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# Responding to COVID-19: How Massachusetts Senior Centers are Adapting

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# Responding to COVID-19: How Massachusetts Senior Centers are Adapting

Ceara Somerville, Caitlin Coyle, and Jan E. Mutchler

August 2020

CENTER FOR SOCIAL AND DEMOGRAPHIC RESEARCH ON AGING
GERONTOLOGY INSTITUTE
McCORMACK GRADUATE SCHOOL OF POLICY AND GLOBAL STUDIES

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## About the Authors

This report was prepared by the Center for Social and Demographic Research on Aging at the University of Massachusetts Boston. Individuals responsible for the report include Ceara Somerville, Caitlin Coyle, and Jan E. Mutchler. We acknowledge with appreciation the assistance of Cindy Bui, Saralyn Collins, Felix Garcia, and Rebecca Mailman with data collection, and Nidya Velasco Roldan for her assistance with the community comparison categories. For questions, comments, or to request additional information, contact us at CSDRA@umb.edu.

## About the Center

The CSDRA provides resources and research expertise to communities, non-governmental organizations, and other agencies that offer services to older adults in Massachusetts. The Center's mission is to inform communities as their populations become older demographically, including research on topics that impact older adults seeking to age in their communities. Established in 2012, the Center has worked with over 40 communities across the Commonwealth.

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## Introduction

The COVID-19 pandemic has swept the United States with force and speed. Massachusetts is one of the hardest hit states in nation, with over 120,000 cases and over 8,500 deaths to date[1]. Local governments across the Commonwealth have had to work quickly to meet the needs of their constituents in a constantly changing environment. With older adults being at high risk of contracting COVID-19, having more severe symptoms, and at higher risk of dying from the disease[2], special efforts are warranted to ensure that they are supported in their efforts to maintain physical distance while meeting needs for food and medical care.

Massachusetts is fortunate in that nearly every community has a municipal entity that operates on behalf of its older residents. Within Massachusetts, 350 municipalities have a Council on Aging (COA), an appointed board of residents that is charged with supporting older adults in the community and linking them with programs and services. Each COA sets its own priorities based on local needs and resources. Most commonly, the COA also operates as a board of directors to a senior center. Currently, there are 342 COA-run senior centers operating in Massachusetts[3]. These centers are welcoming public places for older residents and their families to gather for social, educational, and recreational purposes as well as to obtain information and services with respect to crucial supports like health insurance coverage, access to food, transportation, and assistance with applications for public benefits. Despite the fact that Councils on Aging and Senior Centers are two facets of the same system, we will hereto refer to Councils on Aging (COAs) as the municipal entity dedicated to older persons.

Councils on Aging are considered the "front door" of services and supports for older residents and those who care for them. Prior to the pandemic, COAs offered a wide range of programs and services, designed to meet the varied needs and interests of a diverse older population. Most of what COAs did was in-person, from group activities to one-on-one meetings. These units have had to adapt significantly to continue the important work they do on behalf of older adults in the community. The purpose of this report is to document these adaptations and to illustrate the ways in which COAs have been affected by the pandemic.

This report presents results from a survey conducted by the Center for Social & Demographic Research on Aging (CSDRA) at the University of Massachusetts Boston on behalf of the Massachusetts Councils on Aging[4] (MCOA). The survey presented in this report is the first in a series being conducted to update the MCOA Comprehensive Database of Senior Centers. The series of surveys was intended to capture both the breadth and depth of the programs and services currently being provided by the network of COAs; but also to identify unmet needs and challenges that COAs are facing with the purpose of sharing best practices across the network as well as providing data to inform policy and advocacy. The first survey—from which these results are drawn—was distributed by email to all COAs on April 28, 2020. A recurring set of questions regarding operations and responses to the COVID-19 pandemic was included in this first survey. Email and phone call follow-up was conducted through the month of May, and the survey was closed on June 12, 2020. Surveys were completed predominately by COA directors. Responses were submitted by 308 COAs representing 90% of all COAs in the Commonwealth.

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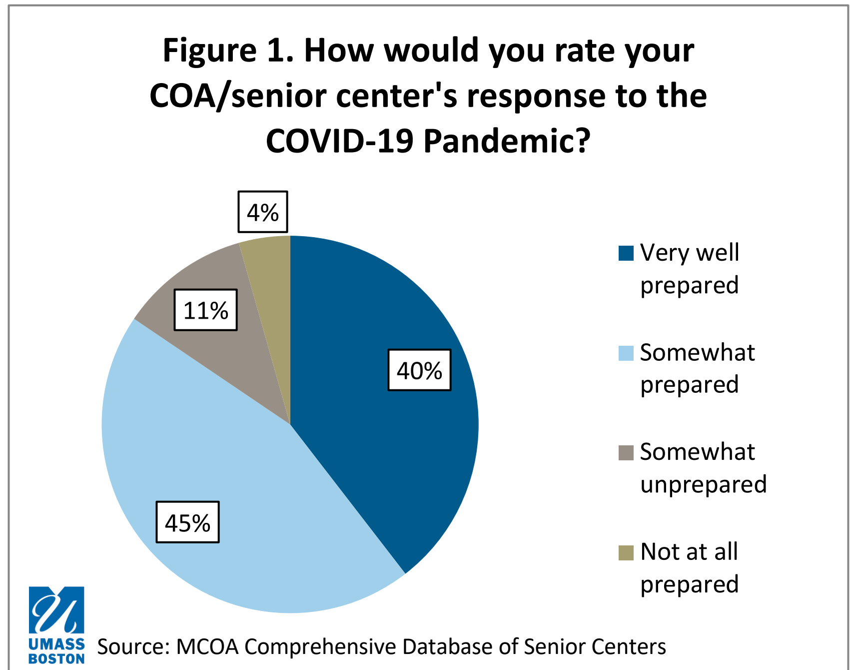
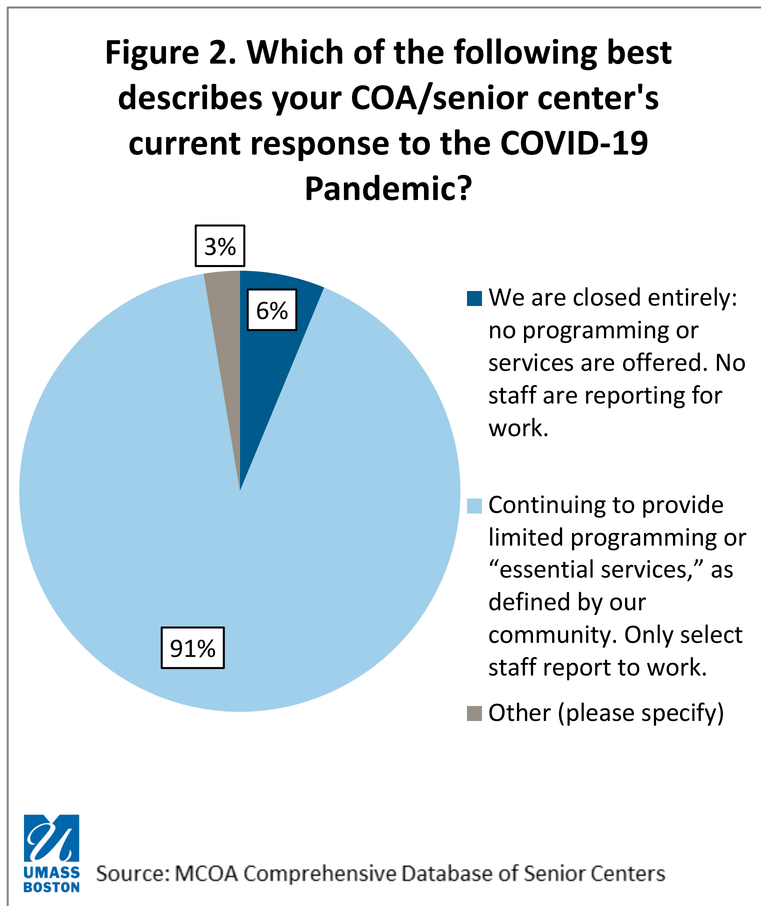
[1] Data retrieved from https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html on August 18, 2020.
[2] https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html
[3] There are four senior centers across the Commonwealth where municipal COAs have established a consortium to provide programs/services regionally. They cover small and rural communities, who individually may not have the capacity to provide a full range of programs and services.
[4] MCOA is a non-profit trade organization representing COAs in Massachusetts (https://mcoaonline.com/).

## Emergency Planning & Preparedness

The conditions of the COVID-19 pandemic developed quickly and rapid response was required by communities. When asked to rate their COA/senior center's overall response to the pandemic, a large share (40%) of Directors reported feeling very well prepared. Almost half (45%) reported feeling somewhat prepared. About 11% felt somewhat unprepared, and only 4% reported feeling not at all prepared (**Figure 1**). Given the unique and dynamic nature of the COVID-19 pandemic, the large share of senior centers reporting good preparedness speaks to the resiliency and resourcefulness of the network.




The vast majority of senior centers were operational at the at the time of this survey, with 91% indicating they were continuing to provide limited programming or essential services to the community (see **Figure 2).** However**,** about 6% were completely closed, reducing access to services for an estimated 29,000 older adults in those communities[5]. An additional 3% of senior centers selected "other," [6] with write-in responses explaining that they do not have a physical senior center to keep open or closed.

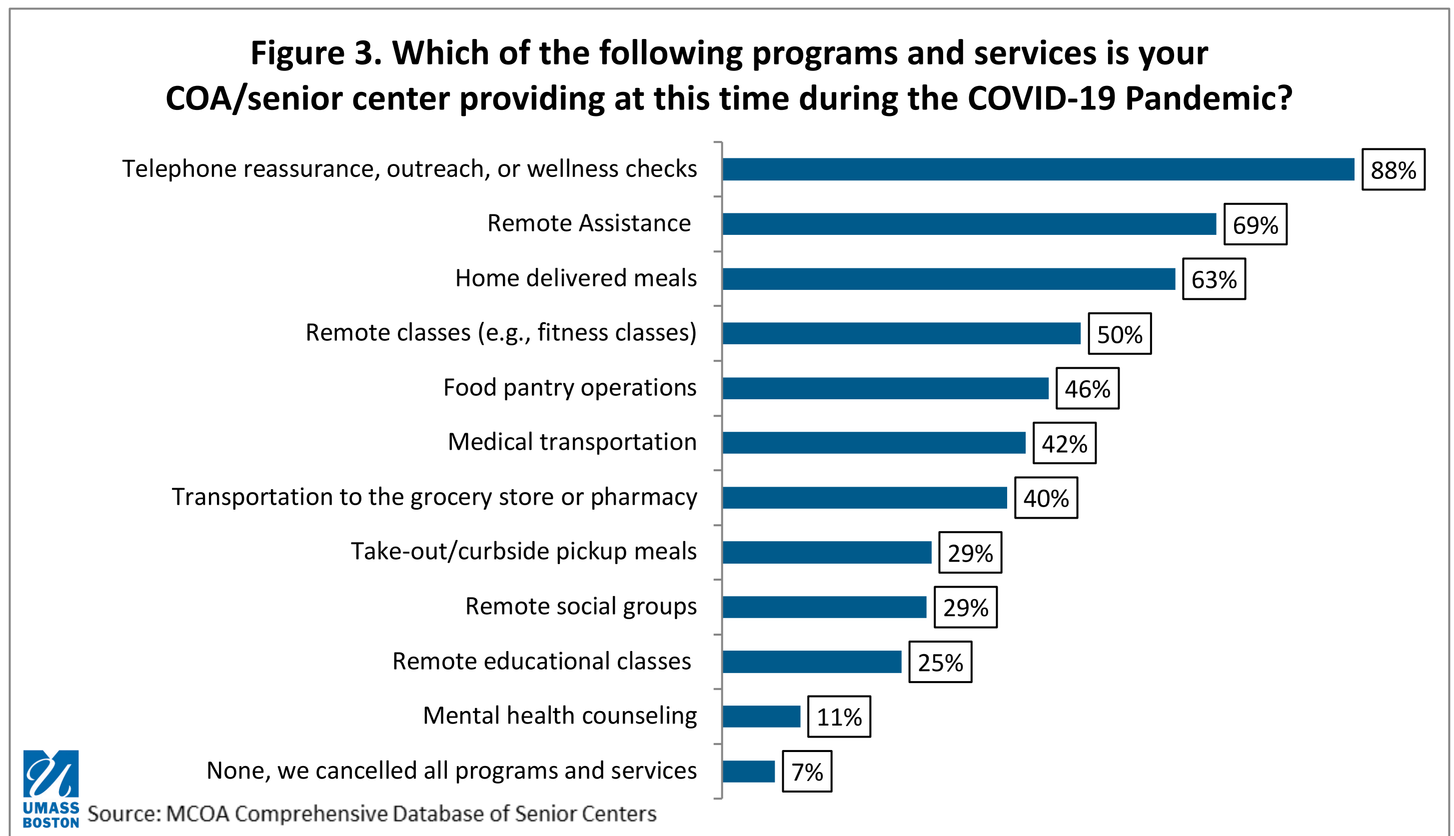
COA directors were asked to provide the date on which they closed in-person operations. Nearly half (46%) closed between March 15 and March 21, 2020, the week that Governor Baker ordered Massachusetts schools closed due to the COVID-19 pandemic. Another 43% closed the week prior (March 8 to March 14, 2020) and a small share (2%) had closed prior to March 8, 2020. The remaining 9% of responding COAs closed

[5] Estimate of adults 60 and older in the communities with completed closed COAs comes from the American Community Survey (ACS) 2018 5-year file. These are primarily COAs in very small communities, with limited resources.
[6] Those who selected "other" and wrote in that they are closed completely or closed and providing essential services were recoded and are reflected in the appropriate category in **Figure 2**. Those who selected "other" and wrote-in that they are still providing essential services were also recoded to that category.

between March 21 and April 16, 2020. Closing the senior center physical spaces is a significant change in what COAs provide and how they operate. Many older adults rely on attendance at the COA for social engagement, civic participation, health and wellness, and meeting other needs and interests.

## Current Programs & Services

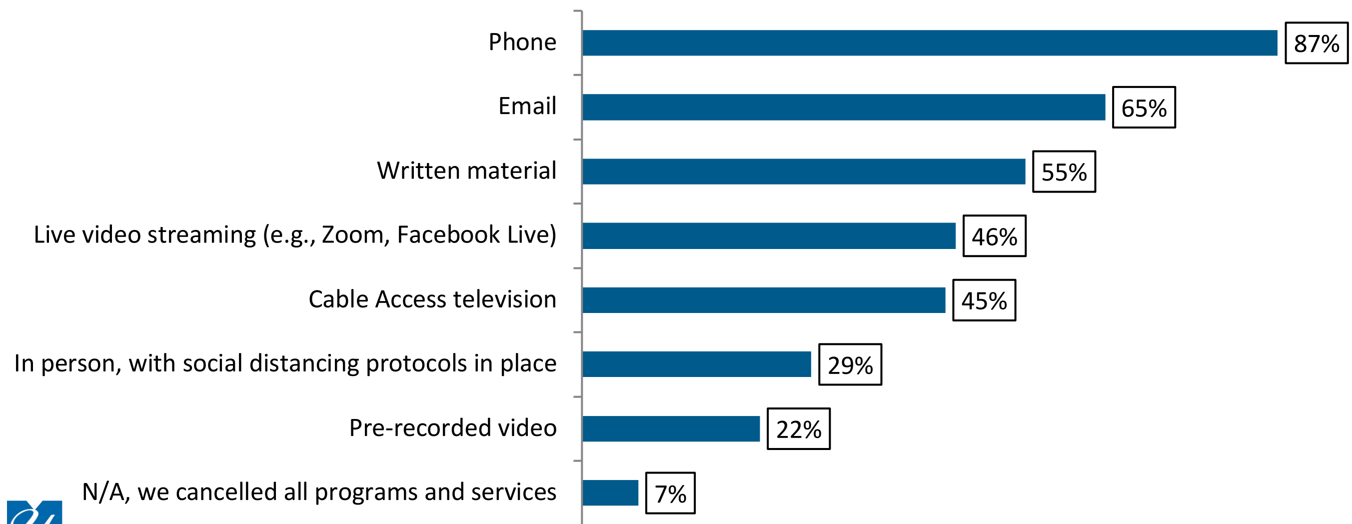
Despite the majority of senior center physical locations being closed, most COAs continue to provide programs and services to their residents. **Figure 3** displays the programs and services most typically still being offered by COAs through the pandemic. Most COAs are prioritizing socialization and nutritional needs as critical services, with 88% of senior centers providing wellness checks by phone, 69% providing remote assistance for social service assistance (e.g., SHINE, SNAP, MassHealth, Housing, Etc.), and nearly two-thirds providing home-delivered meals. Half are maintaining some fitness classes offered remotely, such as through Zoom or public access TV, and many are continuing to offer some transportation services for medical appointments (42%) or for food shopping or to the pharmacy (40%).




Most COAs have maintained the capacity to provide multiple programs and services (results not shown). About 8% are providing just 1 or 2 programs or services, and one-quarter are providing 3 or 4. Yet the majority (56%) is providing 5 to 7 programs and services, with an additional 16% providing 8 or more types of programs and services. Those who are providing just a few (1-2) programs and services are focused on telephone outreach and home-delivered meals, stripping services to the bare essentials.

Continuing to provide programs and services can be a challenge, since most in-person operations are closed entirely with few or no staff on-site. Yet, Massachusetts COAs are turning to a variety of communication methods to remain available to residents and continue to engage them. When asked to identify the primary

methods they are using to provide programs and services during the COVID-19 pandemic, conventional methods—such as phone, email, and mailed written material—are most commonly cited (**Figure 4**). Almost half of COAs reported using live video streaming (46%) or cable access television (45%) to reach the older adults in the community while the physical senior center is closed.




About a quarter (22%) of COAs focus on using 1-2 of the listed communication methods (results not shown). About 43% selected 3-4 methods, using a variety of different ways to reach older adults. Another 35% selected 5 or more methods.

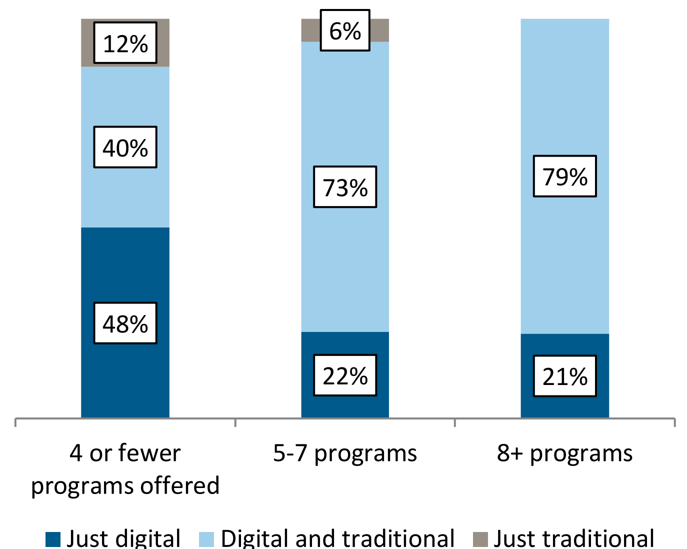



**Figure 5** shows the mix of communication methods used by COAs to provide programs and services broken down by the number of programs and services being offered. Almost half of COAs offering a limited number of programs and services rely exclusively on digital methods (e.g., email, Internet, and television), which compares to about one fifth of COAs who are offering a wider variety of programs and services. Results suggest that COAs that are offering more programs/services through the pandemic increasingly rely on a mix of digital and traditional communication methods (e.g., phone, written material, in–person) to reach seniors. About 12% of COAs offering 4 or fewer programs, and 6% of those offering 5-7 programs only

use traditional methods; no COA that reported offering 8 or more programs or services reported only traditional means of outreach. Especially at this time, digital methods of communication have increasingly become more important to reach a wide net of community members. Additionally, continued use of traditional methods of communication is necessary to reach the older population; through community research projects conducted by the CSDRA[7], it is apparent that many older adults in later life (e.g., 80+) do not have access to digital communication methods, highlighting further the need to use both traditional and digital methods of communication.

## Addressing Social Isolation

Social isolation and feelings of loneliness can have serious health consequences[8] that can be exacerbated by the pandemic. While remaining physically distant from others is necessary to slow the spread of the COVID-19, these conditions can spark feelings of loneliness and depression[9]. For these reasons, it is imperative that mechanisms for keeping older adults connected socially are developed during this pandemic. COAs have recognized the detriments of social isolation and the importance of reducing isolation and loneliness before the pandemic; they have worked hard to prioritize socialization since needing to adapt to the times.

As local leaders on the provision of social engagement opportunities, COA directors were asked an open-response question, "What specific measures has your COA/senior center taken to support social connectedness among residents during the COVID-19 Pandemic?" Nearly every director who responded to the survey wrote a response to this question. A summary of themes, and quotes from respondents[10], is presented in **Table 1**. The responses to this question highlighted various methods used to address social isolation. Most COAs used traditional methods, such as phone calls, to check in with older adults. In many cases, the use of these traditional methods was not entirely new to the COA in response to the pandemic; but rather the pandemic prompted an expansion of these traditional communication methods as a means of reaching more local older adults. Some communities have worked on their technological capabilities to connect with older adults remotely, such as recording videos for cable access television. Meal delivery operations are largely focused on meeting the nutritional needs of older adults, but have had a recognized secondary benefit: having some human contact (though physically distanced) can contribute to combating the effects of isolation and loneliness.

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[7] Please visit https://www.umb.edu/demographyofaging for more information and reports from community projects.
[8] Holt-Lunstad, J., Smith, T. B., & Layton, J. B. (2010). Social relationships and mortality risk: a meta-analytic review. PLoS medicine, 7(7), e1000316.
[9] Erzen, E., & Çikrikci, Ö. (2018). The effect of loneliness on depression: A meta-analysis. International Journal of Social Psychiatry, 64(5), 427-435.
[10] Some responses edited for clarity and length.

| Table 1. Specific Measures Taken to Support Social Connectedness | |
|---|---|
| Phone check-ins | *"**Wellness/Reassurance Calls have become vital for emotionally high-risk seniors**, and has become the focus of our outreach during this pandemic."* |
| Video/online programming | *"A few of our volunteer instructors have either gone to the local Access TV Station to tape a class, or have taped a class and submitted. **Our Local Access TV station has been tremendously helpful in working with us and making this programming available**"*<br><br>*"**Virtual programs {e.g., Chair Yoga} were created and implemented** to prevent social isolation and promote physical and mental health of seniors."* |
| Call groups | *"Have put people in the community in touch with one another to help support each other as needed. **We are a close knit community; and {we} tend to look out for our own community**."* |
| Meal delivery | *"…our Grab-N-Go (Curbside pickup) program has allowed for some "face-to-face" interaction with social distancing protocols so that **those who are mobile but otherwise lacking the ability or desire to use the technology can still interact with known entities**."*<br><br>*"We created **"thinking of you bags"** and delivered them to their doors. We've also added special notes into their lunches."* |

## Challenges Faced

Despite their resourceful nature and resilient spirit, this time of great transition has been difficult for COAs. Thus, as a way of identifying opportunities to support this network, all survey respondents had the opportunity to write-in the most difficult challenges that they have faced since shutting the doors of their senior centers in March. A total of 273 COAs (89% of respondents) wrote in a response. Two predominant themes emerged: challenges for staff and the functioning of the COA, and challenges for older residents. **Table 2** breaks down those categories with more detailed categories that were common in the responses.

COA staff have struggled in terms of technology, communication, and adjusting to the changing work environment. Many cited technology as a challenge: either not having enough or the correct technological capabilities to work remotely, or difficulty in working with the technology. In addition, some respondents cited insufficient communications with other municipal agencies, the network of aging service providers, or from the state. As the situation changes, guidelines and recommendations change quickly, making it difficult for some to keep up with what is current. Between staff changes and switching to remote work, many directors cited burnout and fatigue among staff.

Not only are COAs facing internal challenges to operate, they also cite the issues that older adults are facing and how difficult it is to address those challenges. Many of the challenges that were cited (e.g., social isolation, mental health, nutrition) were present before the pandemic and will likely remain challenges; however, meeting those needs has become particularly difficult during this public health crisis.

| Table 2. Most Difficult Challenges… | |
|---|---|
| **…faced by the COA** | |
| **Lack of or difficulty with technology** | *"**How to learn the technology** to transition to online programming"*<br><br>*"Having **adequate technology** (laptops vs desktops) and/or ability to access desk tops from home"* |
| **Insufficient communication with other municipal departments** | *"**Lack of guidance** from ASAP re: protocol for delivery of meals. Lack of guidance from state regarding liability and use of volunteers to deliver meals…"*<br><br>*"**Being buried in reports and calls** from other organizations asking us to respond to their questions when we are technically called and have to serve our community when we are in."* |
| **Loss of staff** | *"**Reduced staffing**; increased workload for those remaining"*<br><br>*"**One person** trying to do it all"* |
| **Adjusting to working remotely** | *"Both part-time staff members have children and **are challenged by providing home education while attempting to work**."*<br><br>*"**Sheer exhaustion** as we all are quickly evolving as needs change almost daily."* |
| **…about older adults** | |
| **Outreach/communication** | *"**how to reach seniors** who are not connected to email/internet or don't answer their phones to strange numbers"*<br><br>*"**It's been difficult to lose face to face contact** with community members and to pivot to online services, knowing full well the number of people who do not engage with computers at all."* |
| **Social isolation** | *"**Combating isolation** among seniors (and mitigating the health consequences that come with isolation)"*<br><br>*"Hearing of people passing away , **seniors crying because they are lonely**, and making sure everyone has everything they need"* |
| **Nutrition** | *"**Determining our role** for providing necessary food delivery and other errands"*<br><br>*"**Producing 250 weekly meals (instead of 80)** and meeting dietary preferences and restrictions."* |
| **Clinical needs** | *"helping those who need **mental health counseling**"*<br><br>*"**Reassuring people about their health**. Call 911, precautions are being made. If you are sick call your Dr. No one wants to go to hospital…"* |

Respondents were then asked to identify steps or actions taken by the COA to address those challenges. Out of 264 write-in responses, **Table 3** displays the most commonly cited themes. COAs have had to make some internal adjustments to continue to operate during the pandemic. Those adjustments have included budget and staff adjustments, collaborations with other community organizations, and working on the technology capacity among staff. Many directors have been faced with tough decisions about how to allocate their money and on whom they can rely to continue providing for their constituents.

COAs have made changes in their operations to continue their efforts to meet the needs of their older residents. Efforts have included increasing outreach capacity, and finding ways to expand what they already do to meet nutritional, emotional, and clinical needs of older adults; as the situation has changed rapidly, so have COAs.

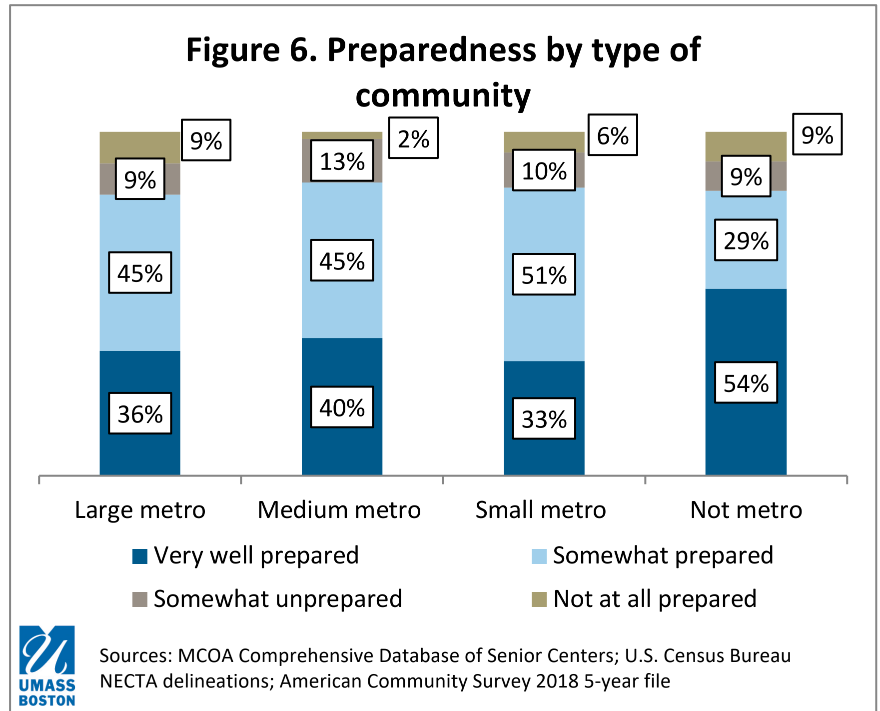
| Table 3. Steps or Actions taken to Address Challenges… | |
|---|---|
| **…faced by the COA** | |
| **Expanded community collaborations** | *"calling programs,* ***partnering with local community agencies*** *such as the Y and local food pantries"*<br><br>*"****Regular communication*** *with municipal co-workers and colleagues in neighboring communities to share protocols, schedules and expectations."* |
| **Made budget adjustments** | *"considering using funds through* ***Formula Grant to provide necessary equipment*** *to continue to work remotely"*<br><br>*"revise budgets,* ***cut spending"***<br><br>*"****Looking for grants*** *to purchase equipment"* |
| **Increased technological capabilities at the senior center** | *"****Working with town IT****, training, practice with technology, got new lap tops and access from home. We have purchase new software to allow us to auto connect by phone and with future e-mail blast capacity from out data base"*<br><br>*"Just doing it,* ***getting over our fears of technology****, over time we all get more comfortable"* |
| **Increased use of volunteers** | *"We have a working relationship with the Quaboag Valley Community Development Corp. to have* ***volunteers do errand running for the seniors*** *so that they can get groceries, prescriptions delivered to them."*<br><br>*"****Recruited and utilized Town volunteers*** *for outreach by phone, food shopping and delivery, trash pickup, sewing and donating masks to COAs to distribute"* |
| **…about older adults** | |
| **Increased outreach efforts** | *"****Coordination of information and referral has been a primary goal****, as well as assisting seniors with applying for various benefit programs."*<br><br>*"****Lots and lots of phone calls*** *checking on seniors both known to us and those being referred as well"* |
| **Increased meal services** | *"Also partnered with [local organization] to identify 120 of the most vulnerable seniors in to* ***have 2-3 boxes of food items delivered to their homes each month****."*<br><br>*"We chose to deliver the congregate meals and* ***got help from the Police Dept****."* |
| **Increased remote programs** | *"We have* ***offered assistance to people to help them learn Zoom*** *and partnered with [local] Media to offer cable programming of exercise classes."*<br><br>*"We are* ***working with our local cable provider*** *to try and get some programming available through the cable channel that does not require back and forth interaction between the public and the center to enjoy"* |
| **Began providing supplies and PPE to older adults** | *"Partnered with the Men's Club to distribute surgical masks to 175 residents,* ***enlisted the help of 6 community members to make handmade masks for us****. One woman made 450 on her own."* |

## Community Comparisons

Individual communities across the Commonwealth have adapted differently to the pandemic, and thus COAs have moved forward differently. Here, we offer some comparisons by selected community characteristics highlighting those differences.

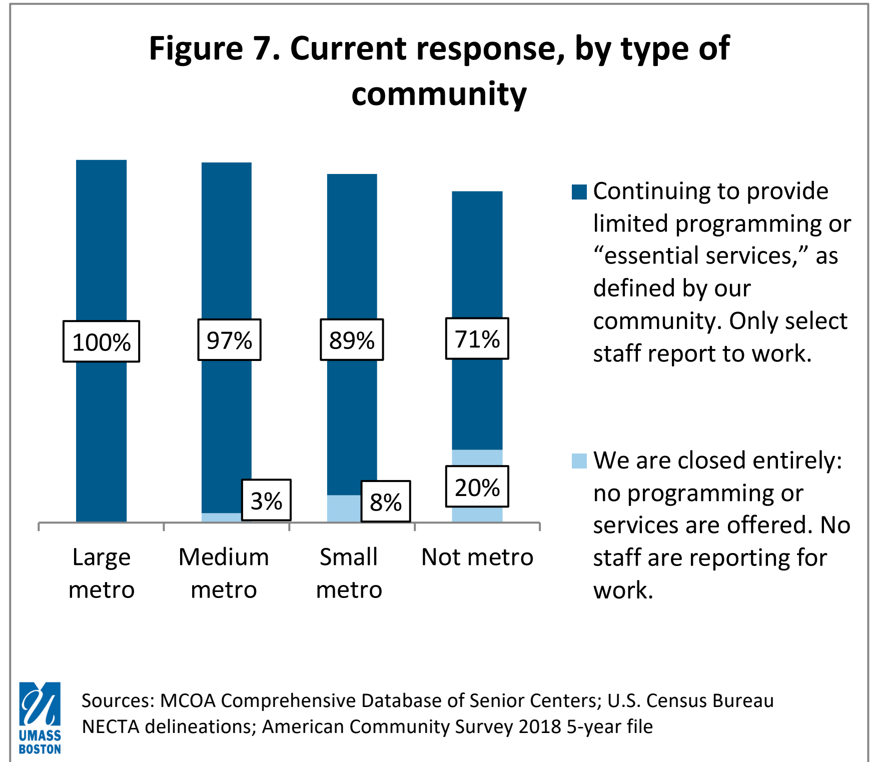
### Emergency Planning & Preparedness

**Figure 6** presents directors' preparedness rating compared by type of community, defined by total population size and proximity to a metro area[11]. About half of non-metro communities reported feeling very well prepared for the COVID-19 pandemic. This compares to 40% of medium metro communities, and about a third of small metro and large metro communities. The greater level of preparedness in non-metro communities may relate to the rural nature of the geography: meaning, COAs in non-metro communities may have smaller operations than their metro counterparts, and thus smaller disruption to their normal operations.




Differences in current operations by community are also evident (**Figure 7**). Nearly 1 in 5 non-metro COAs closed entirely. This drops to just 8% of COAs in small metro communities, and 3% of COAs in medium metro communities. No COAs in large metro communities reported closing completely.

A share of COAs in small communities (3% in metro areas and 9% non-metro areas) that responded to the survey selected "Other" (results not shown), and wrote in that they had no physical space to close.

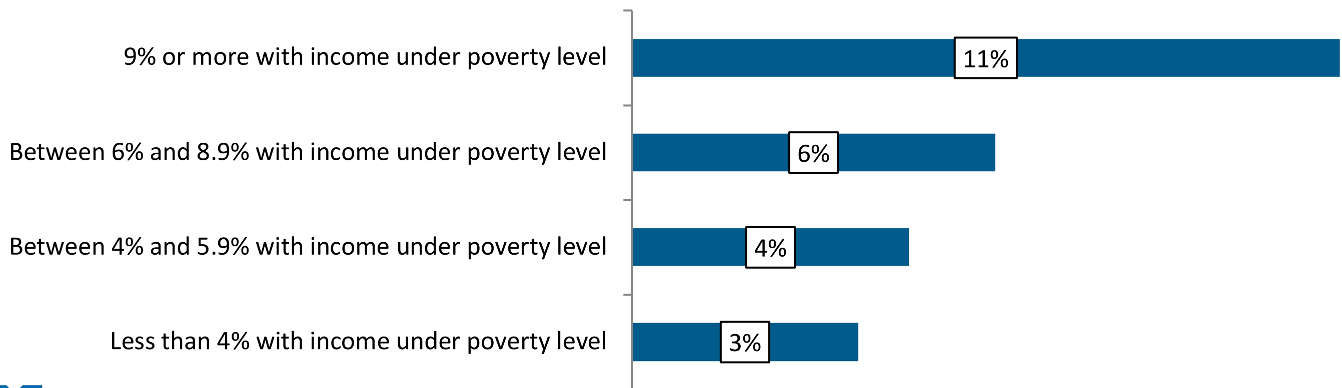



[11] Community categories were computed by the authors. Categories are based on total population size (American Community Survey Estimates 2018 5-year file) and the U.S. Census Bureau New England City and Town Area (NECTA) delineation. Metro areas are defined as regions with an urban core municipality with a population of at least 50,000. Based on this classification, there are 13 large (population greater than 75,000) within a metro area; 161 medium (population between 10,000 and 75,000) municipalities within a metro area; 122 small (population less than 10,000) within a metro area; and 45 municipalities that are not within a metro area, all with a total population smaller than 18,000.

These results highlight stark differences in rural communities for service provision, indicating that how COAs operate—generally and especially through a pandemic—can be characteristically different.

COAs serving communities with greater rates of poverty have had a more challenging time remaining open (**Figure 8**). Among communities where 9% or more of the total population is living under the federal poverty level[12], 11% of senior centers have closed completely. That portion is more than double that for communities with poverty rates of 6% or lower. The discrepancies in COA operations by community poverty level may speak to differences in resources available to maintain operations through the public health crisis; communities with higher rates of poverty may have a greater need for COA operations to meet the needs of older adults in the community, but cannot keep their doors or phone lines open to meet those needs.

**Figure 8. COAs closed entirely, by community poverty level**

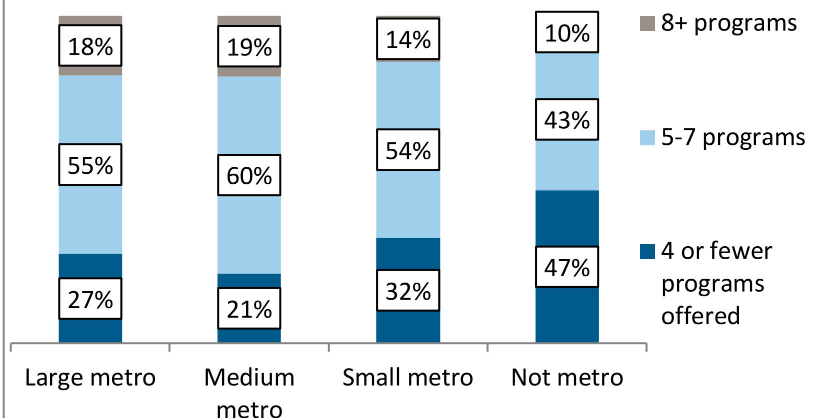


Sources: MCOA Comprehensive Database of Senior Centers; U.S. Census Bureau NECTA delineations; American Community Survey 2018 5-year file

## Current Programs & Services

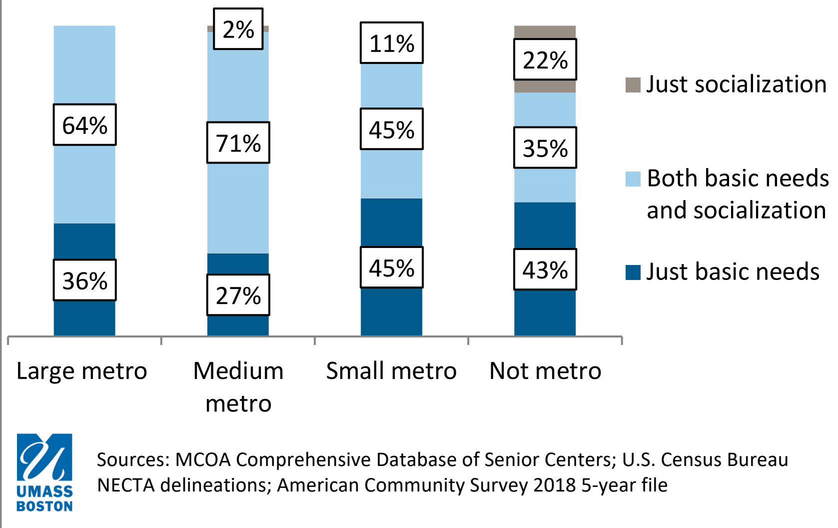
With limited ability to provide programs and services during the pandemic, COAs have had to scale back what they may normally provide, much of which happened on-site. **Figure 9** shows the number of programs currently being offered, by type of community. Almost half of small non-metro communities are providing 4 or fewer programs. At least half of all metro communities are providing between 5 and 7 and programs. Almost 20% of large and medium metro communities are providing 8 or more programs, which compares to 14% of small metro communities, and just 10% of small non-metro communities.

**Figure 9. Number of programs offered, by type of community**



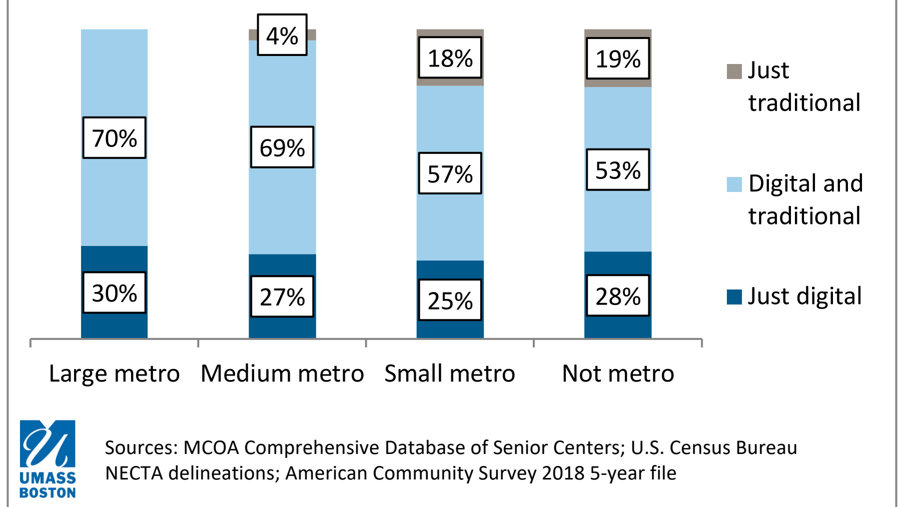
Sources: MCOA Comprehensive Database of Senior Centers; U.S. Census Bureau NECTA delineations; American Community Survey 2018 5-year file

[12] Categories based on poverty level were split at quartiles.




COAs have had to scale back the amount of programs provided as well as the types provided. Almost two-thirds of large metro communities provide a combination of programs aimed at basic needs and socialization programs[13]; similarly, 71% of medium metro communities provide some basic need and socialization programs (**Figure 10**). For small communities, however, there is more variability. Less than half of all small communities are managing a balance of basic need and socialization programs. Around 44% of small communities are providing just basic services, focusing on the immediate needs of the clientele. About 10% of small metro communities are providing only socialization programs; this share doubles for small non-metro communities. COAs in the smallest communities may have limited resources and labor, making it difficult to provide both basic need and socialization programs. Moreover, providing basic need services may require more labor, which small communities may not have, thus choosing to provide something, like remote classes and social groups.

**Figure 12** shows how different types of communities utilize communication methods of reaching their older population. Nearly 70% of large and medium metro communities rely on a mix of digital and traditional methods; slightly more than half of small communities use mixed methods, with a slightly higher share of metro communities (57% vs 53%). Nearly a fifth of all COAs in small communities rely on traditional methods for programs and services—no large communities reported using only traditional methods and 4% of medium metro communities reported using only traditional methods.




[13] Basic need includes Medical transportation, Transportation to the grocery store or pharmacy, Remote Assistance (SHINE, SNAP, MassHealth, Housing, Etc.), Mental health counseling, Home delivered meals, Take-out/curbside pickup meals, Food pantry operations, and Telephone reassurance, outreach, or wellness checks. Socialization includes Remote classes, Remote educational classes, and remote social groups.

## Conclusion

COAs are viewed as the “front door” to the network of health and social services in the Commonwealth and they function as a key social resource for older residents to stay engaged and active in their communities. They are an integral component to the local public health and public safety network, oftentimes the first agency to know about an older adult in distress. Not only has the pandemic differentially impacted older people, but having to close the doors of the COAs and remain socially distant from others has altered the balance of aging supports in Massachusetts.

The contents of this report indicate that the network of COAs are adapting to this new way of living and are continuing to provide essential services and supports to their residents. With their continued resiliency also comes concern about the future. There is still much uncertainty about what COA operations will look like. At time of publication, there is no current decision about what the Formula Grant[14] looks like for FY2021; it is likely that COAs will see their municipal budgets adjusted as well. Both the Formula Grant and municipal budgets make up a significant portion of COA budgets—slashes to those sources will directly affect COA staffing and resources. Additionally, there is no specific guidance at the state level for when COAs will open up again, leaving COAs to make decisions locally with their own municipal governments. COAs do have the support of the MCOA Re-Opening Task Force and other state guidance (e.g., guidelines for food service) that are informing how they can safely increase their operations.

Despite facing a number of uncertainties about the future, COAs continue to do the work that they have always done. COAs are the local agency with “boots on the ground,” and they are working through the pandemic to ensure the health and safety of their constituents. As time progresses, it seems that a new era of COAs is emerging—one that can be characterized as innovative and flexible, and as always, dedicated to promoting independence and quality of life for older residents of the Commonwealth.

[14] The Formula Grant is awarded to every COA from the Executive Office of Elder Affairs. In FY2019, each COA received $12 for every resident over the age of 60, based on the 2010 Decennial Census. (https://www.mass.gov/files/documents/2020/02/10/Elder%20Affairs%202019%20Annual%20Legislative%20Report_Jan%2023%202020%20FINAL.pdf?_ga=2.56628073.25942929.1596825351-2087336506.1593185837). A final decision about the Formula Grant will be made when there is a final General Appropriations Act for the State. Information drawn from MCOA FAQs about COVID-19, updated on 7/27/2020 (https://mcoaonline.com/coronavirus/faqs/)