sensory impairments. Linguistic barriers due either to language differences, literacy levels and technological literacy are another obstacle to enrolling in services and benefits. (CSCS, 2009; Gusmano & Rodwin, 2007; NYAM, 2008a)

These barriers to access lead to under utilization of the benefits and services many older adults need, particularly given the high rates of poverty. For example, an estimated 30% of those in New York City aged 60 and older who are eligible to receive food stamps do not get them.[40] This is a problem not just for those who need better access to food but for the larger community where they live. Hanson and Golan estimate that every five food stamp dollars ($5.00) spent generate $9.20 of economic activity (2002).

The New York City Housing and Vacancy Survey describes one quarter of those in the poorest neighborhoods as living in unsafe conditions, unfit for human habitation. Senior center directors and social workers working with elderly describe the cost of housing as a critical issue (Gusmano & Rodwin, 2007). Yet less than 40% of those eligible for NYC's SCRIE program are enrolled (Gotbaum, 2005).[41] Housing concerns in addition to cost include security of tenure, accessibility for those with disabilities, maintenance, appropriate size, safety, distance from shopping and other services, and access to transportation (Foscarinis *et al.*, 2004), all of which are issues for NYC older adults.

---

[39] An example of informal volunteering is shopping for a housebound neighbor, or offering companionship and conversation.

[40] In general, food stamp eligibility is restricted to those with gross income at 130% of the federal poverty line (FPL) and less (USDA, 2010). Data from the ACS put 311,422 NYC residents aged 60 and older as living at or below 125% of the FPL but show only 218,519 receive food stamps.

[41] This specific problem is being addressed by a structural innovation proposed by the Mayor through the Age-friendly NYC project. See http://www.agefriendlynyc.org/documents/NYC_Age_Friendly_report.pdf, p. 13, 50, 58 and 124.

The number of elderly entitled to but who do not receive various income supports is not a figure publicly available, but the data sources described above offer evidence that income supports are also underutilized and that senior needs in this area remain unmet. As one stakeholder asserted, since most served by senior centers are poor, centers must link people to possible income enhancements: "just as we do meals, we must do entitlements." Stakeholders also noted that efforts to improve income security should include assisting seniors in finding employment.

The center-related need raised most often—more than one-quarter of all center-related responses—at the Age-friendly NYC forums and round tables was the need for increased, easy access to information regarding the services and programs available to the elderly and the aged poor, and help to gain access to these.

Stakeholders and senior center directors agreed that this is one of a center's most crucial functions, but emphasized it is difficult to accomplish with existing staffing resources. Many said that a computer application system that links applications for multiple benefits and general improved Internet access in centers is necessary to fulfill this function. They also repeatedly pressed the importance of having social workers in senior centers and the need for money to educate or train current employees who do not have the expertise required to become case managers. Stakeholders theorized that making assessments and screenings a part of senior center routine would help eliminate the stigma of asking for help.

Providing a link to community resources

Senior centers do and need to serve as a link to community resources—resources outside of public benefits and services and outside of the centers themselves. As previously described, NYC is the largest city in the country and as such has a tremendous number of resources. These resources can mitigate social isolation, offer opportunities for engagement, lifelong learning, cultural and spiritual enrichment and a higher quality of life. There are those that are local to neighborhoods, those that serve people across the city and those that are national attractions and international models. From hospitals to parks to educational, cultural and religious institutions and events; from non-profit organizations and advocacy groups to entertainment venues and businesses; senior centers have a wealth of resources to tap into that are too often missed opportunities.

To increase opportunities for engagement beyond senior centers, stakeholders encouraged senior centers to increase use of activities that bring seniors out into the larger community. Senior center directors requested more resources to be able to bring seniors into the community and more collaboration to share resources, ideas and partners with each other. They also requested that participation in center life not only be measured by meal attendance, because that measure dissuades staff from linking their participants to other centers and resources.

It is the senior center's role to provide access to these resources and help make older adults feel comfortable using them. Centers can provide information access, transportation,

company, organization and affordability that would not be available if older adults reached out alone. Also, by using the community's resources, centers are encouraging those resources to consider how they serve all older adults. And, centers are expanding what they offer, making them more attractive to new visitors.

In addition to benefiting from resources, many seniors are in a position to offer their services to the community. Senior centers can be a hub to recruit and coordinate volunteering and advocacy activities, which both expands the resources available to the center and the community-at-large and prevents social isolation for those who participate.

Stakeholders and senior center directors were emphatic that partnering with existing resources expands what senior centers can accomplish. Stakeholders and senior center directors said that a centralized communication system or a base of information about community resources would help this process, as would sharing resources across senior services and centers.

Providing nutritional support

Hunger is a major concern for older adults, especially those who visit senior centers, a group which is disproportionately poor. Nine percent of Brookdale HIP survey respondents reported eating less than they should have during the past twelve months because they did not have enough money to buy food. Seventeen percent of Hispanics reported not having the money to buy enough food. The same study reports that 11% of those participating in senior centers find it somewhat to extremely difficult to obtain fresh fruit and vegetables in their neighborhoods. Even if fresh fruit and vegetables can be found, nearly 24% of senior center participants describe them as not affordable. A higher proportion of Hispanics (45%) reported feeling that way. Sixteen percent of those who responded to the CSCS survey made at least periodic use of a food pantry. Those with disabilities also often find it difficult to shop for food and prepare meals. ACS data finds 36% of those aged 60 years and older living in the greater New York area as experiencing some form of disability—physical, visual, auditory or cognitive. In a 2003 CSCS survey, of the 150 NYC senior center directors who participated, 80% reported that seniors have difficulty shopping or cooking for themselves (CSCS, 2003). These findings reinforce the importance of meals provided by the centers.

Eating balanced, nutrient-rich meals is more expensive than eating other foods, a problem for those with limited income, but such meals are essential to overall health, especially for controlling and preventing hypertension, diabetes and obesity. Senior center directors shared stories of stretching budgets, building relationships with restaurants, markets and pantries and creative chefs to provide healthy and appealing meals to older adults. The CSCS and borough-wide senior center director meetings found many directors wishing they had the resources to offer a greater variety of meals, meals with more fresh fruit and vegetables, meals in addition to the noontime and weekday offerings and at varied meal times, coordinated with other centers in the area. Participants echoed the directors' comments, and stakeholders also reported that they wished senior centers could show more creativity and variety in how meals were prepared and delivered.

Meals were the most common reason participants in the DFTA survey visited senior centers. From a list of 13 activities, most of which did not include food, participants' first request was for additional meals to be offered at their center, especially breakfast. Staff and stakeholders indicated that senior centers are often emergency food providers or the only source of food for participants on a given day.

Promoting health, mental health and healthy behaviors

The serious health risk and disease burden of NYC's seniors is demonstrated in this report's "Health Outcomes" section. As described, there are high levels of obesity, smoking, alcohol abuse, low levels of exercise and poor nutrition among older adults. High percentages of older adults are also diagnosed with mental illness, diabetes and hypertension—some of which is preventable. The need for promoting health, mental health and healthy behaviors is clear.

Disease prevention and health promotion activities are federally mandated for senior centers, and the state mandates nutrition education programs. Respondents from the CSCS and DFTA surveys describe using these programs and even more said that they would attend if the programs were available to them. According to the CSCS survey, respondents claimed highest rates of participation in health, blood pressure, and cancer screening programs. Fitness programs are also well attended, with 44% of respondents saying that they take exercise classes and 40% saying they participate in dancing. One-quarter said they attend Yoga; the same for Tai-Chi and Walking Clubs, and 17% take Aerobics.

Nearly all of the DFTA survey participants said they want to have additional health screenings and health classes (95% and 93%). Forty-two percent of participants said that health issues limit their participation at the center.

Promotion of health and healthy behaviors does not cover all the health needs of NYC's older adults. There is substantial unmet need for increased access to health care. This need is best measured by the previously mentioned high rate of preventable hospitalizations amongst those 65 and older in New York City and the high percentage of older adults who do not have a primary care provider. Citywide, CHS data shows that nearly 12% of New York City's population aged 65 and older do not have a regular primary care provider, a key to preventative health care.[42] Brookdale HIP found that senior center participants are less likely to have "regular doctor," with a citywide average of 16.4% having no regular doctor, using the ER as the regular source of care, or having multiple "regular doctors." Rates are much higher in the Bronx (24.1%) and Brooklyn (20.3%). Among ethnic groups, Hispanics participating in senior centers are the group least likely to have a regular primary care provider (21.2%). According to CHS, 6.1% of those aged 65 and older did not get needed medical care in the last 12 months. Brookdale HIP asked senior center participants a similar question, and this time, 8% said they did not get medical care they needed. The

[42] This figure combines those who said they had no primary care provider and those who use emergency rooms as their primary care provider.

most common reason offered was no insurance or no money. This was followed by difficulty getting an appointment and difficulty getting transportation. What is disconcerting is that those who come to senior centers are likely to have greater access to help than others in their community do, since they are already linked to one service-providing organization and they are more likely to be mobile than those who do not attend the centers.

Senior centers can help their participants receive the health care services they need by linking them to benefits and other resources, by providing information, conducting screenings, making referrals to appropriate health care providers or to case management services, bringing health professionals into centers and directly helping enroll older adults into health insurance programs. Identifying health needs will not be helpful if screenings do not include confirmation of ability to pay, help applying for Medicare or Medicaid, or referral to subsidized sources of primary care.

Similar strategies can be used to address the unmet need for mental health care. As previously described, the U.S. Surgeon General estimates that one in five older adults has a mental disorder of some kind, yet the U.S. Department for Health and Human Services estimates that only 22% of older adults with mental illness receive treatment from mental health professionals. Mental health care is particularly under-utilized by NYC's ethnic minority communities, especially the black population (Citywide Mental Health Coalition for the Black Elderly, 2010). To assist older adults, senior centers conducting screenings must look for both physical and mental health indicators.

Senior center directors and aging services stakeholders recognize and agreed on the need for senior centers to promote health and healthy behaviors. A considerable number expressed their wish to offer more health screenings and check-ups, as well as additional coordinated services with local medical providers. Several senior center directors attending the borough-wide meetings requested that DFTA provide funding for on-site nurses, possibly to be shared between centers. Several stakeholders added that money spent to provide health assessments and screenings, with referrals to available medical services, will promote senior health and well-being while preventing expensive and unnecessary hospital care.

Cross-cutting Principles to Perform Core Functions

Four key cross-cutting principles that stakeholders felt should inform all planning and service delivery consistently emerged from our consultations.

The first is **prevention**. All aspects of the senior center's functioning should be proactive. The idea is that centers' goals should be to prevent hunger, to prevent social isolation, to successfully access entitlements and benefits, to promote health and to facilitate access to health providers. Since the center is a point of regular contact with seniors, the goal is to anticipate problems and provide programs to educate and prevent before crises strike. Falls, health crises, unneeded visits to the emergency room, elder abuse, eviction, social isolation and financial abuse are often preventable. While centers should also understand and refer seniors to resources for emergency situations, prevention of such emergencies is just as, if not more, important.

The second cross-cutting characteristic is **accessibility**. Programs within the center should be accessible to the greatest number of people possible in whatever group the program is targeting. This means that centers need to take into account language differences, physical and cognitive disabilities, sensory impairments and transportation options. Technology and communication systems should be used whenever possible to advertise programs and facilitate access to benefits and services. There should be an openness to bringing in new visitors to the center and an environment that is welcoming.

The third characteristic involves building **input and participation of older adults** into the governance and decision-making of all centers, whenever possible. They know better than anyone what they need and want from senior centers. Seniors should be seen as individuals with valuable opinions and varying interests. They should also be seen as assets, instead of burdens. This means finding programs that build on their existing skills and talents and challenging them to seek out new opportunities. Having a say in the programs and services in their centers creates pride, ownership and knowledge about how a center operates and the accompanying cost.

The fourth and final strategy is to bring **cultural and linguistic competence and sensitivity** to all center activities. According to stakeholders, staff should reflect the community they serve when possible and/or work to understand the different groups in the community and their needs. They should have an understanding of norms in various cultures around communication, support systems, health and mental health care, languages spoken, values, interests and food choices.

The following section provides models of best practices at senior centers built around the five core functions, drawing on models from around the country and the world. This final section also translates these findings into implications for service delivery.

Models

This section highlights a few senior center programs in the United States and abroad that creatively meet the core functions identified in this report. These include providing opportunities for social engagement, providing a link to public services and benefits, providing a link to community resources, providing nutritional support, and promoting health, mental health and healthy behaviors. They use various combinations of the four methods of service delivery for meeting these core functions: information only; screening, assessment, and referral; direct program or services; and advocacy and mobilization. And they use the cross-cutting principles for meeting the core functions, including prevention, accessibility, input and participation by older adults in program design and delivery and cultural competence and sensitivity.

In attempting to identify model senior center programs locally, nationally and internationally, it is clear that there are thousands of senior centers that meet these core functions through a broad range of strategies. Determining to what degree they meet these functions is difficult, and beyond the scope of this project. Examples were selected from literature on innovative senior center programs and from testimony by experts and community stakeholders. These demonstrate central features of contemporary senior centers or senior center programs. Below are examples of centers that highlight recognized innovative practices across six areas:

- Institutional Structures and Partnerships
- Use of Space and Technology
- Financial and Human Resources
- Programming Methods and Priorities
- Evaluation
- Serving Diverse Populations

Examples in each area were chosen to demonstrate shared approaches to globally aging populations. Many of these models were developed in response to specific communities needs. It would therefore be inappropriate to duplicate these exactly in other settings. However, best practices and innovative ideas of these models can be exported to NYC. Examples of innovative projects in NYC—projects with which stakeholders may be familiar—are also part of each discussion.

Models were drawn from the final report by the New Models of Senior Centers Taskforce, prepared for the National Institute of Senior Centers (NISC) (Pardasani *et al.,* 2009). Additionally, two reports from the National Council on the Aging—"Healthy Aging: A Good Investment—Exemplary Programs for Senior Centers and Other Facilities" and "Together We Care: Helping Caregivers Find Support"—provided further examples (NCOA 2004a, 2004b). Additional information on each site referenced below was gathered through telephone interviews with program directors, who graciously shared annual reports and evaluations when available. International models were drawn from a review of abstracts and posters from the most recent major international conference on aging (2009 International Association of Gerontology and Geriatrics (IAGG) conference), a paper

entitled "Ageing and Well-Being in an International Context" by Jonathan Clifton (2009) for the Institute for Public Policy Research in the United Kingdom, and expert testimony.

Institutional Structures and Partnerships

Institutional structures and partnerships shape the way senior centers operate and the kinds of programs that are run. They provide a framework for governance and decision making, as well a means of raising funds. A good example of effective partnership in NYC is the **Washington Heights/Inwood Council on the Aging (WHICOA)** (http://mbiac.org/bor-wash.shtml), an inter-agency planning and advocacy organization with a membership of over 50 aging services providers in northern Manhattan. WHICOA coordinates services (including varying meal days and times served at different centers, transportation, technology, health and social services) to avoid duplication, optimize effectiveness, maximize resources and create a true continuum of services for older adults in their community. NYC's NORCs provide a wealth of examples of creative partnerships and design. One of those on the Upper West Side, the **Lincoln Square Neighborhood Center** (http://www.lsncny.org) brings together dozens of social service agencies, healthcare, business and cultural institutions to serve older adults living in 14 buildings. Lincoln Square is developed by the community's older adults, who leverage their strengths, cultures, traditions and history to provide the foundation of programming and services. The rest of this section focuses on partnership models within institutions and communities outside NYC.

Fergus Falls Senior Center
(www.ffsenior.org)

Based in rural Minnesota, Fergus Falls Senior Center bases its programming and governance on the active participation of its members. Membership fees are $15 a year, and among the many benefits of membership, such as discounts, notary services, and a newsletter, are "voting privileges." Members can serve on program committees and run for election for their Board. Board members are elected for three-year terms, and elections are held annually. The Board meets monthly, and members who are not on the board are encouraged to speak with the board about the activities and programming at the senior center. A coffee hour is held for members to meet Board members before each board meeting. Fergus Falls Senior Center does not directly employ staff; rather, the director and receptionist are employed by the city of Fergus Falls, and other staff, including a nutritionist or custodial services, are contracted through an outside non-profit. Therefore, governance is primarily through its voluntary, elected board and program committees.

Lowcounty Senior Center
(www.rsfh.com/seniorcenter)

The Low County Senior Center is a non-profit organization in Charleston, South Carolina. The center and its 4.5 acres of land are owned by the city of Charleston. It is also next to a county park. The center is managed by a voluntary hospital system (Roper St. Francis) as

part of its senior services. According to its director, Ms. Bernat, the center is the largest share of the hospital system's senior services; she is employed by the hospital. Despite these affiliations, the center boasts a diversified funding base, and receives little government funding. A full third of its $300,000 budget is raised through membership fees. Furthermore, volunteers complete most of its programming and fundraising. As such, it considers itself to be a model of civic engagement.

Organization for Active Seniors in Society (OASIS)
(www.milwaukeerecreation.net/active-seniors/oasis.htm)

As a result of a countywide project called Connecting Caring Communities, community partners and residents agreed to revitalize an older Milwaukee senior center, turning it into (an) OASIS. Connecting Caring Communities brought together individuals and organizations throughout Milwaukee in order to enhance the quality of life of older residents, and enable better engagement with their communities. In partnership with community stakeholders, the 55+ Senior Center was renovated to include a fitness center, computer classes, a wellness clinic, and many other activities, including meals. Students from the University of Milwaukee staff the fitness center. The newly named OASIS also houses an Alderman's office, a county Sheriff substation, and a voting site, all with the purpose of connecting older adults with their community.

Senior Adult Learning Center
(www.pdx.edu/ioa/salc-faq)

Lifelong learning is among the many goals of senior centers activities across the globe. Some centers, such as the Princeton Senior Center (www.princetonsenior.org) or the Whitney Senior Center are independent non-profit organizations offering seniors a wide range of courses, mostly in the arts and humanities, within their facilities.

The Senior Adult Learning Center (SALC)

SALC is a program offered by Portland State University allowing Oregon residents over 65 years of age to audit courses on campus. Older adults can choose from over 4,000 free courses or others that carry a fee. Auditors are welcome to register for courses provided they are not fully booked. SALC is a "lifelong learning program" of Portland State University and is affiliated with a senior membership organization called the Retired Associates of Portland State University (RAPSU). Membership of RAPSU is open to the public and has very low membership dues ($15 for individuals/$25 for couples). It meets monthly at the student union building of PSU and functions as an independent club with by-laws, a board, and officers. This model offers an alternative form of lifelong learning outside the structure of a traditional senior center.

The lifelong learning model is applied throughout China, which boasts of 26,000 institutions of higher learning for older adults that reach 2.3 million students.

RSVP Singapore – The Organization of Senior Volunteers
(http://www.rsvp.org.sg/about.htm)

RSVP Singapore combines lifelong learning with service opportunities through programs that partners with a variety of institutions in Singapore. Its office is located in a local shopping center, across from a public library, and it operates under the auspices of the National Council of Social Services, with funding from the Ministry of Community Development, Youth, and Sports. It offers an "Active Aging Seniors Program," including physical, social, and scholarly activities. It also offers many opportunities for older adults to volunteer in their communities, including programs to assist mentally ill individuals, mentor school children, host foreign students at the local Polytechnic University and other institutions, guide other seniors visiting a public exhibit on healthy living, and greet arriving passengers in the local airport. Each of these activities is accomplished through partnerships with schools, universities, and government agencies. The organization is managed through a board of directors, several staff, and volunteer program committees.

Use of Space

One of the defining features of a senior center is the center itself. Whether in a church basement or a freestanding state-of-the-art facility, a senior center typically involves connecting of older adults to a physical space. Senior center programming also often involves arranging transportation to and from the space, and often requires appropriate medical equipment or facilities for those who are frail or disabled within the space. In NYC, **University Settlement** (www.universitysettlement.org) co-operates with the Chinatown YMCA in the modern 44,000-square-foot Houston Street building, providing older adults with wireless Internet access, laptops, a pool, gym and art studios. **Lincoln Square Neighborhood Center**, mentioned above, has a Technology Learning Center that provides Internet access and computer training for 150 older adults and 110 children, simultaneously. Several senior centers located in public housing, like the **JWJ Senior Center** in East Harlem, shares its space and some programming with early education programs. In this section, we highlight centers that have been recognized for their use of space, even if that space is not physical, but more conceptual.

Lou Walker Senior Center
(www.co.dekalb.ga.us/humanserv/lou.htm)

Located in Lithonia, Georgia, the Lou Walker Senior Center cites the use of architectural features as way of defying stereotypes of inactive seniors. Its multipurpose facility was built to attract Baby Boomers and caters to its largely African American members. The 40,000 square foot state-of-the-art facility includes a heated therapeutic pool, fitness center, computer lab, art studios, lounges, a library, conference meeting rooms, classrooms, billiard and game room, mirrored aerobics/dance room, beauty/barber shop, gift shop, cafeteria, and formal multipurpose hall. The main hall reportedly overlooks a large and scenic lake.

Fort Collins Senior Center
(http://ci.fort-collins.co.us./recreation/seniorcenter.php)

With a facility that sounds like a luxury resort, the Fort Collins Senior Center is among the many reasons that Fort Collins is ranked by AARP and Money Magazine as one of the best places in the United States to retire. Measuring 40,000 square feet, the Center houses a gym, walking/ jogging track, cardio area, pool, spa, activity rooms, library/media center, organizational work room, conference room, billiards/snooker area, kitchen, wet crafts room, art studio, and outdoors areas. With such a structure, and partners ranging from AARP, Golden Kiwanis, local medical providers, hospitals, businesses, schools, and universities, it offers hundreds of activities for participants each week.

Mather Life Ways Café Plus
(www.matherlifeways.com)

An alternative to the mega senior centers found in more rural parts of the country is an innovative design concept in Chicago, Illinois, called Café Plus. There, stylish cafés serving affordable food to the general public welcome older adults into a multi-service institution without an institutional feel. Beyond each of the three cafes in the Chicago area are small gyms, activities such as computer classes, writing classes and trips, and referrals to social services. The program is managed by Mather LifeWays, a large, local non-profit agency serving seniors through policy, research, institute and residential facilities.

Waterford Senior Center
(http://waterford.k12.mi.us/seniorcenter/)

As traditional multi-generational households have largely broken down in the West—a trend spreading not just in the West but throughout the globe—intentional spaces for intergenerational activity have appeared to fill the growing void. Intergenerational programming is believed to be beneficial for the young and old alike. Furthermore, there appear to be logistical and financial advantages to multi-generational groups sharing spaces. Based in Michigan, the Waterford Senior Center shares a renovated school building with a public library and a childcare center. This arrangement allows three separate organizations to maintain independent spaces while sharing costs associated with the overall building. Co-location also offers opportunities for inter-generational programming and lifelong learning.

Senior Center Without Walls
(www.seniorcenterwithoutwalls.org)

Based in Oakland, California, the Senior Center Without Walls operates activities for home bound older adults over the telephone. Program activities are aimed at offering otherwise isolated individuals opportunities for mental stimulation and socialization. Calls are pre-scheduled according to a topic or theme, and participants can choose between ones that they can join on a drop-in basis and ones that run for a twelve-week session. Offerings include support groups, a sing along session, reading and writing exercises, mind games, and more. Each twelve-week session hosts 60-70 conference calls with about 180

participants, with some on multiple calls each day. The center's director also reports that participants often become friends, calling each other outside of scheduled sessions. By functioning over the phone, the center is also able to allow participants to connect with others through similar centers in other parts of the country. For example, one "special event" is the "Transcontinental Exchange," a bi-coastal call with homebound New Yorkers in the Stanley M. Isaacs Neighborhood Center's call-in program (www.isaacscenter.org/).

Shenendehowa Adult Community Center, Carelinks Program
(www.cliftonpark.org/seniors/)

To address the problem of social isolation and withdrawal from senior center life among frail elderly, the Shenendehowa Adult Community Center developed the Carelinks Interfaith Communiy Caregivers Program for homebound adults and their caregivers. Volunteers from Shenendehowa, most of whom are seniors themselves, make home visits, help with shopping, errands and meal preparation, offer respite for primary caregivers, and offer information and referrals to their homebound peers. They also arrange for transportation and provide reassurance over the telephone. Volunteers offer a connection to the senior center life that frail elders are no longer able to enjoy at the facility itself.

Programming Methods and Priorities

Senior centers are often a hub of activities for older adults, functioning as programming centers for social engagement, physical fitness, and lifelong learning. Most centers also provide congregate meals, community services, and links to public benefits. Programming is most often determined by popular demand, with consideration of the resources available. Many accredited centers also offer evidence based programming. In NYC, several senior centers and other senior service providers focus on one of the core functions previously identified instead of trying to do them all. **One Stop Senior Services** on the Upper West Side (www.onestopseniorservices.org) is an example of this, with the core of its programming being case management. Staff perform in-take, screenings and assessments and then look for immediate solutions, or resolutions, to the often complex issues the older adult-participants present.

Northshore Senior Center in Bothell, Washington
(www.northshoreseniorcenter.org)

The Northshore Senior Center offers 250 classes and activities to over 7,000 individual participants each year. It also offers at least 50 special events per year. Mixed in with popular activities like arts and crafts, music, and horticulture is an evidence-based program called Evergreen Enhance Wellness. Replicated at 200 sites across the country, this program of individualized health management has been shown to "decrease the length of hospital stays, lower the use of psychoactive drugs, alleviate symptoms of mood disorders, and develop a greater sense of self-efficacy" (Pardasani *et al.*, 2009:14). Besides balancing the popular with evidence based programming, the center describes its programming

philosophy as follows: “Some imagine that the goal of senior center staff is to schedule games and activities to keep older people busy. In contrast, at Northshore our job is to greet whoever walks in the door, ask what they want to do and then support them in doing it” (Northshore website).

Elsie Stuhr Center
(www.thprd.org/facilities/stuhr/home.cfm)

Though it offers a range activities aimed at socialization, the Elsie Stuhr Center in Beaverton, Oregon, specializes in fitness. It offers 44 fitness classes a week, reaching 10,000 older adults annually. Funded through the Recreation and Parks Department and affiliated with the International Council for Active Aging, this program offers many resources for gauging physical ability and encouraging physical activity in older adults at all ability levels. They guide participants in assessing their relative physical strength, then group classes based on physical ability. They offer chair-based classes, as well as those at beginner, intermediate, or advanced levels of fitness. They are also constructing a new $1.2 million fitness room.

Third Age Summerhill Active Retirement Group
(www.thirdage-ireland.com/Links.asp)

Based in rural Ireland and formed by an active group of older adults who wanted to address the challenges of aging in a rural area, the Third Age Summerhill program offers a variety of programming aimed at socialization and well-being for members. Though serving a relatively small group of individuals (90 members), the group engages in international advocacy on ageism and discrimination with the intent of having a wide impact on older adults seeking to age in-place worldwide.

Seniornet
(www.seniornet.org)

Operating in 33 states in the United States as well as in Japan, Malaysia and Sweden, Seniornet offers computer training for adults over 50 years of age. Classes take place in libraries, colleges, and community centers, and are mostly volunteer run. It is recognized for its programming by seniors for seniors, and also for its emphasis on community rather than individual learning. Beyond services in four countries, Seniornet hosts a web-based international book club administered by 27 volunteers from around the world.

St. Barnabas Senior Center of Los Angeles
(www.sbssla.org)

St. Barnabas Senior Center in Los Angeles California is a multi-service agency with many programs aimed at lifelong learning and self-expression. The center serves one of the most ethnically diverse and low income areas of the city. Its participants speak many languages other than English, including Spanish, Korean, Mandarin, Cantonese, Armenian, Vietnamese, Japanese and Tagalog. In addition to one-on-one instruction in computers through its Cyber Cafe, the center engages older adults in a Film Making Initiative. Drawing

on its proximity to Hollywood and the television industry, volunteer film industry professionals teach a diverse array of seniors to create their own films and use computerized digital editing software. The center reported that in its second year, students learn advanced film development technologies as well as methods for developing narrative films, such as story boarding and scriptwriting. Both the one-on-one computer lessons and the Film Making Initiative allow bi-lingual members to pair up and work with monolingual immigrants, thereby expanding the participation in senior center life of those with limited English proficiency.

The Laughing Clubs of India
(www.laughteryoga.org)

Demonstrating that well being in aging is not only about learning how to use computers or digital cameras, Dr. Madan Kataria began laughing clubs in India to allow mostly older adults to clear their mind and socialize with peers outside of the extended family structure. Starting in 1995, Dr. Kataria began gathering older adults and their neighbors in a local Mumbai park, and drawing on yoga postures and breathing techniques, generated a therapeutic laughter technique. This practice spread throughout India, and then the world. There are now over 50,000 clubs in fifty other nations, including the United States. The Hindu United Cultural Council's Senior Center in South Ozone Park is home to one such club.

Financial and Human Resources

Senior centers, even those with a strong volunteer base, require funding and staff to operate. Across the country and world, budgets range from tens of thousands of dollars to several million. Ideal U.S. senior centers have diversified budgets, drawing on a mix of government funding, private foundation grants, and individual philanthropic contributions. NYC centers rely almost entirely on public funding, but there are exceptions. One of those is the **Carter Burden Center for the Aging** on the Upper East Side (www.burdencenter.org) which has a $3.9 million budget, a combination of public and private funding and runs a flea market, with the proceeds going to activities for participants. In addition to their staff, the center utilizes local undergraduate and graduate students and over 2,000 volunteers to run its programs. On a much smaller scale, the **Fordham Hill Oval Committee on Elders**[43] in the Bronx has a two-room, approximately 600 square foot volunteer-run senior center from which the Executive Board and 120 members (cost is $25-per-person for two years) set-up and breakdown their own activities, design their own calendars and flyers, have donated all of the televisions, games and furniture in the center, run a photo gallery and plan field trips and special evening and weekend events. This section of the report highlights centers around the country that function with private dollars, the time of

[43] This center does not have a website, but a detailed description of their program can be found through the National Council on Aging at http://www.ncoa.org/strengthening-community-organizations/senior-centers/nisc/the-fordham-hill-oval.html.

volunteers and revenue generating enterprises. There is also an international model of senior care that is cash-free. The intention in this section is NOT to suggest a diminution in need for public funding, but to share strategies of how to augment existing resources.

Senior Center, Inc.
(www.seniorcenterinc.org)

Senior Center, Inc., has operated in Charlottesville, Virginia solely on private funding since it was founded in 1960. Offering over 100 programs, it aims to enable socialization among its 7,500 members. It raises nearly half of its one million dollar budget through individual philanthropy and through grants from foundations and local businesses. The remainder of its revenue comes from membership, program fees, newsletter advertising sales, facility rental fees, and other earned income. Senior Center, Inc., receives no federal, state, or local government funding.

Senior Center Services of Bartholomew County
(www.seniorcenterservices.com)

Since 1960, Senior Center Services has run a non-profit employment program for seniors called Senior Products, Inc., out of its center in Columbus, Indiana. The program began by making children's furniture and wiping cloths and has since expanded into a subcontracted manufacturing operation and a temporary employment service. According to the 2009 NISC report, Senior Products generated $500,000 in sales and services. Advertisement for a recent collaboration with a for-profit temporary staffing agency called Elwood Staffing can be found on its website. This program is intended to keep seniors actively engaged and contributing to their community and is reported to be largely self-sustaining in terms of costs.

West Seattle Senior Center
(www.sc-ws.org)

Rather than create new products, the West Seattle Senior Center in Seattle, Washington decided to generate income by selling donated goods. Storage of goods, such as clothing, furniture, and televisions, became a problem for an agency offering legal and medical services, community housing resources, lifelong learning opportunities, and social events, and its director sought a way to dispose of them. This turned out to be a revenue generating opportunity, leading the director to create Stop N' Shop, a volunteer-run shop that earned an $85,000 profit in 2008. This revenue supplements the senior center's funding and was described as crucial to the construction of a new meeting hall for the center's social activities.

Yad LaKashish
(www.lifeline.org.il)

The Yad LaKashsish senior center in Jerusalem, Israel, generates revenue for its activities through the sale of products created by its member participants. Older adults at Yad LaKashish engage in arts and crafts activities such as box making, ceramics, metal work,

sewing and embroidery, book binding, silk painting and printing, and carpentry. The sale of artwork to tourists and locals both in Israel and abroad generates 35% of the center's annual budget. The remainder of the funding comes from international individual and private donations.

Hureai Kippu

Though not a senior center, this innovative cash-free service model in Japan was developed in a setting in which social services are almost entirely provided by the government. Established in 1991 to serve an increasingly aging population with smaller and more dispersed families, Hureai Kippu is a timebank scheme allowing people who volunteer to serve the elderly to then earn credits toward their own or a relative's care. People earn credits toward this social insurance depending on the amount of time volunteered and the difficulty of the tasks. They can then pay for requested services using their credits or transfer their credits to a relative in the same or in a different location, enabling the relative to "pay" for needed care.

Evaluation

Senior Centers use a variety of methods to evaluate to what degree their programming is liked and whether they are achieving the desired outcomes. These methods range from gathering statistics on usage and conducting customer satisfaction surveys and course evaluations to studies of clinical outcomes. Funding for evaluation activities and available academic partners often determine the quality and quantity of evaluations conducted by facilities[44]. Evaluation also plays a role in accreditation by NISC. New York State has only six accredited senior centers and two are in New York City: **Carter Burden Center for the Aging** and the **Theodora G. Jackson Adult Center** in Jamaica, Queens.[45] There is also evidence that many international senior center programs engage in evaluation work. The evidence most accessible to us is evaluations of health programs run by researchers who publish internationally. Throughout our consultation process, stakeholders expressed the need for better ways to demonstrate the outcomes and effectiveness of their programs. This section highlights examples of the evaluation of both domestic and international senior center programs.

Fort Collins Senior Center
(http://ci.fort-collins.co.us./recreation/seniorcenter.php)

Mentioned earlier, the Fort Collins Senior Center is an example of a center that undergoes rigorous evaluation as part of its NISC accreditation process. Director Barbara Schoenberger vividly described this process as follows: "During 2008 we went thru the

[44] A comprehensive guide to senior center based evaluation research can be found in bibliography prepared by Dr. Manoj Pardasani for the NISC.

[45] The Carter Burden Center for the Aging was accredited in 2003 and the Theodora G. Jackson Adult Center in 2005.

self-assessment process furnished by the National Council on Aging/National Institute of Senior Centers. The process took many months of evaluation with staff, members, participants, volunteers, and members of the community. The results were compiled by area and fill 8 large 3-ring binders. That information was reviewed in a community meeting. The results were submitted to NISC which were then reviewed on and off site by a professional board. We were accredited based on that review. Information from this process was compiled for review of the staff in the development of a 5 year strategic plan. Additionally, we conduct ongoing evaluation of our program, facility and services by surveying users and non-users on a variety of topics. Each programmer is responsible for collecting evaluations on an ongoing basis from program participants. We employ secret shoppers. And, we have monthly meetings with the Senior Center Council who provide feedback to us verbally."[46] This example demonstrates how for many centers, evaluation is not a secondary activity, but central to its operation and strategic planning.

Northshore Senior Center in Illinois
(www.nssc.org)

As part of its evaluation activities, in 2009 the accredited Northshore Senior Center in Northfield, Illinois, developed a program and membership survey. It was designed to measure how well the center is meeting the needs of its participants and to help with planning to attract new members in the coming year. The survey covered its lifelong learning program and classes, program participation and satisfaction, membership satisfaction, communication services, as well as collecting respondent demographics. It was distributed to 4,321 program participants, and 562 individuals responded. Most of the respondents were married females over 75 years of age. The largest group of respondents was between 80-84 years. Results showed that most respondents were satisfied with being a member (96%) and satisfied with the lifelong learning programs (91%). Lectures were by far the most popular activity (63%). Most participants learned about program events through the calendar (94%), rather than the newsletter (42%) or e-mail (22%). A conclusion drawn from the survey was that the center should "cater to the wants and needs of members and other participants rather than deciding what individuals need." In this way, they hoped to attract new (and younger) members.

Evaluation of Brain Fitness Activities among Senior Center Participants in Montreal

Two hundred and fifty seven older women at nine French and English speaking senior centers in Montreal, Canada, participated in a study to assess the effects of brain fitness activities on their physical and mental health. The mixed qualitative and quantitative study by S. Bushfield and T. Fitzpatrick was presented at the 2009 IAGG conference. Researchers concluded, "Multivariate Analysis (MANOVA) with post-hoc Bonferroni-t-tests revealed that activities such as aerobics, strength exercises, career decisions, working for pay, participating in a computer lab, learning new languages, group work and listening to speakers were significantly related to the physical health indicators of self-reported health and chronic conditions. Activities such as laughing together, career decisions, working

[46] Reprinted from an e-mail with permission from Barbara Schoenberger on 2/8/2010.

together on a project, and strength exercises were significantly related to mental health indicators such as overall feelings (spirit), happiness and an interesting life. The results have implications for practitioners and future research in healthy aging."

Serving Diverse Populations

It is important to celebrate diversity in senior center programming. Variations based on race, ethnicity, physical and/or mental disability, and sexual orientation must be considered along with gender, class, education, and socio-economic status when developing facilities and programs for older adults. With regard to ethnic and linguistic diversity, older immigrants living in historic immigrant enclaves are more likely to find centers that specialize in serving people from their ancestral homes. Examples in NYC include the **Casa Boricua Senior Center** (http://volunteer.nycservice.org/org/10324516743.html), serving older Latinos in the Bronx, **Shorefront YM-YWHA of Brighton - Manhattan Beach** (www.shorefronty.org), serving Russian speaking peoples in Brooklyn, or **Korean Community Services** (www.kcsny.org), serving Koreans in Queens, and **India Home** (www.indiahome.org), serving South Asians in Queens. NYC is also home to the **SAGE** (www.sageusa.org), the world's oldest and largest non-profit agency dedicated to serving lesbian, gay, bisexual, and transgender older people. SAGE offers a number of direct service programs as well as technical assistance and training to expand opportunities for LGBT older people across the country. These service providers consider their participants' language, religious beliefs and rituals, holidays, cultural and activity preferences and food preferences in all parts of the center's design.

Challenges appear as immigrants have spread beyond historic immigrant enclaves to areas that do not have cultural or linguistic expertise or in areas faced with multiple immigrant populations at once. Research has found that disparities exist in senior center utilization, with minorities being underrepresented among those attending senior centers (Pardasani, 2004). **University Settlement** (www.university settlement.org) brings together European immigrants of the old Lower East Side with a large population of Latinos and Chinese. The **Elmhurst/Jackson Heights Senior Center,** run by the Institute for Puerto Rican and Hispanic Elderly, conducts comprehensive assessment, information, referral and advocacy for Korean, Cantonese, Spanish and English participants.

This section explores other efforts to serve diverse minority populations in the United States and abroad as well as those who are marginalized based on their sexual orientation.

West County Senior Center

(www.pbcgov.com/communityservices/programs/seniorservices)

Recognizing the isolation of Haitian older adults in the community surrounding a county senior center in Belle Glade, Florida, the center developed an initiative to better integrate this population into the existing center. With support from the Allegany Franciscan Ministries, Inc., the staff developed a program to welcome Haitian older adults into a center that largely served African, Caribbean, Hispanic, and Caucasian elderly. Dr. Ruth McCaffrey

describes the project as follows: "A list of services and supplies needed to help Haitian older adults at the center and make them feel comfortable was developed. This list included transportation to and from the center; hiring a Creole-speaking interpreter who would act as mentor and teacher; and the introduction of Haitian cultural ideas, music, and art to other older adults and staff at the center so they could more easily come to know the Haitian older adults. Finally, a formal introduction party with a Haitian cultural theme was planned to introduce the Haitian older adults to the other members of the center"(McCaffrey, 2007:15). Staff also conducted outreach in local Haitian churches to build support for the integration program. Dr. McCaffrey engaged in evaluation research of this program, and in 2008, published a report indicating that the program was successful at making Haitian participants feel welcome (McCaffrey, 2008).

White Crane Wellness Center
(www.whitecranewellness.org)

Based in Chicago, Illinois, the White Crane Wellness Center engages in health promotion and disease prevention activities with many, diverse immigrant populations in the city. It runs an on-site Wellness Program, offering Thai Chi, Yoga, Aerobic, Healthy Eating and Weights classes. It also operates a Wellness Outreach Initiative, reaching 6,000 older adults in 20 housing and social service sites. Their health and wellness activities reach multiple ethnic groups, including Russian, Romanian, Korean, Japanese, Bosnian, Chinese, Polish, Assyrian, Laotian, East Indian, and Vietnamese, as well as African Americans. It reaches this broad range of groups by collaborating with various partners, including United Methodist Homes and Services, the Coalition of Limited English Speaking Elderly, and World Relief Chicago. By building a network of community-based service providers, the Wellness Center works toward health promotion and disease prevention in the low-income minority, immigrant and refugee elderly in the Chicago area.

Migrant Resource Center, Australia
(www.mrcnorthwest.org.au/aged.htm)

Ethnic diversity is not unique to the United States. In fact, the high rate of global migration throughout the latter half of the twentieth century has resulted in rapid growth in the number of immigrants who are aging in a foreign land. Australia provides an alternate example of a country working to meet the needs of diverse immigrant population groups. The Migrant Resource Center's (MRC) Aged and Disability program seeks to strengthen access to resources among the country's aging immigrants. MRC is an independent non-profit organization that seeks to help with immigrant and refugee resettlement in Australia. Among its programs is a project that seeks to improve access to home and community care for elderly newcomers. It also hosts support groups for ethnically specific communities, including the Turkish, German, Egyptian Coptic, Indian, Sri Lankan, Lao, African, and East Timorese. The support groups operate out of local senior centers and offer activities, information, and support.

Golden Rainbow Senior Center
(www.goldenrainbowseniorcenter.org)

Located in Palm Springs, California, is the Golden Rainbow Senior Center, a community center for lesbian, gay, bisexual and transgender (LGBT) elders and their supporters. Its mission is to provide a welcoming and active environment for LGBT elders in the Coachella Valley, with an emphasis on promoting health, wellness, and socialization. Services include social activities, counseling and social services, lifelong learning, heath and wellness, and fitness. Golden Rainbow is widely recognized by community stakeholders for providing a safe space for older LGBT adults and their families.

Puerta Abierta a la Diversidad, Buenos Aires, Argentina
(http://www.puertaabierta.com.ar/.wg_generado_04.html?rand=931819S)

An alternative to a free-standing center for older LGBT adults can be found in Buenos Aires, Argentina. There, the *Puerta Abierta a la Diversidad* (Diversity Open Door), a non-profit LGBT center, hosts a senior center for individuals over 65 years. The center provides a comfortable place where older LGBT individuals can receive social services, socialize, and receive counseling. *Puerta Abierta* is the first gay and lesbian rights organization in Argentina, and it engages in advocacy to fight the double discrimination faced by those who are both LGBT and elderly.

Synthesis of Key Findings with Implications for Service Delivery

As the above descriptions of NYC's older adult population, existing services and resources, and models of innovative programs suggest, the NYC senior services network faces a formidable challenge in meeting the changing needs of older New Yorkers. Fortunately, the existing network is well established and includes many talented and committed individuals and creative and popular programs. Moreover, NYC has rich resources, services, and benefits on which to draw. Based on review of the data and literature and our ongoing consultation with experts and stakeholders, we offer the findings summarized here. The implications for service delivery these findings infer are more fully explained below.

1. Poverty is pervasive in NYC's older adult population and even more so among senior center users. There needs to be systematic facilitation of access to public benefits in senior centers, ongoing efforts to improve income security and awareness of the needs of those living in poverty.

2. The current and projected population of older adults is incredibly diverse. Senior centers serve a central role as very localized service providers for specific communities and are well positioned to address the needs of NYC's diverse older adults.

3. Greater integration between senior centers and other community resources will provide older adults with more options, better identify gaps and avoid duplication of services.

4. There is a general consensus about the core functions of senior centers. These include providing opportunities for social engagement; providing a link to public services and benefits; providing a link to community resources; providing nutritional support; and promoting health; mental health and healthy behaviors. The link, however, between the functions of senior centers and the best programs to achieve specific outcomes has not been made explicit or evaluated in most cases.

5. Core functions can be met through a range of methods of delivery. These include provision of information only, assessment and referral, a direct service program and/or advocacy.

6. Older adults should be consulted with and involved in directing what happens at senior centers.

7. Proposed charter senior centers or centers of innovation may meet needs that have been difficult to address at the neighborhood center level. These centers will provide services at a location and serve as a resource to non-charter centers in their area of expertise. These centers can be designed to serve special needs, special interests, underserved populations and/or particular neighborhoods.

8. Senior centers have an image problem. To increase participation, reach new populations and secure funding, the image of senior centers must be improved.

Policy and programmatic implications are presented for each of the main findings. The first group are implications for senior centers. The second group represents implications leading to steps that DFTA can recommend that senior centers take. The third group includes implications for DFTA about steps they can take to facilitate service delivery. The fourth group suggests ways other organizations can ensure and expand on successful implementation.

1. **Poverty is pervasive in NYC's older adult population and even more so among senior center users. There needs to be systematic facilitation of access to public benefits in senior centers, ongoing efforts to improve income security and awareness of the needs of those living in poverty.**

DFTA ensures centers will:

- Have staff members who are knowledgeable about neighborhood, city, state and federal programs and benefits that serve poor older adults.
- Offer to screen all senior center clients for eligibility for entitlements and benefits.
- Have capacity to do electronic applications to enroll participants in benefits, or at a minimum, help with paper applications.
- Help participants with the various steps of the enrollment process and/or give them a warm referral to other organizations in the community that assist with enrollment or questions.

DFTA recommends that centers:

- Should be able to locate resources for special populations, including immigrants, those with sensory impairments, those with mental health issues, those with low-literacy and/or technological literacy levels, and LGBT older adults.

- Develop systems for employing staff with case management expertise and/or work with DFTA to increase center clients' access to DFTA-funded or other case management services.
- Develop strategies for linking interested clients with employment opportunities.

Recommendations for DFTA:

- Expand access to comprehensive training for senior center staff on programs and benefits available to older adults and facilitate access to their applications.
- Participate in shaping other agencies' strategies to keep poor older adults in mind, provide information to older adults who do not use senior centers and educate others on the prevalence of poverty in this population.
- Help facilitate centers' access to computer technology for online benefit enrollment.
- Develop systems to improve senior center participants' access to case management services.

Other organizations involvement:

- Enlist benefits specialists (social workers, legal services providers, case managers etc.) to help develop modules and train senior center directors and staff to facilitate access to benefits application systems.

2. The current and projected population of older adults is incredibly diverse. Senior centers serve a central role as very localized service providers for specific communities and are well positioned to address the needs of NYC's diverse older adults.

DFTA ensures centers will:

- Review their population using DFTA data, especially primary languages spoken and country of origin, and compare these data to whom they are currently serving.
- Learn the needs of the populations in their service areas and how they are or are not being served by other resources and attempt to link to them to resources.

- Have cultural and linguistic competence and sensitivity for significant groups that they serve, considering staffing, food served, activities, communication style and holiday celebrations.

DFTA recommends that centers:

- Perform outreach and communication to these groups.

Recommendations for DFTA:

- Make the needs assessment data and analysis available by community district.
- Help people interpret the data.
- Identify individuals and groups within community districts at risk for social and cultural isolation (eg. new immigrants, intra-city population shifts, groups outside of the historically served majority).

Other organizations involvement:

- Facilitate reciprocal information exchange between senior centers and resources in each community (e.g. churches, food stores and groceries, social clubs, cultural centers, banks and pharmacies).
- Foster partnerships with public and private agencies that monitor population shifts and serve specific groups.

3. Greater integration between senior centers and other community resources will provide older adults with more options, better identify gaps and avoid duplication of services.

DFTA ensures centers will:

- Understand the other senior services in their area and coordinate with other centers, with case management, personal care, elder abuse, mental health and health services.
- Involve community leaders and organizations in senior center planning.

DFTA recommends that centers:

- Investigate all services and community resources to make information available, facilitate access, coordinate services, partner to provide services and avoid duplication.

Recommendations for DFTA:

- Make community district level maps available with locations of resources, institutions, transportation and parks.

Other organizations involvement:

- Encourage community boards and city council offices to have a listing of senior services and senior centers that they communicate annually to their constituents and to visit senior centers to discuss pressing issues.
- Educate health providers, home care, personal care agencies and meal delivery providers about other senior services

4. There is a general consensus about the core functions of senior centers. These are providing opportunities for social engagement, providing a link to public services and benefits, providing a link to community resources, providing nutritional support and promoting health, mental health and healthy behaviors. The link, however, between functions of senior centers and the best programs to achieve specific outcomes has not been made explicit or evaluated in most cases.

DFTA ensures centers will:

- Define which of the core functions they are fulfilling.
- Define the outcomes they hope to achieve.
- Define what programs and activities are designed to achieve which outcomes.

DFTA recommends that centers:

- Define how they will measure progress towards defined outcomes.

Recommendations for DFTA:

- Convene a work group of center directors and others to create a defined menu of appropriate measures for different outcomes.
- Improve systems for collecting data on programs and services.
- Train people on appropriate use of those systems and measures.
- Assist centers in linking to evaluators and researchers willing to help with assessment.

Other organizations involvement:

- Work with academic centers to develop appropriate and realistic indicators, recognizing staffing limitations and linguistic needs.
- Ask benefits and service providers in pilot neighborhoods to participate in tracking referrals and benefits enrollment that come from senior centers to measure outcomes.

5. Core functions can be met through a range of methods of delivery. These include provision of information only, assessment and referral, a direct service program and/or advocacy.

DFTA ensures centers will:

- Make a decision on how services will be delivered for various objectives within this range of delivery possibilities and define the modalities they use.
- Set as a minimum standard making information on the main services and resources available to seniors, in each of the core functions, available at every center.

Recommendations for DFTA:

- Define which centers are fulfilling which functions.
- Assess how well services meet core functions and how they are distributed across neighborhoods and for underserved populations and/or those with special needs.
- Use the addition of new charter centers to address significant gaps in services within neighborhoods and for underserved populations and build or extend the capacity of existing neighborhood-based centers to meet the core functions. (See #7 below for more detail.)

6. Older adults should be consulted with and involved in directing what happens at senior centers.

DFTA ensures centers will:

- Include older adults in program planning or governance of the center and offer opportunities for participants to communicate their ideas, preferences, and concerns.
- Orient older adults when they visit a center and orient themselves to each participant.
- Inform participants of changes in the center and invite them to participate, plan and advocate.

DFTA recommends that centers:

- Provide multiple opportunities for older adults to communicate needs and desires.
- Create opportunities for leadership (e.g. advisory councils, teaching classes), volunteer work and employment of older adults.

Recommendations for DFTA:

- Define what "including older adults" means and provide relevant models to centers.
- Define DFTA'S expectations for older adult involvement in governance.

7. **Proposed charter senior centers or senior centers of innovation may meet needs that have been difficult to address at the neighborhood center level. These centers will provide services at a location and serve as a resource to other centers in their area of expertise. These centers can be designed to serve special needs, special interests, underserved populations and/or particular neighborhoods.**

Centers for special needs

- Some charter centers could exist to fill basic needs of individual seniors that cannot be met at a local center because they are so specialized. This could include, but is not limited to, centers that focus on benefits access, technology, immigrant services and legal services. These centers could share their area of expertise and resources with other centers, as needed.

Centers for underserved populations

- These centers could aim to serve groups of people who have needs that stakeholders, seniors and researchers all agree cannot be met effectively in centers that serve the general population. This could include a center for LGBT seniors, a center for older adults who are blind or deaf, a center for

those with mental illness and centers for people with specific cultural and language backgrounds. These centers could serve those who visit the centers directly as well as other centers with participants from these groups.

Centers for special interests

- These centers could aim to attract people who have common interests to a set of clubs, activities and resources. Possible examples include centers that focus on the performing arts, books, sports, nature and technology. These centers could share their area of expertise and resources with other centers.

Enhanced Neighborhood Centers

- These centers will expand capacity, enhance programming and share and coordinate resources with other centers in a geographic area.

8. Senior centers have an image problem. To increase participation, reach new populations and secure funding, the image of senior centers must be improved.

DFTA ensures centers will:

- Create a friendly and organized entrance where new visitors will feel welcome and can learn about services provided at the center and how they might become involved.
- Define special populations to whom they are targeting outreach and empirical evidence that they are targeting a product and using a marketing strategy appropriately (i.e. children caring for their parents, younger seniors, older adults who need social service assistance)

DFTA recommends centers will:

- Learn to make the economic case for themselves

Recommendations for DFTA:

- Create a group of stakeholders, older adults and DFTA staff to meet and discuss a marketing strategy and image concept
- Train staff about how to brand and advocate for themselves, how to promote their activities and how to reach out to the community.
- Provide and share opportunities for senior centers to promote themselves and their work

References

Administration on Aging (AoA) (2009). About AoA. Retrieved 11 January 2010 from http://www.aoa.gov/AoARoot/About/index.aspx , AoA Programs. Retrieved 15 January 2010 from http://www.aoa.gov/AoARoot/AoA_Programs/index.aspx .

Administration on Aging, U.S. Department of Health and Human Services (AoA) (2001), *Older Adults and Mental Health: Issues and Opportunities*. Retrieved on 21 January 2010 from http://www.globalaging.org/health/us/mental.pdf .

Administration on Aging (AOA) (2009). A Profile of Older Americans. Retrieved on 15 April 2010 from http://www.aoa.gov/aoaroot/aging_statistics/Profile/index.aspx.

Alzheimer's Association (2009). "2009 Alzheimer's Disease Facts and Figures." Retrieved 13 January 2010 from http://www.alz.org/national/documents/report_alzfacts figures2009.pdf.

Asian American Federation of New York City (2003). "Asian American Elders in NYC: A Study of Health, Social Needs, Quality of Life and Quality of Care." Retrieved 13 April 2010 from http://www.aafny.org/research/dl/es/elder_report.pdf.

Beard, J.R., Cerdá, M., Blaney, S., Ahern, J., Vlahov, D. & Galea, S (2009). Neighborhood characteristics and change in depressive symptoms among older residents of New York City. *American Journal of Public Health,* 99(7), 1308-1341.

Betancourt, J.R., Green, A.R., Carrillo, J.E., Ananeh-Firempong, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports, 118*, 293-302.

Billings, J., Anderson, G., and Newman, L. (1996). Recent findings on preventable hospitalizations. *Health Affairs, 15*(3), 239-249.

Brookdale Center for Health Aging and Longevity of Hunter College/City University of New York (2009). New York City Senior Center Health Indicators Project. Report to the Commission of New City Department for the Aging, Lilliam Barrious-Paoli Commissioner.

Campbell, V.A., Crews, J.E., Moriarty, D.G., Zack, M.M., Blackman, D.K. (1999). Surveillance for Sensory Impairment, Activity Limitation, and Health-Related Quality of Life Among Older Adults — United States, 1993-1997. *MMRW – Surveillance Summaries, 48*(SS08), 131-156.

Casten, R.J., Rovner, B.W. & Tasman, W.T. (2004). Age-related macular degeneration and depression: a review of recent research. *Current Opinion in Ophthalmology, 5*(3), 181-183.

Centers for Disease Control and Prevention (CDC) (2006). *Improving the Nation's Vision Health: A Coordinated Public Health Approach*. Retrieved on 20 January 2010 from http://www.cdc.gov/visionhealth/pdf/improving_nations_vision_health.pdf .

The Council of Senior Centers and Services (2003). Seniors Eat on Weekends Too. Retrieved 18 April 2010 from http://cscs-ny.org/advocacy/reports/surveyweekendmeal.php.

The Citywide Mental Health Coalition for the Black Elderly, Mental Health and New York's Black Elderly (Harlem, New York: 2008).

Clifton, J. (2009). Ageing and Well-Being in an International Context. Politics of Ageing Working Paper no. 3. London: The Institute for Public Policy Research (ippr). Retrieved 9 March 2010 from http://www.ippr.org/members/download.asp?f=%2Fecomm%2Ffiles%2Fageing%5Finternational%5Fcontext%2Epdf.

Council of Senior Centers and Services, Inc. (CSCS) (2009). 2009 New York City Senior center study project report.

Dalton, D.S., Cruickshanks, K.J., Klein, B.E., Klein R., Wiley, T.L., Nondahl, D.M. (2003). The impact of hearing loss on quality of life in older adults. *Gerontologist*, *43*(5), 661-668.

Department for the Aging (DFTA) (2005). Annual Plan Summary, April 1, 2006 – March 31, 2007. Retrieved on 1 March 2010 from http://www.nyc.gov/html/dfta/downloads/pdf/public_hearings/publichear_annualplan9-05.pdf.

Fiscal Policy Institute (2008). New York City Unemployment in 2009 – The Emerging Crisis. Latham, New York. Retrieved on 1 March 2010 from www.fiscalpolicy.org/FPI_NYC_EmergingUnemploymentCrisis2009_December2008.pdf.

Foscarinis, M., Paul, B., Porter, B. & Scherer, A. (2004). The human right to housing: Making the case in U.S. advocacy. *Clearinghouse REVIEW Journal of Poverty Law and Policy* July–August 2004, 97-114. Retrieved on 15 December 2009 from http://www.cohre.org/store/attachments/Clearinghouse%20Review%20Journal%20Article.pdf.

Frazer, S. (2009). *LGBT Health and Human Services Needs in New York State.* Albany: Empire State Pride Agenda Foundation.

Friedman, M.B., Williams, K.A., Eulo, M., Marquand, A. (2009) Geriatric Mental Health Policy: A Briefing Book. New York: The Geriatric Mental Health Alliance of New York. Retrieved on 21 January 2010 from http://www.mhaofnyc.com/gmhany/GMHPolicyBriefingBook08.2009.pdf.

Friedman, M.B., Kennedy, G.J. & Williams, K.A. (2009). Cognitive camouflage — How Alzheimer's can mask mental illness. *Aging Well*, *2*(2), 16. Retrieved on 21 January 2010 from http://www.agingwellmag.com/archive/030209p16.shtml.

The Geriatric Mental Health Alliance of New York (GMHANYC) (2008). Meeting the mental health challenges of the elder boom. Retrieved on 21 January 2010 from http://www.mhaofnyc.com/gmhany/MeetingMHChallengesElderBoom12_2008.pdf

Gomez, R.G. & Madey, S.F. (2001). Coping-With-Hearing-Loss Model for Older Adults. *Journal of Gerontology*, *56B*(4), 223-225.Gotbaum, B. (March 2005). From low service to no service: How the city fails elderly low-income renters—A report by Public Advocate for the City of New York. Retrieved 12 December 2009 from http://pubadvocate.nyc.gov/policy/documents/ SCRIEFINALReport3-15-05.doc.

Gray, B.H., Scheinmann, R., Rosenfeld, R., & Finkelstein, R. (2006). "Aging without Medicare?: Evidence from New York City." *Inquiry 43*(3), 211-221

Gusmano, M.K., Rodwin, V.G (July 2007). New York City Department for the Aging: Analysis of vulnerability among older persons, DFTA client services, and Medicaid home care.

Hands, S. (2000). Hearing loss in over-65s: is routine questionnaire screening worthwhile? *The Journal of Laryngology & Otology, 114*, 661-665.

Hanson, K. & Golan, E. (2002). Effects of Changes in Food Stamp Expenditures Across the U.S. Economy. *Food Assistance and Nutrition Research Report* 26(6) (August), 1-4. USDA Economic Research Service Retrieved on 17 January 2010 from http://www.ers.usda.gov/publications/fanrr26/fanrr26-6/fanrr26-6.pdf .

Heine, C. & Browning, C.J. (2002). Communication and psychosocial consequences of sensory loss in older adults: Overview and rehabilitation directions. *Disability & Rehabilitation, 24*(15), 763-773.

Herbst, K.G., Humphrey, C. (1980) Hearing impairment and mental state in the elderly living at home. *British Medical Journal, 281*(6245), 903-905.

Holland, L. & Courtney, R. Increasing cultural competence with the Latino community. *Journal Of community Health Nursing, 15*(1), 45-53.

Horowitz, A. & Reinhardt, J.P. (2006). Adequacy of the Mental Health System in Meeting the Needs of Adults Who Are Visually Impaired. *Journal of Visual Impairment & Blindness, Special Supplement, 100*, 871-874

Ku, L. & Flores, G. (2005). Pay now or pay later: Providing interpreter services in health care. *Health Affairs, 24*(2), 435-444.

Ludwig, I. & Schneider, P. A model of comprehensive community-based services for older blind adults. Ed. Weber, N.D. *Vision and Aging: Issues in Social Work Practice.* Binghamton, NY: Haworth Press, 1991.

Maylahn, C. & Melnik, T.A. (2008). Vision impairment and access to eye care. *Behavioral Risk Factor Surveillance System, 14*(1), 1-8.

McCaffrey, R.G. (2008). The lived experience of Haitian older adults' integration into a senior center in Southeast Florida. *Journal of Transcultural Nursing, 19*(1), 33-39.

McCaffrey, R.G. (2007). Integrating Haitian older adults into a senior center in Florida: Understanding cultural barriers for immigrant older adults. *Journal of Gerontological Nursing, 33*(12).

Menjívar, C. & Salcido, O. (2002). Immigrant Women and Domestic Violence. *Gender & Society, 16*(6), 898-920.

National Council on Aging (NCOA) (2004a). Healthy Aging: A Good Investment—Exemplary Programs for Senior Centers and Other Facilities. Washington, DC: National Council on Aging. Retrieved on 9 March from http://www.healthyagingprograms.org/resources/HealthyLiving_GoodInvestment_booklet.pdf.

National Council on Aging (NCOA) (2004b). Together We Care: Helping Caregivers Find Support. Washington, DC: National Council on Aging. http://www.healthyagingprograms.org/content.asp?sectionid=75&ElementID=192.

National Health Policy Forum (2009). "Older Americans Act of 1965" Washington, DC: George Washington University. Retrieved on 1 March 2010 from http://www.nhpf.org/library/the-basics/Basics_OlderAmericansAct_10-08-09.pdf.

New York Academy of Medicine (NYAM) (2008a). Age-friendly New York City summary of input received and suggestions for change. Retrieved on 1 December 2009 from http://www.agefriendlynyc.org/suggestions.html .

New York Academy of Medicine (NYAM) (2008b). *Toward an age-friend New York City: A findings report.* Retrieved on 18 November 2009 from http://www.nyam.org/initiatives/docs/AgeFriendly.pdf .

New York City Coalition Against Hunger (November 2008) *Annual New York City Hunger Survey, Retrieved on 13 April 2010 from http://www.nyccah.org/files/No%20Bailout%20for%20the%20Hungry%20NYCCAH%20Hunger%20Survey%202008.pdf*

New York City (NYC) (2009). Age Friendly NYC: Enhancing our City's livability for older New Yorkers. Retrieved 18 November 2009 from http://council.nyc.gov/downloads/pdf/agefriendly_report.pdf .

NCHS Vital Statistics System for numbers of deaths. Bureau of Census for population estimates. Retrieved on 4 February 2010 from http://webappa.cdc.gov/sasweb/ncipc/mortrate10_sy.html#Advanced%20Options.

Nuyen Ngo-Metzger, N., Massagli, M.P., Clarridge, B.R., Manocchia, M., Davis, R.B., Iezzoni L.I., & Phillips, R.S. (2003). Linguistic and cultural barriers to care: Perspectives of Chinese and Vietnamese immigrants. *Journal of General Internal Medicine, 18*(1), 44-52.

Orr, A.L. (1991). Psychosocial aspects of aging and vision loss. Ed. Weber, N.D. *Vision and Aging: Issues in Social Work Practice.* Binghamton, NY: Haworth Press.

Pardasani, M. (2008). Bibliography of Research on and about Senior Centers. 1978-2008. Compiled for the National Institute for Senior Centers. Available upon request: mpardasani@fordam.edu.

Pardasani. M. (2004). Senior Center: Increasing minority participation through diversification. *Journal of Gerontological Social Work 43*(2-3), 41.

Pardasani, M., Sporre, K. & Thompson, P. (2009). New Models of Senior Centers Task Force Report. National Institute of Senior Centers (NISC).

Pearlberg, G.G. (2004). *Aging In Equity: LGBT Elders in America*. New York: Funders for Lesbian and Gay Issues.

Prevent Blindness America (2008). Vision Problems in the U.S.: Prevalence of Adult Vision Impairment and Age-Related Eye Disease in America. Retrieved on 18 January 2010 from http://www.preventblindness.net/site/DocServer/VPUS_report_web.pdf?docID=1322 .

Ryan, E.B, Anas, A.P., Beamer, M. & Bajorek, S. (2003). Coping with age-related vision loss in everyday reading activities. *Educational Gerontology*, *29*(1), 37-54.

Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders (2010) Improving the Lives of LGBT Older Adults. Retrieved on 12 April 2010 from http://sageusa.org/uploads/Large%20Print%20Advancing%20the%20Lives%20of%20LGBT%20Older%20Adults.pdf

Saunders, G.H. & Echt, K.V. (2007). An Overview of Dual Sensory Impairment in Older Adults: Perspectives for Rehabilitation. *Trends in Amplification, 11*, 243-258.

Scott, I., Smiddy, W.E., Schiffman, J., Feuer, W.J. & Pappas, C.J. (1999). Quality of life of low-vision patients and the impact of low-vision services. *American Journal of Ophthalmology*, *128*(1), 54-62.

Sederer, L.I. (2006). Depression, Social Isolation and the Urban Elderly: Conference on Geriatric Mental Health. New York City Department of Health and Mental Hygiene. Retrieved on 7 December 2009 from http://www.nyc.gov/html/doh/downloads/ppt/dmh/dmh-depression-sederer.ppt .

Thurston, Catherine (2009). Services and Advocacy for GLBT elders (SAGE): Paving the Way for Affinity-Based Senior Services. Care Management Journals, 10(4), 196-200.

Tsai, D.T. & Lopez, R.A. (1998). The Use of Social Supports by Elderly Chinese Immigrants. *Journal of Gerontological Social Work, 29*(1), 77-94.

U.S. Department of Agriculture (USDA) Food and Nutrition Service (2010). Supplemental Nutrition Assistance Program – Eligibility. Retrieved on 5 January 2010 from http://www.fns.usda.gov/fsp/applicant_recipients/eligibility.htm.

U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics, 2003 National Assessment of Adult Literacy. Retrieved on 21 January 2010 from http://nces.ed.gov/naal/estimates/State Estimates.aspx.

U.S. Department of Health and Human Services (HHS) (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

Wang, P.S., Lane, M., Olfson, M., Pincus, H.A., Wells, K.B. & Kessler, R.C. (2005). Twelve-month use of mental health services in the United States: Results from the national comorbidity survey replication. *Archives of General Psychiatry, 62*(6), 629-640.

Wiener, W.R. (1991). The provision of rehabilitation services to elderly persons who are visually impaired. *Journal of Gerontological Social Work, 17*(3 & 4), 69–76.

World Health Organization (WHO) (2003). *Social determinants of health: The solid facts*. 2nd edition. Eds. Wilkinson, R. & Marmot, M. Copenhagen, Denmark: WHO.

Zuckerman, D.M. (2004). *Blind Adults in America: Their Lives and Challenges*. Washington, DC: National Center for Policy Research for Women & Families.

Appendix

Table 1: Basic demographics of New York City population aged 60 and over

	Citywide	Bronx	Brooklyn	Manhattan	Queens	Staten Island
Population all ages	8,067,020	1,324,563	2,481,548	1,555,546	2,240,174	465,189
	–	(16.4%)	(30.8%)	(19.3%)	(27.8%)	(5.8%)
Age distribution						
Total age 60 & over	1,310,048	182,123	396,436	268,063	387,418	76,008
	–	(13.9%)	(30.3%)	(20.5%)	(29.6%)	(5.8%)
Age 60 to 64*	357,729	52,209	102,039	74,208	106,311	22,962
	(27.3%)	(28.7%)	(25.7%)	(27.7%)	(27.4%)	(30.2%)
Age 65 to 74*	498,960	70,177	155,422	100,635	143,963	28,763
	(38.1%)	(38.5%)	(39.2%)	(37.5%)	(37.2%)	37.8%)
Age 75 to 84*	330,503	43,757	102,745	66,592	99,281	18,128
	(25.2%)	(24.0%)	(25.9%)	(24.8%)	(25.6%)	(23.9%)
Age 85 & over*	122,856	15,980	36,230	26,628	37,863	6,155
	(9.4%)	(8.8%)	(9.1%)	(9.9%)	(9.8%)	(8.1%)
Gender						
Men	534,541	70,171	159,426	113,491	158,555	32,898
	(40.8%)	(38.5%)	(40.2%)	(42.3%)	(40.9%)	(43.3%)
Women	775,507	111,952	237,010	154,572	228,863	43,110
	(59.2%)	(61.5%)	(59.8%)	(57.7%)	59.1%)	(56.7%)
Race/Ethnicity						
Asian/Pacific Islander (AP)	119,368	6,074	27,626	24,006	57,438	4,224
% of AP 60 & over citywide	–	5.1%	23.1%	20.1%	48.1%	3.5%
% 60 & over in area who identify as AP	9.1%	3.3%	7.0%	9.0%	14.8%	5.6%
Black	276,318	51,634	115,390	36,944	68,932	3,418
% of black 60 & over citywide	–	18.7%	41.8%	13.4%	24.9%	1.2%
% 60 & over in area who identify as black	21.1%	28.4%	29.1%	13.8%	17.8%	4.5%
Hispanic	255,706	70,378	53,578	63,396	62,491	5,863
% of Hispanic 60 & over citywide	–	27.5%	21.0%	24.8%	24.4%	2.3%
% 60 & over in area who identify as Hispanic	19.5%	38.6%	13.5%	23.6%	16.1%	7.7%
White	639,628	51,369	194,756	140,625	190,718	62,160
% of white 60 & over citywide	–	8.0%	30.4%	22.0%	29.8%	9.7%
% 60 & over in area who identify as white	48.8%	28.2%	49.1%	52.5%	49.2%	81.8%

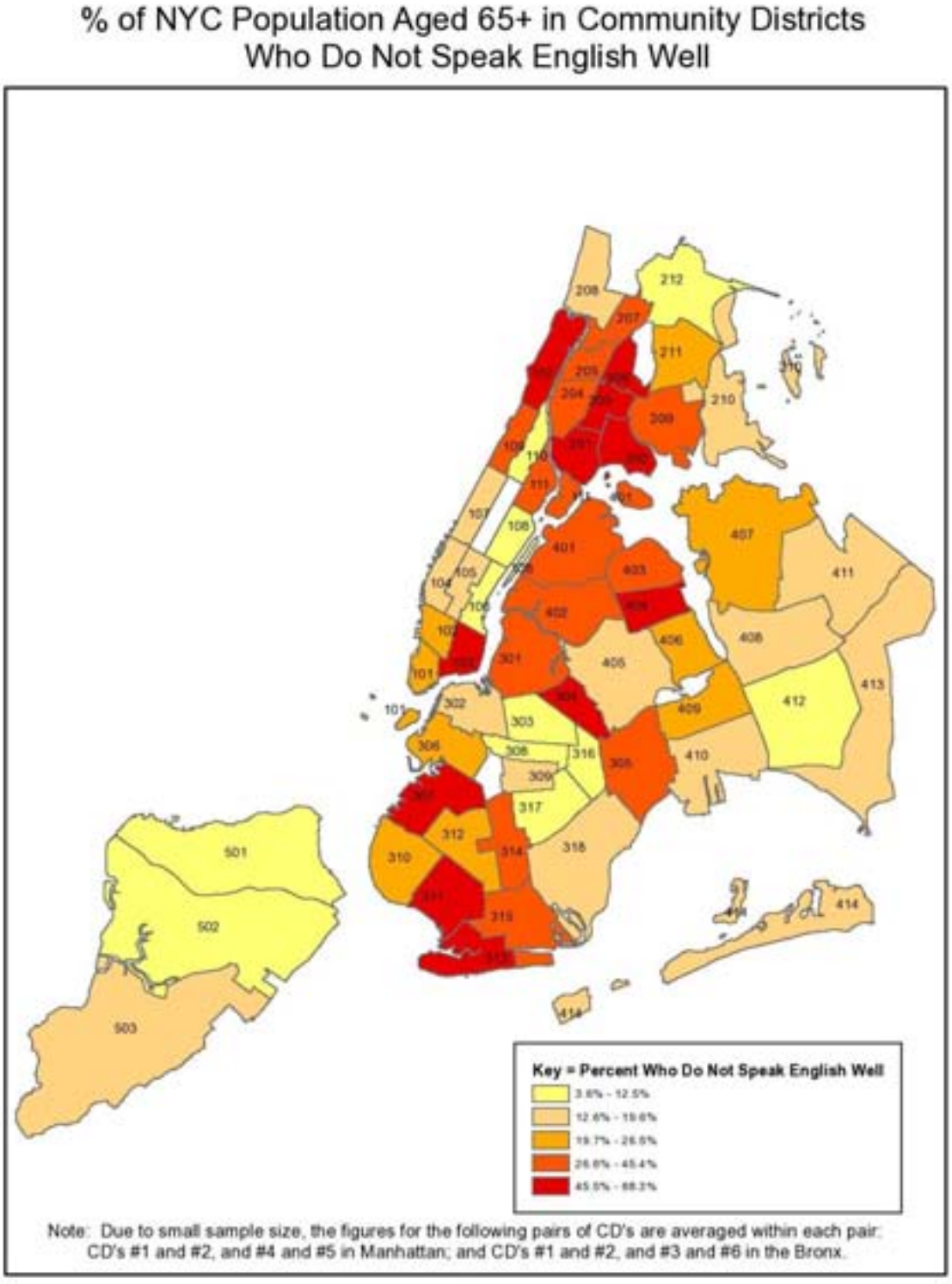
* Percentage figures represent the proportion of all aged 60 and over in the city (or borough) who fall into the designated age bracket.

Data source: American Community Survey (ACS) 2005-2007 Estimates compiled by DFTA

Map 1

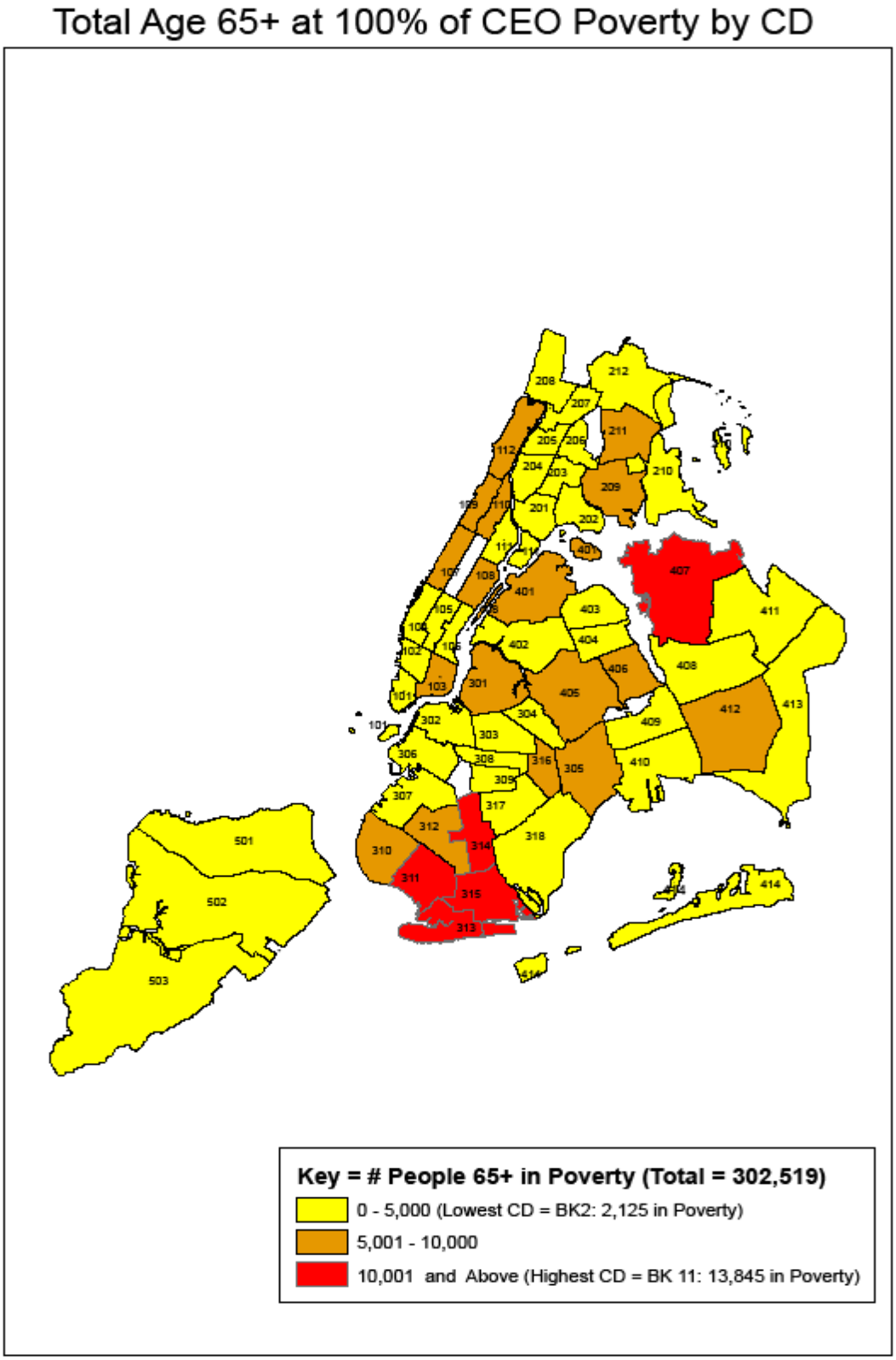

Number of Adults Age 65 and Over and Senior Centers by Census Tract, NYC
Produced by Brookdale Center For Healthy Aging & Longevity
Hunter College/CUNY
0 1.25 2.5 5 7.5
Miles
N
Legend
Senior Center
NYCHA Sr. Center
Highway
Low (Quantile 1)
Mid (Quantile 2)
High (Quantile 3)
Very High (Quantile 4)
THE BRONX
MANHATTAN
QUEENS
BROOKLYN
STATEN ISLAND
Source Data: NYC Senior Centers (NYC DFTA), DCP
Lion (NYC DCP), Census Tract Data (US Census 2000, SF1)
Healthy Model Sites for Aging in Place

Map 2

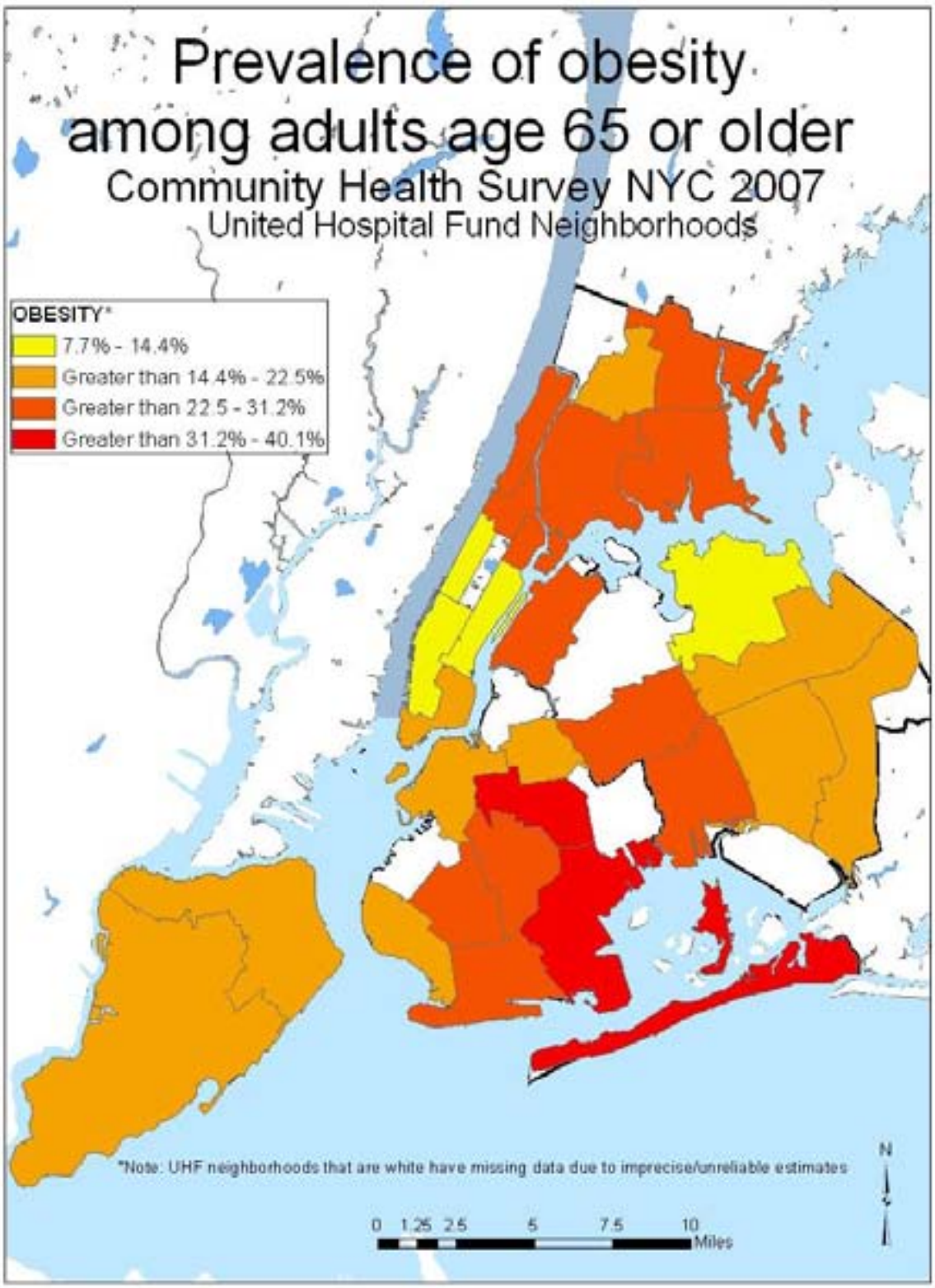


Source: NYC Department for the Aging using American Community Survey (ACS) data from 2005 - 2007

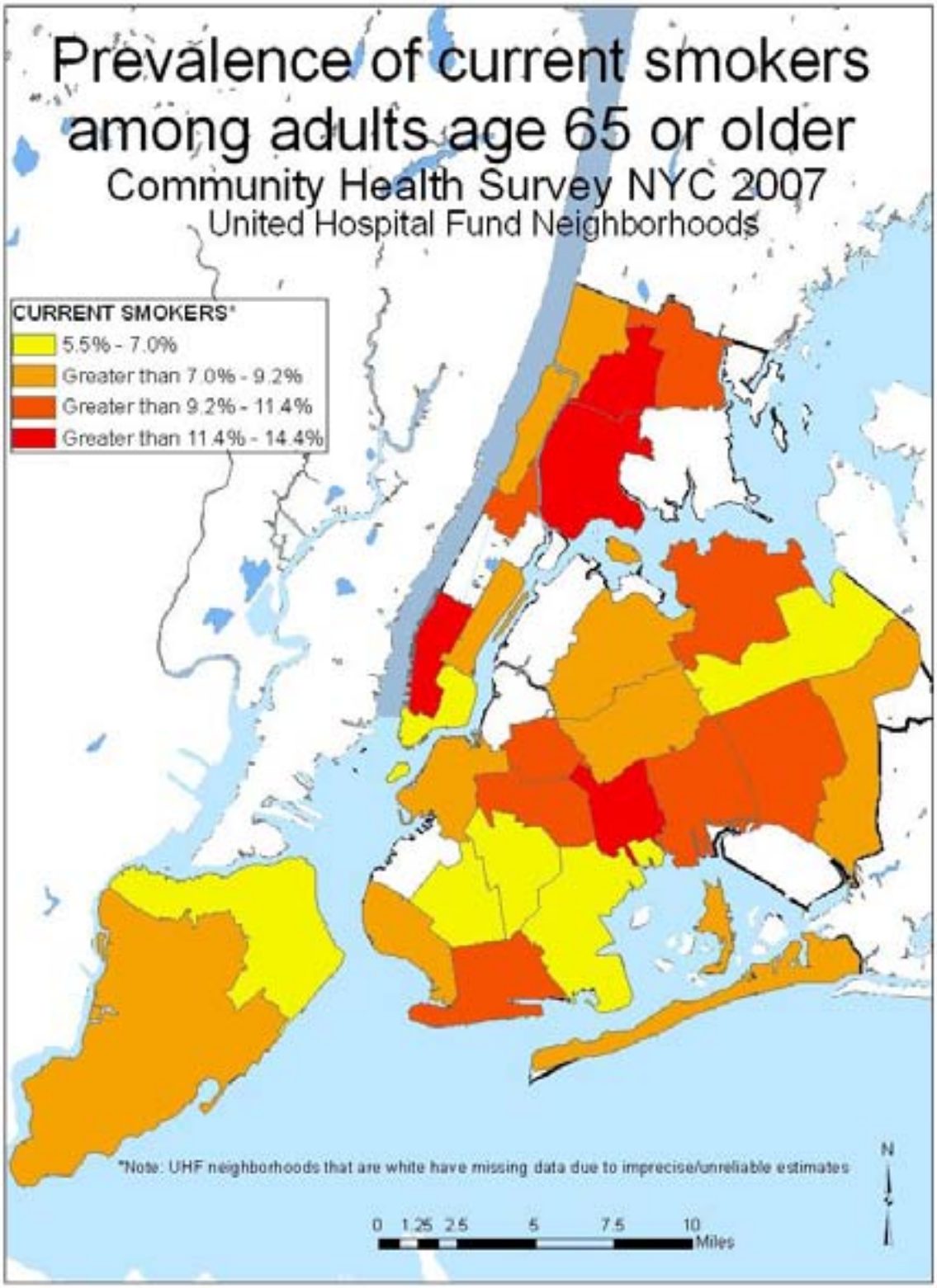
Map 3


Total Age 65+ at 100% of CEO Poverty by CD
Key = # People 65+ in Poverty (Total = 302,519)
0 - 5,000 (Lowest CD = BK2: 2,125 in Poverty)
5,001 - 10,000
10,001 and Above (Highest CD = BK 11: 13,845 in Poverty)

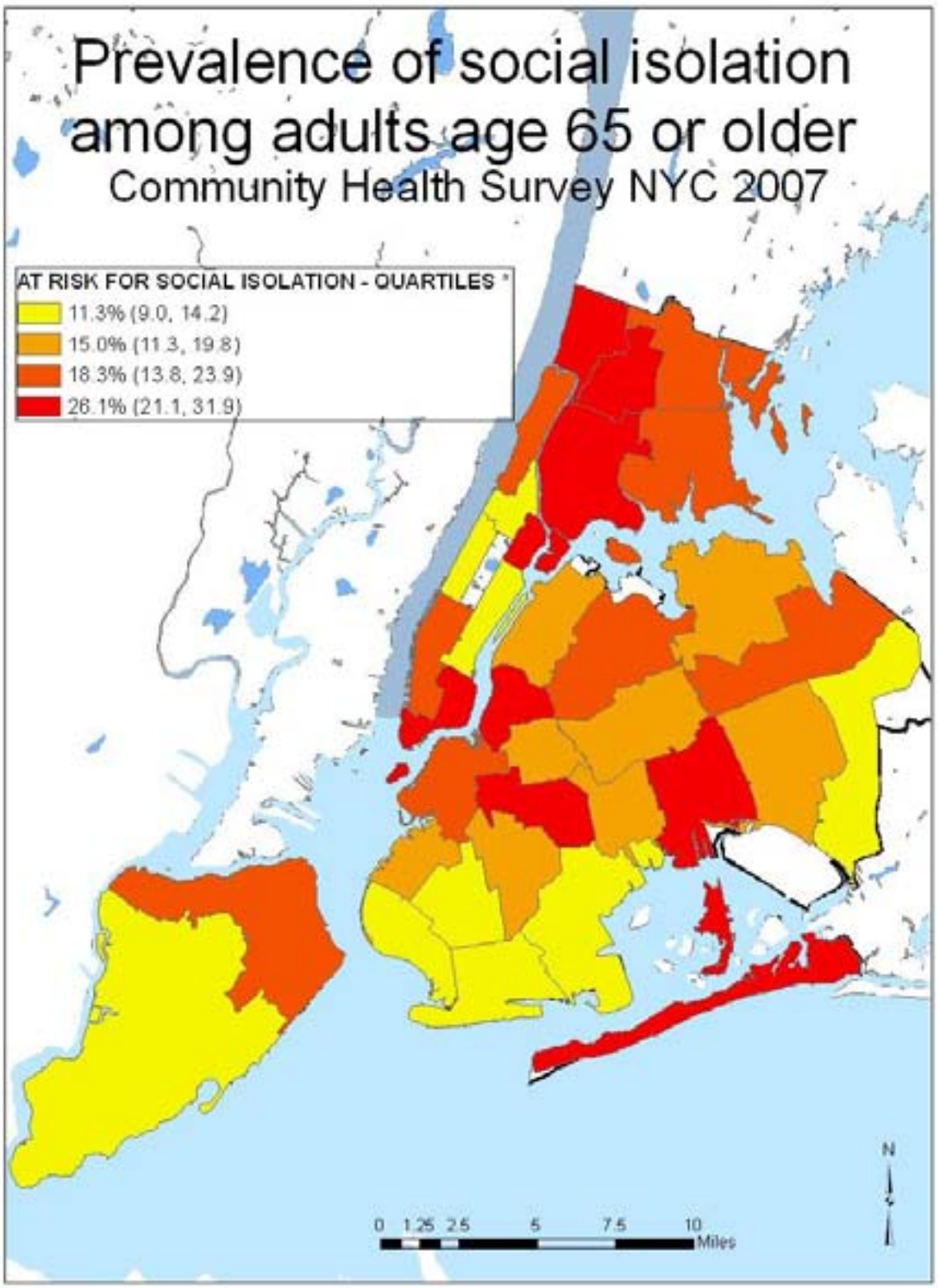
Map 4


Prevalence of obesity among adults age 65 or older
Community Health Survey NYC 2007
United Hospital Fund Neighborhoods
OBESITY*
7.7% - 14.4%
Greater than 14.4% - 22.5%
Greater than 22.5 - 31.2%
Greater than 31.2% - 40.1%
*Note: UHF neighborhoods that are white have missing data due to imprecise/unreliable estimates
0 1.25 2.5 5 7.5 10
Miles
N

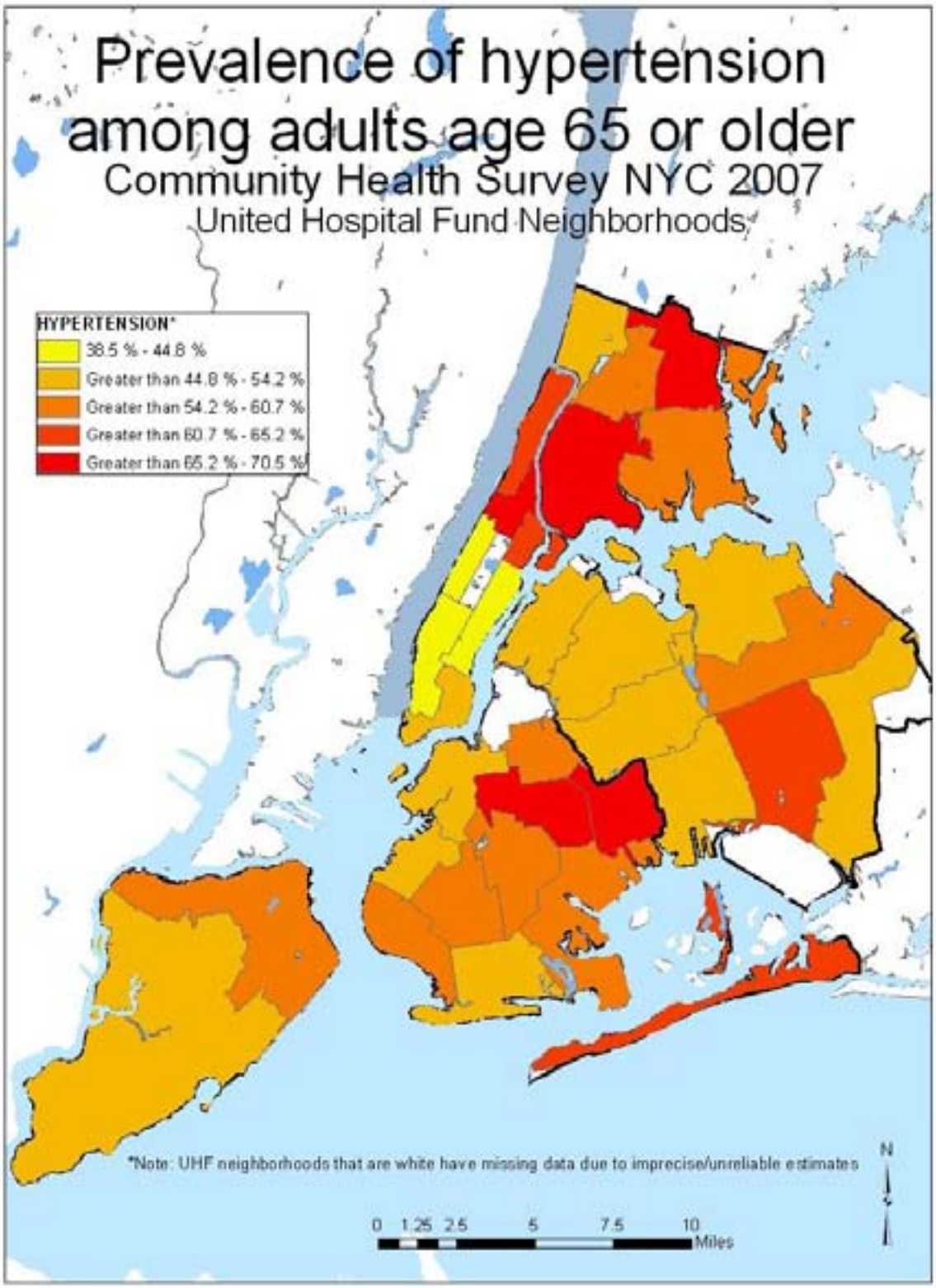
Map 5


Prevalence of current smokers among adults age 65 or older
Community Health Survey NYC 2007
United Hospital Fund Neighborhoods
CURRENT SMOKERS*
5.5% - 7.0%
Greater than 7.0% - 9.2%
Greater than 9.2% - 11.4%
Greater than 11.4% - 14.4%
*Note: UHF neighborhoods that are white have missing data due to imprecise/unreliable estimates
0 1.25 2.5 5 7.5 10
Miles
N

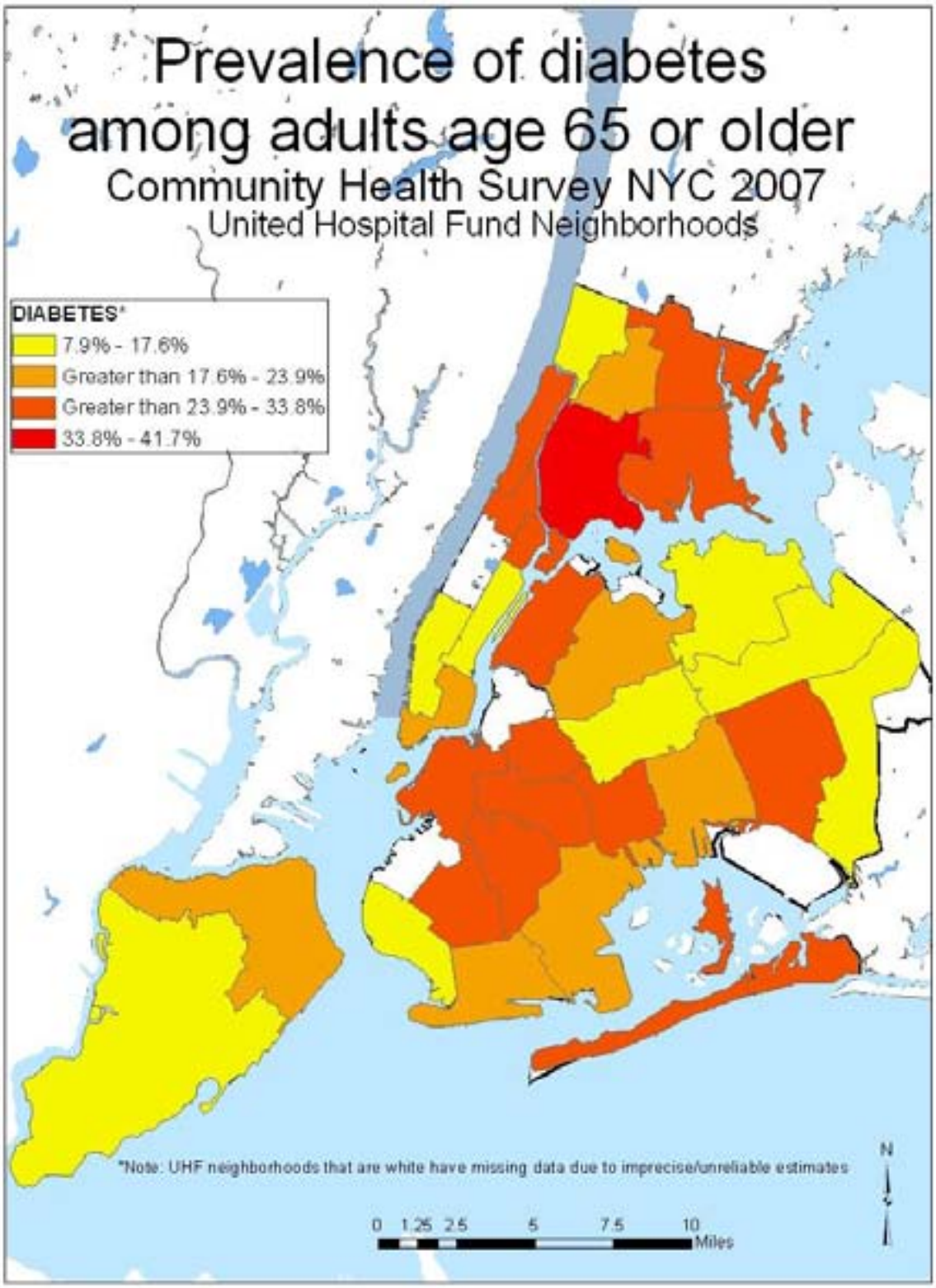
Map 6


Prevalence of social isolation among adults age 65 or older
Community Health Survey NYC 2007
AT RISK FOR SOCIAL ISOLATION - QUARTILES *
11.3% (9.0, 14.2)
15.0% (11.3, 19.8)
18.3% (13.8, 23.9)
26.1% (21.1, 31.9)
0 1.25 2.5 5 7.5 10
Miles
N

Map 7


Prevalence of hypertension among adults age 65 or older
Community Health Survey NYC 2007
United Hospital Fund Neighborhoods
HYPERTENSION*
38.5 % - 44.8 %
Greater than 44.8 % - 54.2 %
Greater than 54.2 % - 60.7 %
Greater than 60.7 % - 65.2 %
Greater than 65.2 % - 70.5 %
*Note: UHF neighborhoods that are white have missing data due to imprecise/unreliable estimates
0 1.25 2.5 5 7.5 10
Miles
N

Map 8


Prevalence of diabetes
among adults age 65 or older
Community Health Survey NYC 2007
United Hospital Fund Neighborhoods
DIABETES*
7.9% - 17.6%
Greater than 17.6% - 23.9%
Greater than 23.9% - 33.8%
33.8% - 41.7%
*Note: UHF neighborhoods that are white have missing data due to imprecise/unreliable estimates
0 1.25 2.5 5 7.5 10
Miles
N

List of Stakeholders:

Michael Adams Services and Advocacy for GLBT Elders (SAGE)
Socrates Aguayo NYC Health & Hospitals Corporation
Anita Altman - UJA Federation of New York
Lois Aronstein American Association of Retired Persons
Sharon Asherman - YM/YWHA, Washington Heights
Lilliam Barrios-Paoli NYC Department for the Aging
Sari Bernstein - Manhattan Borough President
Michael Bosnick NYC Department for the Aging
Amy Boyle - Center for Hearing and Communication
Carla D. Brown - Charles A. Walburg Multi Service Organization
Laray Brown – NYC Health & Hospitals Corporation
Robert Butler - International Longevity Center
Suleika Cabrera Drinane - Institute for the Puerto Rican/Hispanic Elderly
Victor Calise – NYC Department of Parks & Recreation
Gordon Campbell - United Way of New York
David Chen - Chinese American Planning Council
Willing Chin Ma - NYC Housing Authority, Sr. Ctr./Grand St. Settlement
Louise Cohen - NYC Department of Health and Mental Hygiene
Miriam Colon - NYC Authority, Sr. Ctr./Grand St. Settlement
Barbara Cooper - Institute for the Puerto Rican/Hispanic Elderly
Donna Corrado - Catholic Charities of Brooklyn & Queens
Darwin David - Black Agency Executives
Maria del Carmen Arroyo - New York City Council
Bill Dionne - Burden Center for the Aging
Carol Dunn - Inter-Agency Council for Aging of Staten Island
Antoinette Emers - Manhattan Borough Interagency Council
Phyllis Erlbaum-Zur - Bronx Regional Interagency Council on Aging/JHC
Mimi Fahs - Brookdale Center for Healthy Aging and Longevity at Hunter College
Janet Fischer - Henry Street Settlement
Rosa Gil - Comunilife
Fatima Goldman - Federation of Protestant Welfare Agencies
Dona Green – NYC Health & Hospitals Corporation
Zaida Guerrero - NYC Department of Health and Mental Hygiene
Helen Hamlin - International Federation on Ageing
Laurie Hanin - Center for Hearing and Communication
Fern Hertzberg - Washington Heights/Inwood Council on Aging, ARC XVI Fort Washington, Inc.
Carol Hunt - Jamaica Service Program for Older Adults
Esther Jacobson - Jewish Community Center of Staten Island
Chan Jamoona - Hindu United Cultural Council Senior Center
Igal Jellinek - Council of Senior Centers and Services of New York City, Inc.
David Johnson - Washington Heights Community Service
Sophia Jones - Brooklyn Borough President
Vasundhara Kalasapudi - India House
Tom Kamber – Older Adults Technology Services (OATS)
Richard Kuo – Homecrest Community Services Inc.
Evelyn Laureano - Neighborhood SHOPP

Linda Leest - Services Now for Adult Persons, Inc.
Claudette Macey - Ft. Green Senior Citizens Council
Melissa Mark-Viverito - New York City Council
Mary Mayer - New York Citizens' Committee on Aging
Yolanda McBride - New York City Council
Len McNally - New York Community Trust
Verona Middleton-Jeter - Henry Street Settlement
Nancy Miller - Visions
Mira Myteberi - YM/YWHA, Washington Heights
Cao O - Asian American Federation
Gabriel Oberfield NYC Department for the Aging
Shauneequa Owusu - New York City Council
Angeles Pai NYC Department for the Aging
Manoj Pardasani - Fordham University
Yurij Pawluk NYC Office of the Deputy Mayor of Health & Human Services
David Pristin - New York City Council
Wendy Prudencio - Good Companions Senior Center, Henry Street Settlement
Stephanie Raneri - Tuttle Fund
Caryn Resnick NYC Department for the Aging
Marah Rhoades NYC Department for the Aging
Lillian Rodriguez-Lopez - The Hispanic Federation
Diane Rubin - Henry Street Settlement
Lin Saberski NYC Human Resources Administration
Bobbie Sackman - Council of Senior Centers and Services of New York City, Inc.
Julia Schwartz-Leeper - Riverdale Senior Services, Inc
Chelsea Scott NYC Department of Cultural Affairs
Pakhi Sengupta - New York City Council
Rachel Sherrow - City Meals-on-Wheels
Jessica Silver - Manhattan Borough President
Susan Stamler - United Neighborhood Houses
Marcia Stein - City Meals-on-Wheels
Bob Stephens NYC Department for the Aging
Cynthia Summers - NYC Department of Health and Mental Hygiene
Katherine Thurston - Services and Advocacy for GLBT Elders (SAGE)
Maryellen Tria - NYC Department of Health and Mental Hygiene
Julio Urbina - Samuels Foundation
Fredda Vladeck - United Hospital Fund
Nancy Wackstein - United Neighborhood Houses
Larcenia Walton - Bronx Borough President's Office
Lauren Weisenfeld - Samuels Foundation
Marlon Williams - United Way
Wanda Wooten - NYC Housing Authority, Stanley Issacs

List of NYC DFTA-funded full-time senior centers

BRONX

AGING IN AMERICA COMMUNITY SERVICES MOW - AGING IN AMERICA COMMUNITY SERVICES INC.
AIA BAY-EDEN SENIOR CENTER - AGING IN AMERICA COMMUNITY SERVICES INC.
ARTURO SCHOMBERG SENIOR CENTER - INSTITUTE FOR THE PUERTO RICAN HISPANIC ELDERLY
BRONX HOUSE SENIOR CENTER - BRONX HOUSE INC
BRONX RIVER SENIOR CENTER - INSTITUTE FOR THE PUERTO RICAN HISPANIC ELDERLY
CAB E ROBERTS MOORE SENIOR CENTER - BRONX WORKS INC
CAB MORRIS SENIOR CENTER - BRONX WORKS INC
CCBA BETANCES SENIOR CENTER - INSTITUTE FOR THE PUERTO RICAN HISPANIC ELDERLY
CITY ISLAND SENIOR CENTER - PRESBYTERIAN SENIOR SERVICES
COBO MT CARMEL CENTER FOR SR CITIZENS - COUNCIL OF BELMONT ORGANIZATIONS INC
CO-OP CITY SENIOR CENTER - JEWISH ASSOCIATION FOR SERVICES FOR THE AGED
DORA AND HARRY SIMON SENIOR CENTER - YM YWHA OF THE BRONX/RIVERDALE YM YWHA
DOUGLAS LEON SENIOR CENTER - HUNTS POINT MULTI SERVICE CENTER INC
EAST CONCOURSE SENIOR CENTER - BRONX WORKS INC
HEIGHTS CENTER FOR SENIOR CITIZENS - BRONX WORKS INC
HOPE OF ISRAEL SENIOR CENTER - HOPE OF ISRAEL SENIOR CITIZENS CENTER INC
JAMES MONROE SENIOR CENTER - INSTITUTE FOR THE PUERTO RICAN HISPANIC ELDERLY
JASA THROGS NECK SENIOR CENTER - JEWISH ASSOCIATION FOR SERVICES FOR THE AGED
KIPS BAY CASTLE HILL SENIOR CENTER - KIPS BAY BOYS AND GIRLS CLUB
MARBLE HILL SENIOR CENTER - CHILD DEVELOPMENT CENTER OF THE MOSHOLU-MONTEFIORE COMMMUNIT
MARIA ISABEL SENIOR CENTER - HUNTS POINT MULTI SERVICE CENTER INC
MECHLER HALL SENIOR CENTER - AGING IN AMERICA COMMUNITY SERVICES INC.
MELROSE MOTT HAVEN SENIOR CENTER - EAST SIDE HOUSE INC
MILLBROOK - INSTITUTE FOR THE PUERTO RICAN HISPANIC ELDERLY
MITCHELL HOUSES - EAST SIDE HOUSE INC
MOSHOLU MONTEFIORE SENIOR CENTER - CHILD DEVELOPMENT CENTER OF THE MOSHOLU-MONTEFIORE COMMMUNIT
NEIGHBORHOOD SHOPP CASA BORICUA SR CTR - NEIGHBORHOOD SELF-HELP BY OLDER PERSONS PROJECT INC
NORTHEAST BRONX SENIOR CITIZEN CENTER - NORTHEAST BRONX SENIOR CITIZEN CENTER INC
PARKSIDE SENIOR CENTER - PRESBYTERIAN SENIOR SERVICES
PATTERSON HOUSES - EAST SIDE HOUSE INC
PIO MENDEZ - SEBCO DEVELOPMENT INC
PSS ANDREW JACKSON SENIOR CENTER - PRESBYTERIAN SENIOR SERVICES
PSS HIGHBRIDGE SENIOR CENTER - PRESBYTERIAN SENIOR SERVICES
PSS-DAVIDSON SENIOR CENTER - PRESBYTERIAN SENIOR SERVICES
RAIN BAILEY AVENUE - REGIONAL AID FOR INTERIM NEEDS INC
RAIN BOSTON EAST SENIOR CENTER - REGIONAL AID FOR INTERIM NEEDS INC
RAIN BOSTON ROAD SENIOR CENTER - REGIONAL AID FOR INTERIM NEEDS INC
RAIN BOSTON SECOR SENIOR CENTER - REGIONAL AID FOR INTERIM NEEDS INC
RAIN COLLEGE AVENUE SENIOR CENTER - REGIONAL AID FOR INTERIM NEEDS INC

RAIN EAST TREMONT SENIOR CENTER - REGIONAL AID FOR INTERIM NEEDS INC
RAIN EASTCHESTER SENIOR CENTER - REGIONAL AID FOR INTERIM NEEDS INC
RAIN GUNHILL SENIOR CENTER - REGIONAL AID FOR INTERIM NEEDS INC
RAIN MIDDLETOWN SENIOR CENTER - REGIONAL AID FOR INTERIM NEEDS INC
RAIN NEREID SENIOR CENTER - REGIONAL AID FOR INTERIM NEEDS INC
RAIN PARKCHESTER SENIOR CENTER - REGIONAL AID FOR INTERIM NEEDS INC
RIVERDALE SENIOR CENTER - RIVERDALE SENIOR SERVICES INC
SEBCO SENIOR PROGRAMS - SEBCO DEVELOPMENT INC
SISTER ANNUNCIATA BETHEL SENIOR CENTER - BEDFORD PARK MULTI-SERVICE CENTER FOR SENIORS CITIZENS INC
THOMAS L. GUESS COMMUNITY SENIOR CENTER - TREMONT COMMUNITY SENIOR CITIZEN SERVICE CENTER
TILDEN TOWERS SENIOR CENTER - AGING IN AMERICA COMMUNITY SERVICES INC.
TOLENTINE ZEISER NUTRITION PROGRAM - TOLENTINE-ZEISER COMMUNITY LIFE CENTER INC
VAN CORTLANDT SENIOR CENTER - JEWISH ASSOCIATION FOR SERVICES FOR THE AGED
WILLIAM HODSON SENIOR CENTER - WILLIAM HODSON COMMUNITY CENTER INC

BROOKLYN

ABE STARK SENIOR CENTER - BERGEN BASIN COMM DEV CORP/DBA MILLENNIUM DEVELOPMENT CORP
AMICO 59TH STREET SENIOR CENTER - AMERICAN ITALIAN COALITION OF ORGANIZATIONS INC\AMICO
ATLANTIC SENIOR CENTER - RIDGEWOOD BUSHWICK SENIOR CITIZENS COUNCIL INC
ATLANTIC TERMINAL SENIOR CENTER - FORT GREENE SENIOR CITIZENS COUNCIL
BAY RIDGE CENTER FOR OLDER ADULTS - BETHLEHEM EVANGELICAL LUTHERAN CHURCH
BENSONHURST SENIOR CENTER - EDITH AND CARL MARKS JEWISH COMMUNITY HOUSE OF BENSONHURST
BORINQUEN PLAZA NUTRITION PROGRAM - RIDGEWOOD BUSHWICK SENIOR CITIZENS COUNCIL INC
BORO PARK SENIOR CENTER - AGUDATH ISRAEL OF AMERICA COMMUNITY SERVICES INC
BORO PARK YM-YWHA SENIOR CENTER - YOUNG MEN'S AND YOUNG WOMEN'S HEBREW ASSOCIATION OF BORO PAR
BOULEVARD SENIOR CENTER - WAYSIDE OUT-REACH DEVELOPMENT INC
BROOKDALE SENIOR CITIZENS CENTER - AGUDATH ISRAEL OF AMERICA COMMUNITY SERVICES INC
CCNS GLENWOOD SENIOR CENTER - CATHOLIC CHARITIES NEIGHBORHOOD SERVICES INC
CCNS MCGUINESS NOrthSIDE SENIOR CENTER - CATHOLIC CHARITIES NEIGHBORHOOD SERVICES INC
CCNS NARROWS SENIOR CENTER - CATHOLIC CHARITIES NEIGHBORHOOD SERVICES INC
CCNS NORTHSIDE SENIOR CENTER - CATHOLIC CHARITIES NEIGHBORHOOD SERVICES INC
CCNS SAINT LOUIS SENIOR CENTER - CATHOLIC CHARITIES NEIGHBORHOOD SERVICES INC
CCNS ST CHARLES JUBILEE SENIOR CENTER - CATHOLIC CHARITIES NEIGHBORHOOD SERVICES INC
CCNS THE BAY SENIOR CENTER - CATHOLIC CHARITIES NEIGHBORHOOD SERVICES INC
CHRISTOPHER C BLENMAN SENIOR CENTER - FORT GREENE SENIOR CITIZENS COUNCIL
COUNCIL CENTER FOR SENIOR CITIZENS - BROOKLYN SECTION NATIONAL COUNCIL OF JEWISH WOMEN
CYPRESS HILLS FULTON ST SR CENTER - CYPRESS HILLS-FULTON STREET SENIOR CITIZENS CENTER INC

DIANA JONES SENIOR CENTER - RIDGEWOOD BUSHWICK SENIOR CITIZENS COUNCIL INC
DORCHESTER SENIOR CENTER - DORCHESTER SENIOR CITIZENS CENTER INC
EILEEN DUGAN SENIOR CITIZENS CENTER - EILEEN DUGAN SENIOR CITIZENS CENTER INC
F0RT GREENE ALBANY SENIOR CENTER - FORT GREENE SENIOR CITIZENS COUNCIL
FARRAGUT HOUSES SENIOR CENTER - FORT GREENE SENIOR CITIZENS COUNCIL
FORT GREENE HAZEL BROOKS SENIOR CENTER - FORT GREENE SENIOR CITIZENS COUNCIL
FT GREENE GRANT SQUARE SENIOR CENTER - FORT GREENE SENIOR CITIZENS COUNCIL
FT GREENE SENIOR ACTION CENTER - FORT GREENE SENIOR CITIZENS COUNCIL
FT GREENE STUYVESANT HEIGHTS SENIOR CTR - FORT GREENE SENIOR CITIZENS COUNCIL
FT HAMILTON-ST JOHNS CENTER - ST JOHNS/FT HAMILTON EPISCOPAL CHURCH
GRACE AGARD HAREWOOD SENIOR CENTER - FORT GREENE SENIOR CITIZENS COUNCIL
H GILROY SENIOR CENTER - FORT GREENE SENIOR CITIZENS COUNCIL
HABER HOUSES SENIOR CENTER - JEWISH COMMUNITY COUNCIL OF GREATER CONEY ISLAND INC
HOPE GARDENS SENIOR CENTER - RIDGEWOOD BUSHWICK SENIOR CITIZENS COUNCIL INC
HOUSE OF JACOB SENIOR CENTER - SEPHARDIC MULTI SERVICE SENIOR CENTER INC
JASA CANARSIE SENIOR CENTER - JEWISH ASSOCIATION FOR SERVICES FOR THE AGED
JASA HES SENIOR CENTER - JEWISH ASSOCIATION FOR SERVICES FOR THE AGED
JASA LUNA PARK SENIOR CENTER - JEWISH ASSOCIATION FOR SERVICES FOR THE AGED
JASA MANHATTAN BEACH SENIOR CENTER - JEWISH ASSOCIATION FOR SERVICES FOR THE AGED
JASA SCHEUER HOUSE OF CONEY ISL SR CTR - JEWISH ASSOCIATION FOR SERVICES FOR THE AGED
JASA SENIOR ALLIANCE SENIOR CENTER - JEWISH ASSOCIATION FOR SERVICES FOR THE AGED
JASA SHOREFRONT SENIOR CENTER - JEWISH ASSOCIATION FOR SERVICES FOR THE AGED
JASA STARRETT CITY SENIOR CENTER - JEWISH ASSOCIATION FOR SERVICES FOR THE AGED
JASA WILLIAMSBURG SENIOR CENTER - JEWISH ASSOCIATION FOR SERVICES FOR THE AGED
JAY SENIOR CENTER - JEWISH COMMUNITY COUNCIL OF GREATER CONEY ISLAND INC
KRAKUS LUNCHEON CLUB SENIOR CENTER - POLISH & SLAVIC CENTER INC
L H PINK SENIOR CENTER - EAST NEW YORK COUNCIL FOR THE AGING INC
LOS SURES SENIOR CENTER - SOUTHSIDE UNITED HOUSING DEVELOPMENT FUND CORP
MARIA LAWTON SENIOR CENTER - FORT GREENE SENIOR CITIZENS COUNCIL
MARLBORO SENIOR CENTER - JEWISH COMMUNITY COUNCIL OF GREATER CONEY ISLAND INC
MIDWOOD SENIOR CENTER - BERGEN BASIN COMM DEV CORP/DBA MILLENNIUM DEVELOPMENT CORP
OCEAN PARKWAY SENIOR CITIZENS CENTER - JEWISH COMMUNITY COUNCIL OF GREATER CONEY ISLAND INC
PARK SLOPE SENIOR CITIZENS CENTER - PARK SLOPE SENIOR CITIZENS CENTER INC
PENN WORTMAN SENIOR CENTER - EAST NEW YORK COUNCIL FOR THE AGING INC
PROSPECT HILL SENIOR SERVICES CENTER - ST JOHN ST MATTHEW EMANUEL LUTHERAN CHURCH
RED HOOK SENIOR CENTER - THE SPANISH SPEAKING ELDERLY COUNCIL-RAICES INC.
REMSEN SENIOR CENTER - FORT GREENE SENIOR CITIZENS COUNCIL
RIDGEWOOD BUSHWICK SENIOR CENTER - RIDGEWOOD BUSHWICK SENIOR CITIZENS COUNCIL INC
ROSETTA GASTON SENIOR CENTER - WAYSIDE OUT-REACH DEVELOPMENT INC
ROUNDTABLE SENIOR CITIZENS CENTER - RIDGEWOOD BUSHWICK SENIOR CITIZENS COUNCIL INC
SAINT GABRIELS SENIOR CENTER - ST GABRIELS EPISCOPAL CHURCH

SEPHARDIC MULTI SERVICE SENIOR CENTER - SEPHARDIC MULTI SERVICE SENIOR CENTER INC
SHALOM SENIOR CENTER - CROWN HEIGHTS PRESERVATION CORP
SR CITIZENS LEAGUE OF FLATBUSH SR CENTER - SENIOR CITIZENS LEAGUE OF FLATBUSH INC
SUNSET PARK SENIOR CENTER - SUNSET BAY COMMUNITY SERVICES INC
SURF SOLOMON SENIOR CENTER - JEWISH COMMUNITY COUNCIL OF GREATER CONEY ISLAND INC
SWINGING 60S SENIOR CENTER - CONSELYEA ST BLOCK ASSOCIATION INC
TILDEN SENIOR CENTER - WAYSIDE OUT-REACH DEVELOPMENT INC
TIMES PLAZA SENIOR CENTER - THE SPANISH SPEAKING ELDERLY COUNCIL-RAICES INC.
UNITED SENIOR CITIZENS CENTER - UNITED SENIOR CITIZENS OF SUNSET PARK INC
VAN DYKE SENIOR CENTER - WAYSIDE OUT-REACH DEVELOPMENT INC
VANDALIA SENIOR CENTER - BERGEN BASIN COMM DEV CORP/DBA MILLENNIUM DEVELOPMENT CORP
WAYSIDE TOMPKINS PARK SENIOR CENTER - WAYSIDE OUT-REACH DEVELOPMENT INC
WILLIAMSBURG-SATMAR SENIOR CENTER - CONGREGATION YETEV LEV DSATMAR
WILLOUGHBY SENIOR CENTER - FORT GREENE SENIOR CITIZENS COUNCIL
WINDSOR TERRACE SENIOR CENTER - SUNSET BAY COMMUNITY SERVICES INC
WYCKOFF GARDENS SENIOR CENTER - THE SPANISH SPEAKING ELDERLY COUNCIL-RAICES INC.
YOUNG ISRAEL BEDFORD BAY SENIOR CENTER - YOUNG ISRAEL OF BEDFORD BAY INC
YOUNG ISRAEL OF MIDWOOD SENIOR CENTER - YOUNG ISRAEL PROGRAMS INC

MANHATTAN

A PHILIP RANDOLPH SENIOR CENTER - UNITED BLOCK ASSOCIATION INC
ARC FT WASHINGTON SENIOR CENTER - ARC XVI FORT WASHINGTON INC
ASSOC OF BLACK SOCIAL WORKERS SR CENTER - ASSOCIATION OF BLACK SOCIAL WORKERS INC
BENJAMIN FLORES SENIOR CENTER - EAST HARLEM COUNCIL FOR HUMAN SERVICES INC
BRC SENIOR NUTRITION PROGRAM - BOWERY RESIDENTS COMMITTEE INC
CANAAN SENIOR SERVICE CENTER - CANAAN BAPTIST CHURCH OF CHRIST
CARTER BURDEN LUNCHEON CLUB - THE CARTER BURDEN CENTER FOR THE AGING INC
CARVER SENIOR CENTER - INSTITUTE FOR THE PUERTO RICAN HISPANIC ELDERLY
CC FIRST PRESBYTERIAN SENIOR CENTER - CARING COMMUNITY INC
CC INDEPENDENCE PLAZA - CARING COMMUNITY INC
CENTER ON THE SQUARE SENIOR CENTER - CARING COMMUNITY INC
CENTRAL HARLEM SENIOR CENTER - CENTRAL HARLEM SENIOR CITIZENS COALITION INC
CITIZENS CARE SENIOR CENTER - CITIZENS CARE COMMITTEE INC
CITY HALL SENIOR CENTER - HAMILTON MADISON HOUSE INC
COMMUNITY LOUNGE SENIOR CENTER - GUSTAVUS ADOLPHUS LUTHERAN CHURCH
CORSI HOUSE SENIOR CENTER - UNION SETTLEMENT ASSOCIATION INC
COTHOA LUNCHEON CLUB SENIOR CENTER - COTHOA LUNCHEON CLUB INC
CPC PROJECT OPEN DOOR - CHINESE-AMERICAN PLANNING COUNCIL
DYCKMAN SENIOR CENTER - NEW YORK FOUNDATION FOR SENIOR CITIZENS INC
E. HARLEM CNCL NUTRITION PROGRAM - EAST HARLEM COUNCIL FOR HUMAN SERVICES INC
EAST HARLEM COAL (JWJ SENIOR CENTER) - UNION SETTLEMENT ASSOCIATION INC
EAST RIVER SENIOR CENTER - UNION SETTLEMENT ASSOCIATION INC
EDUCATIONAL ALLIANCE - UNITED JEWISH COUNCIL OF THE EAST SIDE INC
ENCORE LUNCHEON CLUB - ENCORE COMMUNITY SERVICES
GAYLORD WHITE SENIOR CENTER - UNION SETTLEMENT ASSOCIATION INC
GODDARD-RIVERSIDE SENIOR CENTER - GODDARD-RIVERSIDE COMMUNITY CENTER

GOOD COMPANIONS NUTRITION - HENRY STREET SETTLEMENT
GRAND COALITION OF SENIORS SENIOR CENTER - GRAND STREET SETTLEMENT INC
HAMILTON GRANGE SENIOR CENTER - CONVENT AVENUE BAPTIST CHURCH
HARGRAVE SENIOR CENTER - FIND AID FOR THE AGED
HUDSON GUILD SENIOR SERVICES - HUDSON GUILD
JACKIE ROBINSON SR CTR AT GRANT HOUSES - CHARLES A WALBURG MULTI SERVICE ORGANIZATION INC
JACOB RIIS SENIOR CENTER - THE EDUCATIONAL ALLIANCE INC
JASA WEST SIDE SENIOR CENTER - JEWISH ASSOCIATION FOR SERVICES FOR THE AGED
JOHN PAUL II FRIENDSHIP CENTER - POLISH & SLAVIC CENTER INC
JUDITH WHITE SENIOR CENTER - GREENWICH HOUSE
KENNEDY SENIOR CENTER - CENTRAL HARLEM SENIOR CITIZENS COALITION INC
LA GUARDIA SENIOR CENTER - NEW YORK FOUNDATION FOR SENIOR CITIZENS INC
LENOX HILL SENIOR CENTER - LENOX HILL NEIGHBORHOOD HOUSE INC
LENOX HILL SENIOR CENTER II - LENOX HILL NEIGHBORHOOD HOUSE INC
LEONARD COVELLO SENIOR CENTER - INSTITUTE FOR THE PUERTO RICAN HISPANIC ELDERLY
LILLIAN WALD HOUSES - UNITED JEWISH COUNCIL OF THE EAST SIDE INC
M MCLEOD BETHUNE SENIOR CENTER - UNITED BLOCK ASSOCIATION INC
MANHATTANVILLE-RIVERSIDE SENIOR CENTER - UNITED BLOCK ASSOCIATION INC
MORIAH OLDER ADULT LUNCHEON CLUB - AGUDATH ISRAEL OF AMERICA COMMUNITY SERVICES INC
MOTT STREET SENIOR CENTER - NEW YORK FOUNDATION FOR SENIOR CITIZENS INC
NY CHINATOWN SENIOR CENTER - CHINESE-AMERICAN PLANNING COUNCIL
OUR LADY OF POMPEII SENIOR CENTER - CARING COMMUNITY INC
PELHAM FITZ SENIOR CENTER - CITIZENS CARE COMMITTEE INC
PRESBYTERIAN SENIOR CENTER - PRESBYTERIAN SENIOR SERVICES
PROJECT FIND CLINTON SENIOR CENTER - FIND AID FOR THE AGED
PROJECT FIND COFFEEHOUSE SENIOR CENTER - FIND AID FOR THE AGED
PROJECT FIND HAMILTON HOUSE - FIND AID FOR THE AGED
PROJECT FIND WOODSTOCK SENIOR CENTER - FIND AID FOR THE AGED
RAIN INWOOD SENIOR CENTER - REGIONAL AID FOR INTERIM NEEDS INC
RIVERSTONE SENIOR LIFE SERVICES SR CTR - RIVERSTONE SENIOR LIFE SERVICES INC.
ROOSEVELT ISLAND SENIOR CENTER - ROOSEVELT ISLAND SENIORS ASSOCIATION INC
SAINT NICHOLAS SENIOR CENTER - CITIZENS CARE COMMITTEE INC
SCHOMBURG SENIOR CENTER - EAST HARLEM COUNCIL FOR HUMAN SERVICES INC
SIROVICH SENIOR CENTER - THE EDUCATIONAL ALLIANCE INC
SMITH HOUSES SENIOR CENTER - HAMILTON MADISON HOUSE INC
STANLEY ISAACS SENIOR CENTER - STANLEY M ISAACS NEIGHBORHOOD CENTER INC
STEIN SENIOR CENTER - EAST SIDE COMMUNITY GROUP FOR SENIOR SERVICES INC
THEATER ARTS SENIOR CENTER - EAST HARLEM COUNCIL FOR HUMAN SERVICES INC
UBA BEATRICE LEWIS SENIOR CENTER - UNITED BLOCK ASSOCIATION INC
UJC ADULT LUNCHEON CLUB - UNITED JEWISH COUNCIL OF THE EAST SIDE INC
UNIVERSITY SETTLEMENT NUTRITION - UNIVERSITY SETTLEMENT SOCIETY OF NEW YORK INC
WASH HGTS COMMUNITY SVC SENIOR CENTER - WASHINGTON HEIGHTS COMMUNITY SERVICE INC
WEST SIDE FEDERATION SENIOR CENTER - WEST SIDE FEDERATION FOR SENIOR AND SUPPORTIVE HOUSING INC
WILSON M MORRIS SENIOR CENTER - COTHOA LUNCHEON CLUB INC
YM-YWHA OF WASH HGTS - INWOOD SR CTR - YM YWHA OF WASHINGTON HEIGHTS AND INWOOD INC

QUEENS

ALLEN COMMUNITY SENIOR CITIZENS CENTER - ALLEN AME CHURCH ALLEN COMMUNITY SENIOR CENTER
ALPHA PHI ALPHA SENIOR CENTER - ALPHA PHI ALPHA SENIOR CITIZENS CENTER INC
BROOKS SENIOR CENTER - BROOKS MEMORIAL UNITED METHODIST CHURCH
CCNS BAYSIDE SENIOR CENTER - CATHOLIC CHARITIES NEIGHBORHOOD SERVICES INC
CCNS CATHERINE SHERIDAN SENIOR CENTER - CATHOLIC CHARITIES NEIGHBORHOOD SERVICES INC
CCNS DELLAMONICA SENIOR CENTER - CATHOLIC CHARITIES NEIGHBORHOOD SERVICES INC
CCNS HILLCREST SENIOR CENTER - CATHOLIC CHARITIES NEIGHBORHOOD SERVICES INC
CCNS OZONE PARK SENIOR CENTER - CATHOLIC CHARITIES NEIGHBORHOOD SERVICES INC
CCNS SEASIDE SR CTR - CATHOLIC CHARITIES NEIGHBORHOOD SERVICES INC
CCNS ST MARYS SENIOR CENTER - CATHOLIC CHARITIES NEIGHBORHOOD SERVICES INC
CCNS STEINWAY SENIOR CENTER - CATHOLIC CHARITIES NEIGHBORHOOD SERVICES INC
CCNS WAKEFIELD SENIOR CENTER - CATHOLIC CHARITIES NEIGHBORHOOD SERVICES INC
CCNS WOODHAVEN SENIOR CENTER - CATHOLIC CHARITIES NEIGHBORHOOD SERVICES INC
CPC QUEENS NAN SHAN SENIOR CITIZEN CTR - CHINESE-AMERICAN PLANNING COUNCIL
ELMCOR SENIOR CENTER - ELMCOR YOUTH & ADULT ACTIVITIES INC
ELMHURST JACKSON HEIGHTS SENIOR CENTER - INSTITUTE FOR THE PUERTO RICAN HISPANIC ELDERLY
FLORENCE SMITH SENIOR SERVICE - CORONA CONGREGATIONAL CHURCH
FOREST HILLS COMMUNITY HOUSE SENIOR CTR - QUEENS COMMUNITY HOUSE INC.
GLENRIDGE SENIOR CITIZENS MULTI SVC CTR - GLENRIDGE SENIOR CITIZEN MULTISERVICE AND ADVISORY CENTER IN
HANAC ANGELO PETROMELIS SENIOR CENTER - HELLENIC AMERICAN NEIGHBORHOOD ACTION COMMITTEE INC
HANAC ARCHBISHOP IAKOVOS SENIOR CENTER - HELLENIC AMERICAN NEIGHBORHOOD ACTION COMMITTEE INC
HANAC LINDSAY SENIOR CENTER - HELLENIC AMERICAN NEIGHBORHOOD ACTION COMMITTEE INC
HOWARD BEACH SENIOR CENTER - SOUTH EAST QUEENS MULTI SERVICE SENIOR CITIZENS CENTER INC
IPR HE CORONA SENIOR CENTER - INSTITUTE FOR THE PUERTO RICAN HISPANIC ELDERLY
JASA BROOKDALE - JEWISH ASSOCIATION FOR SERVICES FOR THE AGED
JASA ROY REUTHER SENIOR CENTER - JEWISH ASSOCIATION FOR SERVICES FOR THE AGED
JSPOA FOSTER LAURIE SR CTR - JAMAICA SERVICE PROGRAM FOR OLDER ADULTS INC
JSPOA FRIENDSHIP NUTRITION CENTER - JAMAICA SERVICE PROGRAM FOR OLDER ADULTS INC
JSPOA ROCKAWAY BLVD SENIOR CENTER - JAMAICA SERVICE PROGRAM FOR OLDER ADULTS INC
JSPOA THEODORA JACKSON SENIOR CENTER - JAMAICA SERVICE PROGRAM FOR OLDER ADULTS INC
KOREAN AMERICAN SENIOR CENTER - KOREAN COMMUNITY SERVICES OF METROPOLITAN NEW YORK INC
KOREAN AMERICAN SENIOR CENTER - FLUSHING - KOREAN COMMUNITY SERVICES OF METROPOLITAN NEW YORK INC
LAURELTON ROSEDALE SENIOR CENTER - ST LUKES BAPTIST CHURCH
LEFRAK SENIOR CITIZENS CENTER - ELMCOR YOUTH & ADULT ACTIVITIES INC
MIDDLE VILLAGE OLDER ADULT CENTER - RABBI ISRAEL MEYER HACOHEN RABBINICAL SEMINARY OF AMERICA IN

NEWTOWN ITALIAN SENIOR CENTER - ITALIAN SENIOR CITIZENS CENTER
PETER CARDELLA SENIOR CITIZEN CENTER - PETER CARDELLA SENIOR CITIZEN CENTER INC
POMONOK SENIOR CENTER - QUEENS COMMUNITY HOUSE INC.
QUEENSBRIDGE-RIIS SENIOR CENTER - JACOB A RIIS NEIGHBORHOOD SETTLEMENT HOUSE INC
RAICES ASTORIA SENIOR CENTER - THE SPANISH SPEAKING ELDERLY COUNCIL-RAICES INC.
RAICES CORONA SENIOR CENTER - THE SPANISH SPEAKING ELDERLY COUNCIL-RAICES INC.
RAVENSWOOD SENIOR CENTER - HELLENIC AMERICAN NEIGHBORHOOD ACTION COMMITTEE INC
REGO PARK SENIOR CENTER - QUEENS COMMUNITY HOUSE INC.
RIDGEWOOD OLDER ADULT CENTER - RIDGEWOOD OLDER ADULT CENTER AND SERVICES INC
ROBERT COUCHE SENIOR CITIZEN CENTER - MERRILL PARK CIVIC ASSOCIATION INC
ROCHDALE SENIOR CENTER - ROCHDALE VILLAGE SOCIAL SERVICES INC
ROCKAWAY PARK SENIOR CENTER - JEWISH ASSOCIATION FOR SERVICES FOR THE AGED
SELFHELP AUSTIN ST SENIOR CENTER - SELFHELP COMMUNITY SERVICES INC
SELFHELP BEN ROSENTHAL SENIOR CENTER - SELFHELP COMMUNITY SERVICES INC
SELFHELP CLEARVIEW SENIOR CENTER - SELFHELP COMMUNITY SERVICES INC
SELFHELP LATIMER GARDENS SENIOR CENTER - SELFHELP COMMUNITY SERVICES INC
SELFHELP MASPETH SENIOR CENTER - SELFHELP COMMUNITY SERVICES INC
SELFHELP PRINCE STREET SENIOR CENTER - SELFHELP COMMUNITY SERVICES INC
SNAP OF EASTERN QUEENS SENIOR CENTER - SERVICES NOW FOR ADULT PERSONS INC
SNAP ROSEDALE SENIOR CENTER - SERVICES NOW FOR ADULT PERSONS INC
SOUTH JAMAICA SENIOR CENTER - JAMAICA SERVICE PROGRAM FOR OLDER ADULTS INC
SUNNYSIDE COMMUNITY SENIOR CENTER - SUNNYSIDE COMMUNITY SERVICES INC
UNITED HINDU CULTURAL COUNCIL SENIOR CTR - UNITED HINDU CULTURAL COUNCIL OF USA NORTH AMERICA INC
WOODSIDE SENIOR CENTER - SAMARITAN VILLAGE INC
YNG ISRAEL WAVECREST BAYSWATER SR LEAGUE - YOUNG ISRAEL PROGRAMS INC
YOUNG ISRAEL FOREST HILLS SENIOR LEAGUE - YOUNG ISRAEL PROGRAMS INC
YOUNG ISRAEL QUEENS VALLEY - YOUNG ISRAEL PROGRAMS INC

STATEN ISLAND

ARROCHAR FRIENDSHIP CLUB SENIOR CENTER - STATEN ISLAND COMMUNITY SERVICES FRIENDSHIP CLUBS INC
BERRY HOUSES FRIENDSHIP CLUB SENIOR CTR - STATEN ISLAND COMMUNITY SERVICES FRIENDSHIP CLUBS INC
CASSIDY COLES SENIOR CENTER - COMMUNITY AGENCY FOR SENIOR CITIZENS INC
CYO SENIOR GUILD LUNCH - CATHOLIC CHARITIES COMMUNITY SERVICES ARCHDIOCESE OF NY
FOREVER YOUNG SENIOR CENTER - COMMUNITY AGENCY FOR SENIOR CITIZENS INC
JCC SOUTH SHORE SR CTR - JEWISH COMMUNITY CENTER OF STATEN ISLAND INC
MARINERS HARBOR SENIOR CENTER - CATHOLIC CHARITIES COMMUNITY SERVICES ARCHDIOCESE OF NY
MOUNT LORETTO FRIENDSHIP CLUB SENIOR CTR - STATEN ISLAND COMMUNITY SERVICES FRIENDSHIP CLUBS INC
NEW DORP FRIENDSHIP CLUB SENIOR CENTER - STATEN ISLAND COMMUNITY SERVICES FRIENDSHIP CLUBS INC
NEW LANE SENIOR CENTER - COMMUNITY AGENCY FOR SENIOR CITIZENS INC
SOUTH BEACH SENIOR CENTER - COMMUNITY AGENCY FOR SENIOR CITIZENS INC
STAPLETON SENIOR CENTER - CATHOLIC CHARITIES COMMUNITY SERVICES ARCHDIOCESE OF NY

STATEN ISLAND FRIENDSHIP CLUB - STATEN ISLAND COMMUNITY SERVICES FRIENDSHIP CLUBS INC
TODT HILL FRIENDSHIP CLUB SENIOR CENTER - STATEN ISLAND COMMUNITY SERVICES FRIENDSHIP CLUBS INC
WEST BRIGHTON SENIOR CENTER - CATHOLIC CHARITIES COMMUNITY SERVICES ARCHDIOCESE OF NY

List of Naturally Occurring Retirement Communities (NORCs) in NYC
Source: United Hospital Fund

Bronx

Name of Program	Sponsoring Agency
Ampark Senior Services NORC Program (1995)	Bronx Jewish Community Council (BJCC)
Co-op City NORC Program (1995)	JASA
Parkchester Enhancement Program for Seniors (1999)	Beth Abraham Health Services
Pelham Parkway NORC (1999)	Bronx Jewish Community Council

Brooklyn

Bensonhurst NNORC (2007)	Edith and Carl Marks JCH of Bensonhurst
Sheepshead/Nostrand Suportive Services (1999)	Builders For Family & Youth (BFFY)
Shorefront NNORC (2007)	Shorefront Y of Brighton-Manhattan Inc.
ShoreRidge Cares NNORC (2006)	The Bay Ridge Center for Senior Services
Spring Creek NORC (1999)	Spring Creek Senior Partners
Surfside Gardens (2007)	JASA
Trump Outreach Program (1996)	JASA
Trump for Us (1999)	JASA
Warbasse Cares for Seniors (1993)	JASA

Manhattan

1199 Plaza (2006)	JASA
B.E.S.T. Grand Street (2006)	Grand Street Settlement
Chinatown NORC (2006)	Visiting Nurse Service of New York
Co-op Village Senior Cares (1992)	Educational Alliance
Elliot Chelsea NORC (2006)	Hudson Guild, Inc.
Ft. George VISTAS NORC (2005)	Isabella Geriatric Center, Inc.
Heart of Greenwich Village (2007)	Village Center for Care
Il Corazon NNORC (2006)	Isabella Geriatric Center, Inc.

Manhattan (continued)

Knickerbocker Village Senior Services (1999)	Hamilton-Madison House
Lincoln-Amsterdam Senior Care (1999)	Lincoln Square Neighborhood Center
Lincoln House Outreach (1999)	DOROT
Morningside Retirement and Health Services (1986)	Morningside Retirement Health Services
Penn South Program for Seniors (1986)	Penn South Social Services, Inc.
Phipps Plaza West NORC (1999)	Phipps Community Development Corp.
Sage Harlem (2005)	SAGE
Smith Houses (2006)	Hamilton-Madison House
Stanley M. Isaacs NORC (1995)	Stanley M. Isaacs Neighborhood Center
Village View (2007)	Educational Alliance
Vladeck Cares NORC (1993)	Henry Street Settlement
West Side NORC (1999)	Goddard Riverside Community Center

Queens

Big Six Towers NORC (1996)	Selfhelp Community Services, Inc.
Clearview Assistance Program (1996)	Samuel Field YM &YWHA
Deepdale Cares (1999)	Samuel Field YM &YWHA
Forest Hills Co-op NORC (1999)	Forest Hills Community House
NORC WOW (2005)	Samuel Field YM & YWHA
Northridge/Brulene/Southridge NORC (1999)	Selfhelp Community Services, Inc.
Queensbridge Houses NORC (2007)	Jacob A. Riis Neighborhood Settlement House
Queensview/N. Queensview NORC (1996)	Selfhelp Community Services, Inc.
Ravenswood RISE (1999)	HANAC
Rochdale Village (1999)	Rochdale Village Social Services, Inc.