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A Handbook of Community Services For
the Elderly in Guadalupe County

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by

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Chapter One

Introduction

The elderly is the fastest growing group in the United States. As people grow older, they gradually experience physical and cognitive impairments. Their needs are like any other people, but their ability to care for themselves starts to decline. In order to promote independence and self determination, legislators enacted statutes to assist the elderly to remain in their homes, such as the Social Security Act of 1935 and the Older Americans Act of 1965. These two pieces of legislation were the hallmark that led to a wide range of services for the elderly, administered by different agencies throughout the nation.

Given the patchwork system,¹ one would expect problems with accessing information about services available for the elderly, as funding for those programs comes from different sources. To this effect, a test was conducted in Guadalupe County. The results were as follows, (1) programs that provide information, such as the Informal and Referral Network, are only accessible in metropolitan areas, (2) similar services are provided by different agencies, (3) there is a lack of coordination of services, (4) staff is not trained to facilitate access, (5) information is not easily accessible at the local level.² (6) No one or any local agency has the responsibility to prepare a comprehensive list of

¹ Based on literature review.

² Inquirer has to navigate through endless recorders without reaching appropriate staff.

services for the elderly in Guadalupe County.³ As result, the elderly population and their caregivers in Guadalupe County do not have easy access to reliable information about services available in the community.

The purpose of this research is to fulfill the gap that exists in Guadalupe County due to the lack of information about services available to the elderly. This paper is two-fold, (1) to create a Needs-Model Framework to organize services available in Guadalupe County, and (2) to prepare a comprehensive Handbook for the elderly, their caregivers and professional staff that matches the needs of the elderly to services available in the area. The next section of this chapter introduces the organization of the paper.

Organization of the Paper

Chapter Two, Legislative Setting, begins by providing a historical overview of events that led to the enactment of the major pieces of legislation responsible for creating the array of services for the elderly currently implemented throughout the country. The Social Security Act of 1935 and amendments, and the Older Americans Act of 1965 are discussed. Medicaid, Medicare, Supplemental Security Income, and Block Grants are also addressed.

Chapter Three, Institutional Setting, explores the aging network at the federal, state, and local government that were created as result of the Social Security Act and the Older Americans Act and amendments. The issue of poverty is discussed, since it plays an important role in eligibility of services.

³ There is general directory prepared by the Community Council of South Central Texas about services available in Guadalupe County for the general population, arranged in alphabetical order by the name of the organization or agency. This information is mainly toward meeting the needs of families and children.

Chapter Four introduces the Conceptual Framework; it presents a demographic profile of the elderly and discusses extensive literature concerning the needs of the elderly. Identified needs are classified in major groups, minor groups, and sub-groups, and the “Needs Model-Framework” is designed.

Chapter Five, Methodology, discusses the operationalization of the “Needs Model-Framework” to create the handbook of services to the elderly in Guadalupe County. This chapter explains the research design and the reason for selecting a case study approach. It discusses the advantages of using document analysis, informal interviews, and field trips to operationalize the conceptual framework.

Chapter Six, Conclusion, provides an overview of services available in Guadalupe county that matches the identified needs of the Needs Model-Framework. Observations about accessibility of services are provided at the end of the chapter.

The purpose of this paper does not allow for the developing of a Results Chapter. Instead, a comprehensive Handbook of Community Services For The Elderly in Guadalupe County (Appendix A) is presented. The Handbook is organized based on the Needs-Model Framework discussed in Chapters Four and Five.

Chapter Two

LEGISLATIVE SETTING

Introduction

Policy makers affect the existence or non-existence of services, the quality and quantity of services, and the amount of social security and benefits an individual receives. The purpose of this chapter is to review significant federal legislation that mandates the implementation of social services that assist elderly Americans to live independently in their communities. Governmental programs and community services implemented as result of this legislation are also discussed.

A Brief History

Prior to industrialization, support for the elderly was perceived as a form of informal contract between generations. Children and relatives were the main caregiver support for their older parents. Industrialization, however, brought a demographic change, and the family became a less reliable source of support. Fertility declined, and the number of household members became smaller. Life expectancy increased and older people lived longer. Due to the geographical shift of the workforce during

industrialization, elderly Americans found themselves with less familial support to assist them in their last years of their lives (Pampel, 1998, pp. 26-27). By the middle of the 19th century, the only provision of assistance to the old, the blind, and other needy groups was institutionalization. The shift to place dependents away from their homes was due to the developing of a capitalist economy (Koff, 1999, p. 47). It was believed that by institutionalizing dependents, other members of the familiar group would produce more in this capitalistic society.⁴

By the middle of the 19th century, even physicians considered the elderly as disabled and susceptible to a variety of diseases. The recommendation was for them to withdraw from the workforce, seek medical assistance, and retire in order to retain their energy (Haber, 1983, p.81).

Despite these views, however, in the late 19th century, programs developed to provide assistance to the frail and dependent elderly. Old age homes and pension plans programs were implemented to assist these individuals after they retired from the workforce.

In 1861 legislation enacted the Civil War Veterans' pension to support many elderly in the post-Civil War era. Initially, this military benefit was restricted to the disabled and the diseased, but later was amended to include benefits to all soldiers and dependents who served in the Union army. In 1904, President Theodore Roosevelt expanded a standard part of the pension law to include the incapacity associated with aging. Thus every aged Civil War Veteran became entitled to benefits (Koff & Park, 1999, p. 49). By 1907, the degree of disability was according to age such that:

... the applicant, upon attaining the age of sixty-two, would be considered

⁴ See Scull (1977), Rothman (1971), Coll (1969)

‘disabled one-half in ability;’ at sixty-five he became two-thirds incapacitated; and after seventy he reached total disability... Unless proven otherwise those beyond seventy would be considered overaged.” (Haber, 1983, p. 112).

After 1910, the Civil War pensioners’ population began to decline rapidly. Federal responsibility for income assistance shifted from the federal to state government. These state-level systems were poorly operated and were based on the assumption that poverty was a form of social disease. State and local governments resented the assistance claiming it was a burden for them as “the poor were a population which floats between the almshouse, the jail, and the slums” (Stevens & Stevens, 1974, p.5).

According to Haber (1983, pp. 107, 108) prior to the 20th century, the private sector showed little interest in providing benefits for retirees or establishing residential facilities for the elderly. By 1910, only forty-nine companies had implemented pension plans, and two percent of the elderly (65 years and older) were cared for in old age homes. As Americans began moving into and around urban areas, age restrictions often prohibited them from participation in the workforce due to age restrictions. Urban and industrial growth caused occupational segregation to the elderly which translated into a significant misrepresentation in the dominant modern America (Haber, 1983, p.32). While two thirds of men over age sixty-five were in the workforce by 1890, less than half of that proportion were actively working by 1930, leaving forty percent of the nation’s elderly economically dependent (Koff, 1999, p. 51).⁵

During the Great Depression, public officials, corporate executives, labor leaders and the voluntary sector agreed the federal government must do something to help

⁵ See also Lammers, (1983).

workers to remain in the workforce. In order to create positions for the younger generation, the consensus was that the elderly should retire (Morrow-Howell, Hinterlong & Sherraden, 2001, p. 27, 28). The enactment of the Social Security Act of 1935 was significant, because it represented the hallmark of federal responsibility for the care of the aged, unemployed, handicapped, and poor people (McElvaine, 1993, p. 256, 257).

The Social Security Act of 1935

Initial Provisions

The massive economic decline during the Depression in the 1930s created a need for income support for the elderly, the poor, and the unemployed. This need was beyond the ability of state and local governments to provide (Catchens, 2002 p. 206). In 1935, the Social Security Act of 1935 signed by President Franklin D. Roosevelt addressed some of these unmet needs. Today, this Act remains the cornerstone of U.S. policy on aging.

Title I of the 1935 Act created a federal-state program for providing assistance to the elderly poor. States had discretion in setting eligibility criteria, and the federal government yielded its right to establish “minimal standards of decency and health,” (Morrow-Howell, Hinterlong & Sherraden, 2001, p. 29). The federal-state program under Title I was funded through matching cash grants to states to aid three groups: the aged, the blind, and the dependent children of widows (Catchen 2002, p. 206).

Title II established the compulsory old-age insurance whereby employers and employees collected funds for future retirements. Funding for this program came from earmarked payroll taxes levied on workers and their employers with an initial

contribution of one-half of 1 percent of the employee's salary. Aged workers 65 or older were not required to retire, but their eligibility for continued monthly pensions was tied to a ceiling placed on their income (Achenbaum, 1986, pp. 152-154).

The Act also designated a social security number to each employer and worker. Numbers were assigned in the local post offices; social security numbers were subsequently used by states and local government to identify those individuals that meet financial eligibility criteria for subsidized services.⁶

Medicare

Like the 1930s, the decade of the 1960s was one of social upheaval and pressure for political change. The most monumental administrative change involved the passage of the Medicare Bill on July 30, 1965. With the enactment of this amendment, the Social Security Administration became responsible for administering a new social insurance program that extended health coverage to almost all Americans ages 65 or older. Almost 20 million beneficiaries enrolled in Medicare in the first 3 years of the program (Social Security Administration, 2003).⁷ The passage of this bill was significant, because it was signed at a time when nearly half of the elderly Americans had incomes below federal poverty levels. Many of them had problems obtaining private insurance (Bettelheim, 2001, p. 131).

As it still exists today, the Medicare program primarily covers hospital and surgical care and the medically necessary rehabilitation period that follows. It provides care in skilled nursing facilities, limited home health care, and some hospice care.

⁶ Interview with Patricia Shields, February 11, 2003.

⁷ In 1965, during the Great Society, another important legislation was enacted to provide services for the elderly, The Older Americans Act (OAA). The OAA will be discussed following the Social Security Act.

Medicare, however, does not provide for long-term care, custodial care, or outpatient prescription drugs (Bettelheim, 2001, p. 132). This federally financed program does not cover extended rehabilitative and social support services needed by the chronically ill either.

Initially, Medicare's benefits for the elderly had two components: Medicare Part A and Medicare Part B. Part A, also known as hospital insurance, is provided free to Americans entitled to Social Security. Part A is financed through a payroll tax of 1.45 percent of income, paid by the employer and employee; it covers most of inpatient hospital treatment, skilled nursing facility care, and some home health and hospital care. Most hospitals are reimbursed according to a prospective payment system (PPS) that pays hospitals a fixed amount of money (Bettelheim, 2001, p.132). According to Light (1997, p.55) the implementation of PPS in 1983 had a tremendous impact in the hospital industry, as administrators quickly reduced staff, medical services, and shortened the length of hospital stay. Thus, this reimbursement system did not necessarily translate into quality of medical services to the Medicare beneficiary.

Optional Medicare Part B covers 80 percent of physicians' office visits and outpatient services. Part B premium is deducted from the Social Security monthly benefits.⁸ Hinckley and Hill (1997, p.242) explain that Medicare reimburses physicians using the resource-based relative value system (RBRVS). Participants physicians cannot charge their patients more than 115 percent of the fee schedule amount.

With the passage of the Balance Budget Act of 1997, Congress added another component to the Medicare program. It created Medicare Part C, which to this date, provides expanded options for individuals enrolled in Medicare Parts A and B. Part C

⁸ Medicare Part B premium for 2003 is \$ 58.70

gives the elderly the opportunity to enroll in managed-care plans and other private forms of insurance. In 1997, legislators established protections for Part C enrollees to include access to emergency services, external reviews of participating plans, and the ability to appeal medical treatment decisions.

Medicaid

Medicaid was enacted by Title XIX of the Social Security Act and became law in 1965 as part of President Lyndon Johnson's War on Poverty. Medicaid continues as a joint federal-state matching entitlement program to provide health care to needy individuals. The federal government contributes over 50 percent of the program cost and sets standards for eligibility and basic benefits to ensure consistency throughout the nation. The states have discretion and are in charge of administering the Medicaid program. They have the option to determine additional categories of beneficiaries as well as other services (Brandon & Bradley, 1997, p. 340).

Since states establish eligibility standards and determine type and extent of services and payment rates, programs vary from state to state. All programs have three purposes in common: (1) providing long-term care for the sick, disabled, and elderly, (2) offering comprehensive health insurance for low-income children and families, and (3) reimbursing hospitals that treat a disproportionate share of needy patients who cannot pay their bills.

Medicaid was initially designed primarily as a health-care program, but it has become the main source of public funding for nursing home care and long-term care for

the elderly and disabled. Medicaid is important, because it pays for the co-payments and deductibles not covered by Medicare. It also provides payment for prescription drugs and other services (Bettelheim, 2001, p. 128).

Changes made to the Omnibus Budget Reconciliation Act of 1981 allowed for states to apply for Medicaid waiver programs to fund home and community-based services under their Medicaid program. Eligibility for these services varies by income and resource. This is important, because it allows elderly people who meet eligibility criteria to obtain the supportive services needed to remain in their homes.

Supplemental Security Income

Supplemental Security Income (SSI) was created in 1972 and implemented in 1974. It provides financial aid to low-income elderly Americans, the blind, and the disabled. It replaces Title I (Old Age Assistance), Title X (Assistance to the Blind), and Title XIV (Aid to Permanently and Totally Disabled). General tax revenues finance this program. Benefit payments in fiscal year 2000 were estimated at \$ 29.2 billion. Eligibility is determined by income and countable resources (Koff & Park, 1999, p. 174; Bettelheim, 2001, p. 230). In 2003, the maximum monthly SSI payment is \$ 552 for individuals and \$ 829 for eligible couple (Social Security Administration, CFDA: 96.006)⁹.

Social Security Act Title XX

⁹ Eligibility for SSI benefits would not be explained at this time. It is not a contributor factor toward the completion of the handbook (Resources for the Elderly). Entitlements would not be discussed in detail.

Title XX was signed into law in 1975. This legislation allowed states to receive grants from the federal government for social services for the elderly, persons with disabilities, and children. The goal of the program is to assist individuals to (1) achieve or maintain economic self-support, (2) maintain self-sufficiency, (3) prevent remedy for abuse, neglect or exploitation of children and adults who are unable to protect themselves, (4) prevent inappropriate institutional care by providing less restrictive alternatives, and (5) secure referral or admission for institutional care or providing services to individuals in institutions (Dodgen, 1999).

In 1981 federal matching funds for social services and staff training were combined into a new block grant to states. Most federal requirements were removed. This new block grant became the “Social Services Block Grant,” Title XX. These changes were part of the Omnibus Budget Reconciliation Act, PL 97-35 (OBRA). Unlike prior federal matching funds, the 1981 act capped funding, increased state flexibility, and made the Social Services Block Grant into an entitlement to the states. Funding was set at \$ 2.4 billion in 1982, and increased to \$ 2.7 billion in 1985. In 1996, however, funding levels declined to \$ 2.38 billion with a significant reduction in 2001 to \$ 1.75 billion (Sciamanna, 2003).

States are awarded funds according to a population formula. Federal laws allow these funds to be applied toward the following services: case management, congregate meals, counseling, day care, education and training, employment, foster care, home-based and home related services, home delivered meals, housing, independent and transitional living services, information and referral, legal and protective services, substance abuse

treatment, and transportation.¹⁰ Funds from this title also support local and non-profit programs. The act also gives states discretion over these funds for administration and staff training directly related to services funded under this title (Dodgen, 1999).

The Older Americans Act of 1965

According to Gelfand (1999, pp. 11-14) the major influence on programs for elderly Americans has been the enactment of the Older Americans Act (OAA) passed by Congress in 1965. It established the primary vehicle for organizing and delivering community-based services through a coordinated system at the state level. Initially, the Act emphasized small grants awarded to state agencies on aging to fund social services programs. Later on, additional funding was authorized for the states to coordinate planning and activities. Since its passage, the OAA has been amended twelve times. The 1969 and 1992 amendments were significant, because they stipulated grants for states and added a large number of initiatives and activities of the Administration on Aging.

Major provisions of the original act included the establishment of the Administration of Aging (AoA)¹¹ and grants to states for community planning, services, and training. The Act also stipulated that state agencies on aging be established to administer the programs (Butler, Lewis, and Sunderland, 2002, p. 229). The 1967 amendments directed the AoA to undertake a study of personnel needs in the aging field.

OAA Titles: Grants for State and Community Programs in Aging

¹⁰ Services to families and children not mentioned (out of the scope of this paper).

¹¹ As result of a reorganization plan in 1991, the AoA became an independent agency that reports directly to the Secretary of the Department of Health and Human Services.

As mentioned earlier, the 1969 amendments are significant because they outline the types of services that should be provided at the local level in order to develop “comprehensive and coordinated services” to enable adults to maintain “maximum independence” (OAA, Sec. 301).

Title III supports services aimed at assisting the elderly such as, transportation, outreach, information and assistance, case management, homemaker and home health aides, chore maintenance, and supportive services for families of older individuals who are victims of Alzheimer’s disease. It also provides funding for congregate and home delivered meals, adult day care, legal assistance and recreation. The 1973 amendment authorized funds for model projects, senior centers and multidisciplinary centers of gerontology. In 1974 Title III added a special transportation program (Butler, Lewis and Sunderland, 2002, p. 228). In 1992, supportive activities for caregivers of frail elderly were added to the act. Also, these amendments include a list of 12 disease prevention and health promotion services that range from health assessments and screening to nutritional counseling, to physical fitness, dance, music, and art therapy (Gelfand, 1999, p. 17).

Title IV of the act authorizes funding for research and training in the field of aging. ¹²Title VI awards funds to 220 tribes and native organizations to meet the needs of older American Indians, Aleuts, Eskimos, and Hawaiians. Title VII focus on the “Vulnerable Elder Rights Protection.” It addresses the need for strong advocacy to protect and enhance the basic rights and benefits of elderly Americans (Butler, Lewis and Sunderland, 2002, p. 230). The important component of Title VII is the authorization of the Long-Term Care Ombudsman Program, Programs for the Prevention of Abuse, Neglect and Exploitation, Legal Assistance, Benefits Outreach, Counseling and

¹² Title V of OAA, Multipurpose Senior Centers, was repealed October 18, 1978. Pub.L.95-478

Assistance Programs. Another significant change of this amendment is the funding formula. Grants are awarded according to census data based on the percentage of each state's population that is aged sixty or older (OAA, Betthelheim, 2001, p. 163).

In 2000, Congress established an innovative new program: The National Family Caregiver Support Program. The following year, grants for \$ 125 million were awarded to State agencies on aging to provide support services to caregivers and families caring for their frail elderly parents or relatives. The National Family Caregiver Program also recognizes the needs of grandparents who are caregivers of their minor grandchildren (AoA, 2003). Services under this program include: information to caregivers about available services, assistance in gaining access to supportive services, individual counseling and training, respite care, and other supportive services.

Table 2.1 shows the President's Proposed FY 2003 Health and Human Services Appropriation Bill to Congress.¹³ The trend has been to increase or maintain the same level of funding for direct services and reduce appropriation request for Titles related to administration, training and research.

¹³ Latest information available.

Table 2.1 Older Americans Act 2003 Proposed President's Appropriation Bill

Program	OAA Title	FY 2001 (1)	FY 2002 (1)	FY 2003 President's Budget Request
Supportive Services and Centers	III-B	\$ 325,027	\$ 356,994	\$ 357,000
Congregate Meals (actual appropriation)	III-C1	483,979 (378,412)	491,699 (390,000)	491,000
Home Delivered Meals (2) (actual appropriation)	III-C2	194,405 (151,978)	222,525 (176,500)	224,525
National Family Caregiver Support Program (3)	III-E/ VI-C	124, 981	141,500	141,500
Preventive Health Services	III-D	21,120	21,123	21,562
Training, Research, Discretionary Projects	IV	35,852	38,273	27,837
Aging Network Support Activities (4)	II	1,812	2,379	2,379
Grants to Indian Tribes (actual appropriations)	VI	25, 407 (23,457)	27,675 (25,729)	27,675
Vulnerable Older Americans	VII	14,181	17,681	17,681
Alzheimer's Disease		8,962	11,496	11,500
Program Administration		17,219	18,102	17,986
TOTAL AoA		\$1,253,898	1,350,433	1,342,357

Source: U.S. Administration on Aging- Budget Division, July 18, 2002.

(1) Amounts include rescissions but exclude transfers under the Secretary's 1% transfer authority.

(2) The President's FY 2003 budget request includes a proposal to transfer the Department of Agriculture funding of Nutrition Services Incentive Program (NSIP) to AoA under Titles III-Ca, II-C2, and VI. For comparability purposes, the actual appropriations for these programs during FY 2001 and 2002 are indicated in bold below that line (but are non-additive). In FY 2003, NSIP funds are distributed across the three AoA nutrition programs on a pro-rata basis.

(3) Congress earmarked \$ 5 million of these funds in FY 2001 for the Native American Caregivers program under Title VI-C of the reauthorized Older Americans Act and \$ 5.5 million in FY 2002.

(4) Aging Network Support Activities, or Title II, consists of the Eldercare Locator and Pension Counseling. These programs, previously funded in Title IV, were moved permanently to Title II.

Chapter Three

INSTITUTIONAL SETTING

Introduction

The preceding chapter introduced the major acts of Congress that fostered the development of an infrastructure of agencies to assist elderly Americans to live independently after retirement. Funding for the implementation of services at the federal level comes from two major sources: The Block Grants of the Social Security Act, and grants from the OAA. The Administration on Aging (AoA), a division of the U.S. Department of Health and Human Services, is the leading agency to coordinate services authorized by the Older Americans Act. Federal legislation grants the AoA responsibility in the promotion and coordination of programs and services among federal, state, local government agencies, and profit and non-profit organizations. This approach has given states and communities considerable discretion in determining the content and organization of services to individuals.

The purpose of this chapter is two fold: (1) to identify the agencies that play an active role in the aging network, and (2) to discuss the role of poverty as a factor

influencing service eligibility. These institutions form the intergovernmental network that ultimately serve the elderly of Guadalupe County.

The Aging Network

Over the last few decades, programs serving the elderly have expanded consistently with the growth of the older population. Federal programs, authorized by Social Services Block Grants and the Older Americans Act, provide a greater variety of services. About two thirds of the states operate home and community-based activities that are solely state funded. The private sector also plays a role in this aging network (GAO, 1991, p.3).

The services provided by Medicaid, Social Security Block Grants, and the Older Americans Act are not uniformly accessible among states, because eligibility in terms of income or poverty will vary. At the same time, similar programs are administered by different agencies, including department of social services, health, aging, transportation and others. Agencies also have different arrangements when coordinating programs at the county and local levels (GAO, 1991).

At the federal level, the leading administering agencies are the Social Security Administration and the U.S. Department of Health and Human Services.¹⁴ In Texas, the following agencies deliver the majority of long-term care community services for the elderly: Texas Department of Health and Human Services, Texas Department on Aging, Texas Department of Human Services, Texas Department of Mental Health and Mental

¹⁴ State agencies under Texas Health and Human Services deliver the majority of services for the elderly. However, other Texas state agencies under US Department of Education, HUD, US Department of Justice, US Department of Transportation also provide services/assistance in cooperation/coordination with Texas Department of Aging.

Retardation, Texas Commission for the Blind, Texas Commission on Alcohol and Drug Abuse, Texas Department of Protective and Regulatory Services, Texas Rehabilitation Commission, Texas Department of Health, Texas Commission for the Deaf and Hard of Hearing. Other agencies such as Texas Department of Transportation, Texas Department of Economic Development, Texas Department of Criminal Justice, Comptroller of Public Accounts, Texas Higher Education Coordinating Board also are part of the aging network (TdoA, 2000). In Guadalupe County, the Alamo Area Council of Government (AACOG) unit of the AAA of South Central Texas , the Community Council of South Central Texas (CCOSCT), local private and non-profit organizations such as the Salvation Army, United Way, Food Bank and Guadalupe County Valley Hospital are part of this network.¹⁵

The Social Security Administration

The Social Security Administration (SSA) is an independent governmental agency¹⁶ that administers the Old-Age Survivors, and Disability Insurance (OASDI) and the Supplemental Security Income Program (SSI), which is a national means-tested entitlement program for low-income elderly, blind, and the disabled (Littman & Robins, 1997, p.329, Bettelheim, 2001, p. 220). In order to qualify for SSI, an elderly person 65 or older must be poor with limited income and resources. In 2003, in Texas, the income limit for an individual is \$ 552, and the resources limit is \$ 2,000. For a couple, the

¹⁵ Information gathered from contacts with local organizations, co-workers at the Texas Department of Protective and Regulatory Services, staff from Texas Department of Human Services, Alamo Area Council of Government, and local officials in Guadalupe County . No literature available at the local level.

¹⁶ Until March 31, 1995, The SSA was part of the Department of Health and Human Services. As independent agency, it continues working closely with that agency.

income limit is \$ 829 with a maximum of \$3,000 in assets.¹⁷ In 2001, the SSA distributed approximately \$ 431.9 billion in Social Security Benefits and \$ 32.2 billion in SSI. This represents nearly 74% increase in benefits and almost double increase in supplemental income from previous decade (SSA, 2003).¹⁸

The money to fund Social Security comes from its own separate payroll tax, which is compulsory for almost everyone who receives wages or salary, including self-employed persons. The payroll tax is divided equally between employer and employee. Such rate has significantly increased from 2% in 1937 to 12.4%, along with another tax for Medicare hospital insurance (Moody, 2000 p. 230).

The U.S. Department of Health and Human Services

General Information

The Department of Health and Human Services (HHS) is the largest grant-making agency in the federal government, providing almost 60,000 grants per year. This federal agency is in charge of protecting the health of all Americans, especially those who are the least able to help themselves. HHS works closely with state, local, and tribal governments. Funded services are provided at the local level by state, county or tribal agencies, or through private sector grantees. The Department administers more than 300 programs for all Americans, such as:

- Medical and social science research

¹⁷ Any person younger than 65, must meet disability criteria in addition to income and resource limits to qualify for SSI. Certain assets are protected and not considered resources such as, a house (homestead), one automobile, burial plots, insurance with cash value under certain amount. Income limit for eligibility varies from state to state.

¹⁸ Last available data published by SSA. In 1990 Social Security awarded \$ 247.8 million in benefits and \$ 16.1 in Supplemental Security Income. Only 31% of benefits awarded in 2001 correspond to the elderly population, 56% to disabled adults, and 13% to children.

- Preventing outbreak of infectious disease, including immunization services
- Assuring food and drug safety
- Medicare (health insurance for the elderly and disabled Americans), and Medicaid (health insurance for low-income people)
- Financial assistance
- Substance abuse treatment and prevention
- Community programs for the elderly
- Comprehensive services for Native Americans

The Department's programs are administered by 11 HHS operating divisions, including 8 agencies in the U.S. Public Health Service and 3 three human services agencies. The Administration on Aging (AoA) , Centers for Medicare and Medicaid Services (CMS), and the National Institute on Aging (NIA) are the operating divisions in charge of elderly programs and services.

Administration on Aging

The Administration on Aging (AoA) is one of the HHS Operating Divisions. AoA is the “focal point and advocate agency for older persons and their concerns” (HHS, 2003). The AoA administers the federal programs mandated by the Older Americans Act and amendments. These programs help vulnerable elderly remain in their homes by providing supportive services. The AoA works closely with its nationwide network of

regional offices and State and Area Agencies on Aging to plan, coordinate, and develop community level systems.

Centers for Medicare and Medicaid Services

The Centers for Medicare and Medicaid Services (CMS), former Health Care Financing Administration, administers the Medicare and Medicaid programs that provide health insurance for the elderly and disabled Americans. Medicaid, a joint federal-state program, gives health coverage to low income persons, children, and institutionalized individuals who meet eligibility criteria.¹⁹

National Institute on Aging

The National Institute on Aging (NIA) was enacted in 1974 to provide leadership in aging research, training, health information dissemination and other programs relevant to aging and older people. Subsequent amendments to this legislation designated the NIA as the primary federal agency on Alzheimer's research.

The NIA's mission is to improve the health and well-being of older Americans through research and to (1) support and conduct high quality research on aging process, age-related diseases, and other related problems; (2) train and develop highly skilled research scientists from all population group; (3) develop and maintain a state-of-the-art resources to accelerate research progress; and (4) disseminate information and

¹⁹ As of July 1, 2001, the Health Care Financing Administration (HCFA) is now the Centers for Medicare and Medicaid Services.

communicate with the public and interest groups on health and research their findings and recommendations (NIA, 2003).

Network in Texas

In Texas, long-term care is defined as “the provision for personal care assistance related to health and social services given episodically or over sustained period to assist individuals of all ages and their families to achieve the highest level of functioning possible, regardless of the setting in which the assistance is given” (THRC §22.0011). The enactment of the major pieces of legislation discussed in Chapter Two allow poor elderly citizens in Texas to begin receiving regular long-term state assistance since 1936 (Texas Institute for Health Policy Research, 2002). As new legislation is enacted, state agencies are created to implement congressional acts.

Today, Social Security continues providing income assistance at the federal level, while agencies under the Texas Health and Human Services (Texas Department on Aging, Texas Department of Human Services, Texas Department of Mental Health and Mental Retardation, Texas Department of Protective and Regulatory Services and others) implement services funded by the Older Americans Act and Social Security Grants.

Texas Department on Aging

The Texas Department on Aging (TDoA) is responsible for conducting research and providing expertise on aging issues to state agencies and the legislature. TDoA

administers federal funds for nutritional, social and supportive services for older Texans as well as other funds from the Centers for Medicare and Medicaid Services. The OAA, however, is the primary source of funding for the agency. Services are provided through a statewide network of Area Agencies on Aging (AAA), using funds and resources from the federal, state, and local levels. There are 28 AAA in Texas (SB 535, 2003).

AAAs plan, coordinate, and advocate for a comprehensive service-delivery system addressing older Texan's short and long-term needs. AAAs work with federal, state and local officials, local citizen advisory councils, senior constituents, service providers, and the private, non-profit and voluntary sector to develop community-based services. AAAs verify the need for these services through needs assessments, public hearings, information and assistance logs, and other means.

Through contracts and vendor agreements with numerous providers across the state, AAAs provide a wide array of services. Volunteers play an important role in this process. All Americans 60 years of age and older are eligible for OAA-funded services, however, the Act requires targeting programs to "those in greatest social and economic need, with particular attention to low-income minorities" (SB 535, 2003).²⁰ This includes older people who (1) live in rural areas, (2) have the greatest economic need (particularly low-income minorities), (3) have severe disabilities, (3) have limited English proficiency, and (4) suffer from Alzheimer's disease or related disorders with neurological and organic brain dysfunction.

²⁰ Maria Wilson, AACOG, states that information about income and resources is gathered, but does not preclude the elderly from receiving services. However, services are limited up to \$ 1,200 per calendar year. Usually provider services and home-maker assistance is up to 3 months or until dollars amount reach the cap.

Texas Department of Human Services

The Texas Department of Human Services (TDHS), through their program Community Care for the Aged and the Disabled, provides the majority of long-term care services for qualified elderly in Texas such as: Home Delivered Meals, Community-Based Alternatives, Primary Home Care, Emergency Response, Residential Care, Adult Foster Care, Respite Care, Adult Day Care, In-Home Family Support Program, Special Services to Persons with Disabilities, Special Services to Persons with Disabilities-24 hours attendant care, Program for People Who Are Deaf-Blind With Multiple Disabilities, Family Care and others.

Sources of funding vary from Medicare (Title XVIII), Social Services Block Grant Title XX alone, Title XX with State Grants, Title XIX (Medicaid) and State Matching Funds, or solely State Funding. Applicants must meet the medical or functional assessment score²¹ and financial eligibility criteria. Limits for income and resources differ among programs. (THDS, 2003 pp. 2-52). The Handbook (Appendix A) covers detailed descriptions of these services.

For the FY 2003-2004, the income and resource limit for eligibility of services is as follows:

- \$ 1,635 income per month for an individual, \$ 3,270 for a couple.
- \$ 5,000 or less in resources for an individual, \$ 6,000 or less for a couple.²²

²¹ Functional assessment is completed during the initial visit with the client to determine level of impairment in performing activities of daily living. Degree of limitation is scored from 0-3 (22 questions) individual scores are then added. If total score is 24 or more, person is eligible for services.

On 03/30/03 the House Appropriations Committee wrapped up the mark-up budget decision for health and human services agencies FY 2004-2005. Functional score increased from 24 to 29. This increase will result in 56,669 people losing services (elderly and disabled). Also see Adult Day Care Association (2003).

²² Applicant also must meet functional score and/or medical need. Meeting eligibility criteria does not necessarily mean services would be provided. Except for provider/attendant care, most services have long

TDHS also manages the Food Stamp Program that helps low-income families buy nutritious food from local retailers. This benefit is funded by the United States Department of Agriculture (USDA). Unlike other services for the elderly, eligibility is contingent upon all household members income and resources combined (TDHS, 2003).

With respect to income, most households must meet both, the gross and net income tests, but a household with an elderly person or a person who receives certain types of disability payments only has to meet the net income test. Gross income means a household's total, non-excluded income, before any deductions have been made. Net income means gross income minus allowable deductions (TDHS, 2002). Table 3.1 shows the maximum income limits to qualify for Food Stamps assistance.

Table 3.1 Household Income Limits for Food Stamps Program for 2003

People in Household	Gross Monthly Income	Net Monthly Income
1	\$ 960.00	\$ 739.00
2	1,294.00	995.00
3	1,628.00	1,252.00
4	1,961.00	1,509.00
5	2,295.00	1,765.00
6	2,629.00	2,022.00
7	2,962.00	2,279.00
8	3,296.00	2,535.00
Each additional person	+ \$ 334.00	+ \$ 257.00

Source: Texas Department of Human Services (2002).

interest lists. Availability is subject to appropriation of federal and state funds. Release from interest lists varies from county to county.

With regards to countable resources, households may have up to \$ 2,000 in countable resources, such as bank account, or \$ 3,000 if at least one person is 60 years or older, or is disabled. Certain assets are exempt: A home and a lot, the resources of people receiving SSI or Temporary Assistance to Needy Family (TANF), most retirement pension plans, one or two vehicles under certain conditions. There is no time limit for food stamp benefits for families with children, elderly, or the disabled.

The Texas Department of Mental Health and Mental Retardation

The Texas Department of Mental Health and Mental Retardation (TDMHMR) is a partnership of consumers, family members, service providers and policy makers that creates options responsive to individual needs and preferences. Through indirect administration, TDMHMR assures the efficiency, quality and effective management of services provided to persons with mental illnesses and with mental retardation.

TDMHMR is divided in two distinctive programs: Mental Health and Mental Retardation. Services funded by state grants and federal dollars are similar to the ones provided by TDHS. The difference is the disability related condition. Under TDHS, the impairment is usually related to a medical condition such as Diabetes, High Blood Pressure, Heart Problems, Brain Injury, etc. In order to qualify for services under the TDMHMR, however, the elderly must have a mental health condition (Schizophrenia, Major Depression, Bipolar) or be diagnosed with Mental Retardation prior to the person's 18th birthday.²³

²³ Information provided by former MHMR workers Flo Lockett (MH) and Kasey Mays (MR), January 2002.

The Texas Mental Health and Mental Retardation Act of 1965²⁴ authorized local agencies to assume responsibility for local administration of MHMR services. For the next 10 years, centers developed with significant variation in administration and services. Local centers lacked accountability and experienced serious financial problems. As consequence, in 1976, the Texas Council for Community MHMR Centers was created.

The purpose of the Texas Council of Community MHMR Centers, Inc. is to provide an organization through which local MHMR centers can work together as a public system serving Texans with mental illness, mental retardation, and chemical dependency. Their mission is to improve services in local communities with other provider systems, deliver quality services needed by their consumers, and provide accountability to their sponsoring governmental entities, their other funding sources, and the State governance for its investments in services.

Bluebonnet MHMR is the local Community MHMR center in Guadalupe county. All residents in the county are eligible for services, regardless of their age or economic status. Services are available on a sliding scale based on household's income. No one is denied participation in a program because of inability to pay. The local Community MHMR centers bill directly to Medicaid and Medicare. Some centers do not accept individuals with private insurance. It is an option of each particular community center (Bluebonnet MHMR, 2002).

Texas Department of Protective and Regulatory Services

²⁴ TDMHMR is also in charge for the administration of state schools and state hospitals.

The Texas Department of Protective and Regulatory Services (TDPRS) investigates reports of abuse, neglect or exploitation of the elderly²⁵ or disabled individuals in TDMHMR state schools, state hospitals and centers, Community MHMR, local MHMR authorities, home and community settings (TDPRS Handbook, 2003).²⁶

TDPRS also provides services to alleviate the problems such as, financial assistance to pay for rent, utilities, food, shelter, medical appointments, prescription drugs, referral to appropriate service providers and others. To qualify for services, the person must be in state of abuse, neglect or exploitation. Services are available to all elderly persons without regard to income or resources.

TDPRS works in cooperation with other agencies such as TDHS, law enforcement, MHMR, AoA, etc. TDPRS has legislative authority to file legal lawsuits on behalf of the neglected, abused or exploited elderly person to remedy the abuse. TDPRS can also seek guardianship over those individuals who totally lack capacity to care for themselves, and when no other qualified person is available to protect the elderly or disabled client (HRC, Chapter 48, Title 2).²⁷

Texas Commission for the Deaf and Hard of Hearing

Texas Commission for the Deaf and Hard of Hearing (TCDHH) provides elderly persons a variety of services, such as accessibility to sign language or oral interpreters, information and referral to additional services and community resources, referrals for

²⁵ Under TDPRS rules, an elderly is a person 65 years of age or older.

²⁶ Investigations to nursing homes are made by the Texas Department of Human Services, Long-Term Care Regulatory Program, not by the Texas Department of Protective and Regulatory services.

²⁷ For further authority refer to HRC Section 48.

adaptive equipment, independent living and recreational activities, financial assistance to purchase specialized equipment for access to telephone services.

Texas Commission for the Blind

The Texas Commission for the Blind assists visually impaired elderly persons with in-home training to live independently, financial assistance with eye examinations, training to improve mobility and orientation, counseling, recreation and socialization. Reimbursement for services is based on a sliding scale according to household's income.

Local Network

Alamo Area Council of Governments (AACOG)

The Alamo Area Council of Governments (AACOG), established in 1967, is a voluntary association of local governments and organizations that serves its members through planning, information, and coordination of activities.

Twelve counties comprise the AACOG: Atascosa, Bandera, Bexar, Comal, Frio, Gillespie, Guadalupe, Karnes, Kendall, Kerr, Medina and Wilson. AACOG provides services authorized by the OAA to elderly individuals 60 years or older such as nutrition, in-home assistance, transportation, senior centers, benefits counseling, legal assistance, care coordination, information, referral and prescription assistance, nursing home ombudsman, health maintenance, home repair, home modification, adult day care, respite care, emergency response systems, escort service, and others.²⁸

²⁸ Although OAA was established to provide assistance by developing a set of programs to support the nation's elderly (all person 60 or older), preference is given to individuals in greatest financial need.

In Guadalupe county, most services authorized by the Social Security Act Block Grants are provided by local Texas Department of Human Services, Guadalupe County Mental Health and Mental Retardation, and Texas Department of Protective and Regulatory Services. Other state agencies such as Texas Department of Housing and Community Affairs work closely with local housing authorities (Section 8, Subsidized Housing) to assist low-income elderly to live independently.

Community Council of South Central Texas

The Community Council of South Central Texas (CCSCT) administers the local transportation program, meals on wheels, congregate meals, senior centers for elderly residents, health information, nutritional education, blood pressure clinic, escort services, emergency response referrals, and others.

CCSCT also assists the elderly with utility bills and repairs or replacement of inefficient heating and cooling systems under the Comprehensive Energy Assistance Program (Garcia-Castillo, 2000, p. 44). Programs and services provided by the CCSCT target low-income elderly persons.²⁹

However, no one who meet aged criteria is denied services. States' discretionary authority allows them to set priorities according to availability of funds.

²⁹ CCSCT services to elderly is based on poverty thresholds, unless service is provided with contract with TDHS (different eligibility requirement) or AACOG (OAA assistance to all elderly 60 years or older). CCSCT also administers the Head Start Program, Guadalupe County Transportation System, and Family Planning Program.

The private sector and non-profit organization such as Connections, Guadalupe Valley Hospital, United Way, Salvation Army, local Red Cross, local shelter, are also part of the aging network.

The Role of Poverty In Accessing Services For The Elderly

Although the OAA does not preclude older people from receiving services funded by the Act, assistance is limited to meet short term needs within a calendar year.³⁰ In order to qualify for long-term subsidized services funded by block grants, older Americans must meet income and resource limits. The next section examines poverty and measures of poverty used to established eligibility requirements for most social services.

Defining Poverty

Most services and programs for the elderly are provided by agencies under the leadership of the Health and Human Services Commission. For the purpose of this section, poverty is defined as a condition under which individuals or entire families do not have sufficient economic resources or income to pay for their basic needs. These needs include food, housing, shelter, utilities, health care, transportation, and clothing (HHSC, 1997).

Since 1965, there have been two official versions of poverty measurement: the poverty thresholds and the poverty guidelines. The poverty thresholds are the primary version of the Federal poverty measure, issued by the Bureau of Census and generally used for statistical purposes. On the other hand, the poverty guidelines are issued by the Department of Human Services and are used for administrative purposes in determining

³⁰ OAA does not specify time limitation for programs, these limits are set by AoAs and state agencies, based on availability of funds.

financial eligibility for public assistance. Citro and Michael (1995) discuss the flaw in the official poverty thresholds, as it does not reflect the nation's current poverty population. In response to this concern, in 1992 the Panel on Poverty and Family Assistance of the National Academy of Sciences, National Research Council, conducted a thorough review of the poverty measure and recommended replacing it with the new experimental poverty thresholds.

Poverty Thresholds

The poverty threshold was first developed by Mollie Orshanky, an analyst with the Social Security Administration, who established a single authoritative measure to calculate economic impoverishment. The Orshanky's poverty thresholds were originally determined as three times the cost of minimally adequate diet, based on the U.S. Department of Agriculture's economy food plan. To determine poverty status, the gross cash income was compared with the appropriate threshold, adjusted for family size. This poverty measure was appropriate during the 1960s when in-kind programs such as Food Stamps, Medicaid, AFDC, and subsidized housing remained small (Corbett, 1999, p. 51).

Programs implemented during the Great Society era represented an important source of support for low-income families. All these subsidies and financial assistance were not taken into account in the Orshanky's calculation. Table 3.2 shows the Poverty Thresholds for 2002 by Size of Family and Number of Related Children under 18 years. The poverty thresholds vary according to the family composition (number of adults younger than 65, older than 65, and number of children younger than 18).

Table 3.2 Poverty Thresholds for 2002 by Size of Family and Number of Related Children Under 18 years (In U.S. Dollars).

Size of Family Unit	Related Children Under 18 years								
	0	1	2	3	4	5	6	7	8
1 person 65 +	9,359 8,628								
2 persons 65 +	12,047 10,874	12,400 12,353							
3 persons	14,072	14,480	14,494						
4 persons	18,556	18,859	18,244	18,307					
5 persons	22,377	22,703	22,007	21,469	21,141				
6 persons	25,738	25,840	25,307	24,797	24,038	23,588			
7 persons	29,615	29,799	29,162	28,718	27,890	26,924	25,865		
8 persons	33,121	33,414	32,812	32,285	31,538	30,589	29,601	29,350	
9 persons	39,843	40,036	39,504	39,057	38,323	37,313	36,399	36,173	34,780

Source: U.S. Census Bureau. Last revised February 26, 2003.

Introduction to the Experimental Poverty Measures

In 1992, questions about the poverty measure gave rise to the National Research Council (NRC) study panel. At the request of Congress, the Panel on Poverty and Family Assistance was established. In 1995, the panel issued a final report and recommendations for change, *Measuring Poverty: A New Approach* (Corbett, 1999, p. 52).

The NRC panel recommended that the poverty measure be based on a concept of satisfying the family's needs on the three components of basic necessity: food, clothing and shelter (including utilities). The poverty threshold would be determined by using data from the most recent Consumer Expenditure Survey (CEX) on the consumption of these three items, plus a percentage for other necessities such as personal care. Also, the threshold should reflect the economies of scale in larger families and differential needs of

children. The panel also recommended a poverty concept to include after-tax money income plus in-kind transfer payments for food and shelter, minus family's non-discretionary expenses (child care, medical costs, etc). Based on these calculations, the NRC determined that about one-in-five families currently considered in poverty has higher income than some families not receiving Earned Income Credit, food stamps, or that faces medical and child care expenses (Citro & Michael, 1995).

This study also suggested adjusting the thresholds for geography to accommodate the large differences in housing between metropolitan areas, rural, and less populated sectors. These recommendations were supported by the U.S. Census Bureau, The Bureau of Labor Statistics, The Institute for Research in Poverty, The Office of Management and Budget and others (Focus, 1999). Finally, in June 1999, the U.S. Census Bureau issued the first Experimental Poverty Threshold Measures, 1990-1997.³¹

Although the Experimental Poverty Measures have been recently incorporated in the U.S. Census Bureau, this does not influence, improve or reduce the elderly's accessibility to services. Experimental and poverty thresholds are basically for statistical purposes (calculate number of persons in poverty) and do not determine income eligibility for social programs.

Poverty Guidelines

The most significant measure for accessing subsidized services is the poverty guidelines. The poverty guidelines are used for administrative purposes and are issued by the Department of Health and Human Services (HHS). They are a simplification of the

³¹ To view US Experimental Poverty Measurements , please refer to U.S. Census Bureau. Information not included in this paper, because it does not contribute to the purpose of research.

poverty thresholds and are used to determine financial eligibility for certain federal, state, and local programs (Fisher, 1996).

A major reason for issuing guidelines distinct from the poverty thresholds is that the thresholds for a particular calendar year are not published in final form until late summer of the following calendar year. If poverty guidelines are not issued, HHS and other state and local agencies must use two-year old data in determining eligibility for programs during the first half of each year.

The HHS poverty guidelines are used in setting eligibility criteria for a number of federal programs. Some programs use a percentage multiple of the guidelines, such as 125 percent, 150 percent, or 185 percent of poverty thresholds. This decision is made at different times and by different congressional committees or federal agencies (Fisher,

1996). Some of the examples of federal programs for the elderly that use poverty guidelines in determining eligibility are: Food Stamps (Department of Agriculture), Low-Income Home Energy Assistance (Health and Human Services), Weatherization Assistance (Department of Energy), Senior Community Employment Program (Department of Labor), Legal Services for the Poor (Legal Services Corporation). Major means-tested programs that do not use the poverty guidelines in determining eligibility include Supplemental Security Income (SSA), Housing Assistance Programs (Department of Housing and Urban Development), and Social Services Block Grants.

Since states and local governments have discretion in the administration of block grants, some states and county governments, including the private sector, have chosen to use the federal poverty guidelines in some of their own programs to assist poor residents

of their communities. Some of these programs are, legal indigence for court purposes and medical services, state health insurance services, assistance with prescription drug programs, and assistance with utilities and others.³² Table 3.3 shows the Poverty Guidelines for 2002 issued by the Department of Health and Human Services. Federal, state, and local governments follow these guidelines when determining income eligibility for services.

Table 3.3 Health and Human Services Poverty Guidelines for 2002 (In U.S. Dollars)

Size of Family Unit	48 Contiguous States and D.C.	Alaska	Hawaii
1	8,860	11,080	10,200
2	11,940	14,930	13,740
3	15,020	18,780	17,280
4	18,100	22,630	20,820
5	21,180	26,480	24,360
6	24,260	30,330	27,900
7	27,340	34,180	31,440
8	30,420	38,030	34,980
For each additional person add	3,080	3,850	3,540

Source: *Federal Register*, Vol. 67, No. 31, February 14, 2002, pp. 6931-6933.

Comments

³² Information based on paper presented by Gordon M. Fisher June 6, 1996, at the annual meeting of the Sociological Practice Association, Arlington, VA.

The institutional setting is confused and mingled. Similar programs are administered by two or more agencies under different eligibility criteria. Federal mandates have created a maze of services for the elderly difficult to navigate. The literature available is not clear in identifying the complex aging network and distinguishing main institutions participants in the process. Thus, accessibility is affected.

Two main sources of federal funding must be identified in the Aging Network: The Social Security Block Grant and the Older Americans Act. Often, similar services are paid by two different agencies (Meals On Wheels, by AAA; and Home Delivered Meals by TDHS), depending on the funding source. The benefit of this complex network is the availability of many services and alternatives for the elderly to live independently. Thus, it is critical that elderly consumers be aware of the services available in the community and understand that eligibility criteria are significantly different among programs.

The following chapter identifies the needs of the elderly population that lays the foundation for the conceptual framework of this research.

Chapter Four

Introducing the Conceptual Framework

Introduction

The purpose of this chapter is three-fold: (1) to describe the needs of the elderly population, (2) to start the classification process for the developing of the conceptual framework, and (3) to develop the handbook and framework for the research. Elderly needs are categorized into major groups and sub-groups. The summary of needs is used to develop the model framework for the handbook. In addition, the national profile of Older Americans is examined, and the literature concerning the needs introduces

demographic and economic characteristics of elderly persons in Texas and Guadalupe County.

Profile of elderly Americans

In 2002, the Administration on Aging (AoA) released the Profile of Older Americans report that indicated the elderly are the fastest growing group. Since 1900, the percentage of Americans 65 and over has more than tripled (4.1% in 1900 to 12.4% in 2000), and the number has increased eleven times (from 3.1 million to 35.0 million). The profile emphasizes that the older population itself is getting larger. In 2000, the 65-74 age group (18.4 million) was eight times larger, and the 75-84 was even 34 times larger. The significance of this profile is that the “baby boomers,” (45-64) have increased by 34% during this period. By 2001, the “baby boom generation” will begin to reach retirement age, and by 2030, it is projected that one in five people will be elderly. The size of the older population is projected to double over the next 30 years (The American Geriatric Society, 2000). Thus, this growth will put severe financial stress on programs for the elderly. The government will be forced to pay out more in benefits than it takes in from payroll taxes and interest income (Bettelheim, 2001, p. 23).

Needs of the Elderly

Physical aging is inevitable. The existing literature reveals that muscle strength decreases gradually after the fifth decade of life (Balogun and Katz, 2002, p. 39). The primary signs of disability in older adults include (1) decline in basic and instrumental activities of daily living, (2) deterioration of cognitive capacity, (3) decline in visual and

auditory senses, (4) motor deficits that translates into muscle weakness, (5) lack of social support system, and (6) external factors such as finances and transportation (Balogun and Katz, 2002, p. 51). These changes affect the elderly in general, regardless of their social and economic status. Thus, older people face inevitable decline in their faculties. There will be a transition from healthy life to death, and the quality of life during these last years depends largely in the social support and services available to the elderly.³³ Building an infrastructure of services aids in guaranteeing elderly Americans live their final days with dignity.

The following section describes the needs of the elderly population. The literature is classified into major categories: (1) Employment and Education, (2) Financial, (3) Housing, (4) Legal, (5) Physical, Medical, and Mental Health, (6) Protection, and (7) Social Activities.

Category 1: Employment and Education

1.1. Employment

After retirement, many older people continue to work. For some, this work consists in taking advantage of **volunteer activities** they were too busy to engage in while they were employed. For a large proportion of retirees, **employment** after retirement represents a supplement to their income (Thorson, 2000, p. 328).

In certain instances, older individuals choose to pursue new careers. Supportive policies, **job training**, and **employment services** can help the elderly to participate in the workforce. Congress has declared that older people are entitled to equal opportunity

³³ Interview with Dr. Patricia Shields, February 11, 2003.

employment and must not be discriminated against because of age. Congress has also provided the elderly with equal access to education and training (US. Federal Code §42).

The aging of the population as explained at the beginning of this chapter will substantially affect certain occupations and industries. Those most affected are educational services, health services, public administration, and some manufacturing (Dohm, 2002, p. 24). The AARP 2002 Work and Career Study, based on a national survey of workers ages 45 to 74, found that 69 percent of respondents are planning to work after retirement years. That study also suggested that the majority of respondents believed age discrimination exists in the working world (Montenegro, Fisher, & Remez, 2002, p.1).

Elderly people are no longer penalized for entering the workforce after retirement. Social Security has significantly changed since its adoption in 1935. The Act has been amended to include incentives to work longer. Changes include a phased increase in the normal retirement age beginning in 2003, adjustments to the annual growth in delayed benefits, and elimination of the annual earnings test for persons at full retirement age (Steuerle & Spiro, 1999 p.1). The problem with employment, however, is two-fold (1) finding employers who do not discriminate against the elderly, and (2) finding a sufficient number of part-time jobs (Gelfand, 1999, p. 112).

Perhaps the easiest, initial step to assist the elderly in obtaining employment is helping them to understand their skills and abilities. This type of counseling increases their chances of getting a job. Counseling clinics provide the retiree with supportive help, foster the development of self-assurance, and help with occupational adjustment. **Counseling** helps the elderly to overcome fears such as poor motivation, insufficient

work history, noticeable lag period since their last job, and the lack of appropriate skills to meet the challenges of the labor market (Gelfand, 1999, 113).

1.2 Education

In order to attain the skills needed to reenter the workforce, the retiree may require the necessary training and education to increase his chances of obtaining the job.

Educational programs offer older adults opportunities to learn and improve social interaction. Congress supports education for older adults by declaring that they are entitled to “participate in and contribute to meaningful activity within the widest range of civic, cultural, education and training, and recreational opportunities” (US FC § 42).

Educational opportunities may not be appropriate for all elderly persons, since many factors can negatively influence their ability to learn, such as poor hearing and vision, cognitive impairment, and other physiological changes that interfere with the elder’s ability to retain and retrieve information (Scharlach & Robinson, 2002).

In a study conducted by the Texas Department on Aging in 2002, the educational levels of older Texans continue to be lower than those of younger age groups. According to the 2002 Census, 61.7 percent of Texans age 65 and older have at least a high school diploma compared to 76.7 percent of those age 18 to 64. The percentage of older adults who have completed high school also varies considerably by race and ethnicity. Anglos have the largest percent of high school graduates (74%), which is consistent with the Anglo population, followed by Asians and Pacific Islander (63%), African-Americans (46%) and Hispanics (37%). Notably, Hispanics are the larger minority of elderly, but have the lowest percentage of high school graduates (U.S. Census, 2000).

Category 2. Financial Assistance

Financial security is a priority for elder Americans. Generally, the economic status of older people has improved over the past few decades.³⁴ Various income sources, Social Security, pension plans, personal savings, and employment earnings play an important role in determining economic stability. Only a small percentage of elderly people live below the poverty level (10.1%).³⁵ In Texas, almost less than 9% live in poverty,³⁶ and in Guadalupe County elderly in poverty accounted for 9.5% of residents.³⁷ In 2000, the national median income for elderly people was \$ 18,778.³⁸ Income disparities, however, continue to exist between older minorities and older Anglos. Poverty rates among African-American and Hispanic elderly are 2.5 times greater than the Anglos (Hudson, 2002). Thus, elder minorities are at greater need for **income assistance**.

Elderly rely on their Social Security Benefits to meet their financial needs. About 90 % of all elderly received **Social Security Benefits**, 59 % earned some income from other saved resources, 41 % drew pensions, and 22 % earned income from jobs.³⁹ There is a concern about the future of Social Security once the “baby boomers” reach retirement age. Estimates indicate that by 2016, spending will exceed tax revenues, and the trust funds are expected to be exhausted by 2038 (GAO, 2001).

³⁴ See Seperson (2002) p. 20.

³⁵ See U.S. Bureau of the Census. Poverty in the United States: 2001, P-60-219, Issued September 2002.

³⁶ See U.S. Bureau of the Census: March of 2001. Current Population Survey (CPS) for Texas.

³⁷ See U.S. Bureau of the Census, Census 2000: Profile of Selected Economic Characteristics. Geographic Area: Guadalupe County, Texas.

³⁸ See SSA Office of Policy of Research, Publication No. 13.

³⁹ See SSA Pub. 13-11727

Another source of income is employer-provided pension plans. Income from such plans is an important factor to determine if the elderly would be better or worse off after retirement. Unfortunately, 48% of retirees do not receive pensions, and the proportions of those who have them have not increased substantially since the 1970s (Munnell, Sunden, & Lidstone, 2002).

In Texas, older people can improve their income by availing themselves of **tax benefits**, including **federal income tax relief**, and **property tax exemptions**. For example, people 65 and older have higher income thresholds to determine whether they have to file a federal income tax return (Anderson, 2001). They also have higher standard deduction. Some Texas cities have homestead exemptions that reduce the burden of property taxes.⁴⁰ Current state law provides for the freezing of school taxes on the homesteads of older Texans.

Another issue facing the frail elderly population is the need for someone to help them **manage their money**. Many older people need assistance with paying their medical bills and managing their financial affairs. This is particularly true for people with memory problems, declining vision, limited English fluency or loss of dexterity in their hands. Most prefer assistance that allows them to retain control over how their money is spent and to safeguard their right to privacy. The Texas Money Management Program offers daily **money management** services to low-income older adults and people with disabilities (Family Elder Care, 2003).

Category 3. Housing

⁴⁰ Phone conversation with staff at Guadalupe County Appraisal District, January 12, 2003.

In 2001, 80% of elderly persons owned their homes and 20% were renters.⁴¹ Home ownership, however, decreases dramatically among the oldest group. Some older adults are forced to give up their homes due to declining health, depleted financial resources, or substandard housing conditions. (OAPI, 2002 p.20-3).

There is limited **affordable housing** for the elderly these days. Affordability problems affect both homeowners and renters. The majority of elderly renters are struggling to meet the high price of rental units. The financial responsibility of paying a mortgage, in addition to property taxes and utilities, simultaneously burdens homeowners. The majority of elderly people want to stay in their own homes,⁴² and the most affluent elderly have increasingly shown interest in **retirement communities** with specific age limits for residents (Gelfand, 1999, p. 154-155).

There are federally funded programs to assist elderly with housing needs such as public housing. In spite of that, sometimes it is difficult for them to live in these units, since many local housing authorities require that older residents who need supportive services meet this need if they are to remain in their units (Gelfand, 1999, p.157).

Another alternative program that allows the poor elderly person access to affordable housing is Section 8 (Existing Housing Program). Section 8 or subsidized rent is also known as “the voucher.” It allows the person to look for an apartment or a house owned by a private individual who is contracted with the Section 8 Program. Unlike the private sector, the renter is only responsible to pay up to 30% of his or her income, as if he or she were living in public housing (Gelfand, 1999, p. 157-158).⁴³

⁴¹ American Housing Survey for the United States in 2001, Current Housing Reports H150/01

⁴² 1992 Survey by the American Association of Retired Persons.

⁴³ Section 8 allows greater versatility than living in public housing; rules are not excessively, and pets are usually allowed. This attracts elderly people. However, when living under Section 8, the renter is

Other programs, such as HUD's Home Investment Partnership program and the USDA's rural Rental Housing Program, provide loans and/or grants that can be used to purchase, construct, or rehabilitate affordable housing. Programs, such as HUD's multifamily Housing Mortgage Insurance Program, encourage the construction of affordable housing by ensuring lenders against loss of mortgages. Programs such as the Low-Income Housing Tax Credit use tax incentives to direct private capital toward the creation of affordable rental housing.

Affordability housing is not the only the problem affecting the elderly population with respect to their living arrangements. **Energy cost** also depletes the elderly from their financial resources. Social Security recipients spend between 13% to 19.5% of their budgets in home energy costs (TDHCA, 2003). A person who cannot financially meet the cost of energy, particularly in the highest consumption months, increases the risk of heat-related illness or hypothermia, and many include death (CDC, 2003). In some cases, Texans choose to forego medication and food in order to pay their utility bills (TDHCA, 2001, p. 94).

Sometimes homeowners may not be aware that the use of less efficient systems and appliances contributes to higher energy costs. **Home improvement** could increase energy efficiency and lower the utility cost (TDoA, 2002, p.20). The Texas Department of Housing and Community Affairs conducted the Community Needs Survey (2001) and more than three quarters (81%) of respondents expressed a major or moderate need for **weatherization** of existing homes to increase energy efficiency (HUD, 1999).

responsible for utilities. In Guadalupe County and surrounding areas, public housing rent includes the cost of electricity, waste management, and water.

The TDHCA administers two energy assistance programs, The Comprehensive Energy Assistance Program (CEAP) and the Weatherization Assistance Program (WAP). The CEAP, funded by the U.S. Department of Health and Human Services (DHHS), provides consumer education, assistance with paying utility bills, and funds for repair or replacement of heating and cooling systems. The WAP, funded by the Department of Energy, DHHS, and the Systems Benefit Funds, provides energy conservation education, and funds the installation of weatherization measures. Priority for both programs is given to the elderly, persons with disabilities, and households with children under age six (TDHCA, 2001, 28-29).

Along within the scope of home energy efficiency and weatherization, there is a need for **home repairs and rehabilitation**. According to HUD, 1.5 million elderly households lack basic elements of housing security, such as complete plumbing or a reliable source of heat.⁴⁴ One-half million of these elderly households are substandard dwellings that pose a threat to their safety and welfare. In 2001 TDHCA conducted a Community Needs Survey and found that 83% of respondents said their housing is in need of repairs, and they perceived it as a serious problem.

In addition to home repairs, many elderly person with physical impairments need **accessibility improvements** to maintain their independence. Houses may require adaptations to accommodate a wheelchair: widened doors, walk-in showers, and wheelchair ramps, hand-rails, and grab bars. The TDoA administers funds granted by the OAA to assist with these improvements. Under the In-Home and Family Support Program or the Community Based Services Medicaid Waivers, the TDHS has a

⁴⁴ See HUD, Housing Our Elders.

component dedicated to these types of improvements. Funds for these programs, however, are very limited (TDoA, 2002).

The HUD HOME program administered by the TDHCA has funds to rehabilitate rental and owner-occupied housing. HOME can also be used for assistance with accessibility, for example, the cost associated with a wall removal. In rural areas, such as Guadalupe County, the USDA's Home Repair Loan and Grant Program offer repair loans with 1% interest rate to low-income persons and provide home improvement grants to persons age 62 and older who are unable to repair the loan. This program also provides funds to make a home accessible to people with disabilities (Department of Agriculture, 2003).

There are other alternatives to public housing and home modifications, depending on the economical status of the elderly person. More affluent elderly may choose to live in Continuing Care retirement communities (CCRCs). They may contain a nursing home or assisted services within the complex, but the elderly lives independently in condos or apartments. They may opt for this type of **retirement housing**, because it provides welcomed security as well as opportunities to improve socialization (Thorson, 2000 p.263).

There are times when the elderly does not have any other option than entering a **nursing home**, because of the need of skilled or intermediate care and depending on the number of hours of actual nursing care an individual receives. Sometimes this living option is housed in the same facility as **Intermediate Care Facilities (ICF)** or **Personal Assistance**. In this case, Medicaid can pay for the cost of the facility, which generally includes room and board, custodial care, skilled care such as medical

consultation, nursing services, and most rehabilitation therapies. Other need such as dental services, some medications, beautician and barber services are not typically covered under this program (Lustbader & Hooyman, 1994, p. 326; Thorson, 2000, p. 264).

There are also instances in which the elderly does not need skilled nursing care or intermediate care services. He or she may need **Adult Foster Care**, which is considered community living arrangements. The elderly person is provided with room, board, and supervision, but he or she must be physically able to attend her personal needs, such as grooming, toileting, and feeding.⁴⁵

Housing types such as Intermediate Care Facilities, Adult Foster Care, Personal Care, and Nursing Homes, can be paid privately or through governmental programs administered by the Texas Department of Human Services.

Category 4. Legal

Elderly persons and their families are sometimes unprepared or unaware of the difficult situation they may encounter in later life when trying to make decisions over their loved ones' affairs. The capacity for making these decisions may be impaired as the elderly person ages. While the person is still able to manage his or her affairs, he or she may consider to secure that his or her wishes are carried out in the later years of his or her life. Various legal means can assist in the management of assets and health care when the person becomes incapacitated: Durable Power of Attorney, Durable Power of Attorney for Health Care, and Revocable Living Trusts.

⁴⁵ Interview with D'Laine Haggan, Community Care for the Aged and the Disabled Manager, on November 20, 2002.

A **Durable Power of Attorney** is a document that allows the elderly person to give authority to another agent to make financial or legal decisions, or both, and financial transactions on the elder's behalf. "Durable" means that it continues into effect even after the elderly person becomes incapacitated.⁴⁶

The Durable Power of Attorney, however, does not authorize the agent to make health care decisions on behalf of the principal. If an elderly person wishes for someone else to make these type of choices, the **Durable Power of Attorney for Health Care**⁴⁷ is the legal document that grants those powers. A Durable Power of Attorney for Health Care is an advance directive that allows the elderly to appoint a health care agent to make health care decisions for the grantor in the event that this one is unable to communicate his or her wishes.⁴⁸

A Durable Power of Attorney for Health Care may or may not give the agent authorization to make decisions regarding life-sustaining treatment, depending on the wishes of the elderly. Sometimes the person may not want anyone to make health care decisions, but wants medical staff to know his or her wishes regarding the use of life-sustaining treatment in the event that the person becomes terminally ill or permanently unconscious. If this is the case, the elderly has the option to execute a **Living Will**.⁴⁹ Most states include these types of instruction (life-sustaining treatment) incorporated in the Durable Power of Attorney for Health Care.⁵⁰ The **Living Will**, however, is not

⁴⁶ See Family Caregiver Alliance (2001), Clifford (1996), Cane (1995).

⁴⁷ A health care agent (Durable POA for Health Care) does not have the authority to make legal and financial decisions. Similarly, agents under the Durable POA who do not have authority to make health care decisions.

⁴⁸ Governing directives vary from state to state. Also See Clifford (1996), Cane (1995) and Family Caregiver Alliance (2002).

⁴⁹ Also known as Directive to Physicians.

⁵⁰ See Family Caregiver Alliance (2002), Clifford (1996), Cane (1995).

extended to instruct paramedics about the person's wishes. The **Out of Hospital Do Not Resuscitate** instructs emergency medical personnel and other health care professionals to forego resuscitation in and out of hospital settings.

Depending on the wishes of the elderly person, another legal alternative is the **Revocable Living Trust**. A living trust is a method of distributing property. A living trust is set up during the beneficiary's lifetime. The trust document provides for the distribution of the settlor's assets upon his or her death. The trustee distributes the trust assets directly to the beneficiaries. There is no automatic court supervision or probate of this distribution process as there is under a Will. This is generally faster and less costly than the procedures related to a Will.

Sometimes the elderly may prefer to execute a **Will** instead of a Living Trust.⁵¹ Wills are written documents that state how to distribute assets after death and can make estate administration proceed more quickly and smoothly (ABA, p.56). Wills are relatively simple and inexpensive to prepare. While the law does not require a lawyer to write a will, it is safer to have an attorney handling this legal procedure. If a person dies without a will or trust, or has not transferred property in some other way, the state determines how the property is distributed.

Category 5. Physical, Medical, and Mental Health

5.1 Physical Health

As stated earlier, aging affects every individual in society. The body experiences an inevitable slowing and decline. Age-related physical changes occur gradually and are

⁵¹ I have known clients whom prefer to execute a Will, because it is too complicated for them to understand what a Living Trust entails.

not always visible. Physical changes are not happening equally among the elderly population. Each person has individual needs and self-care requirements. For example, a situation of a poor, rural elderly person cannot be compared to that of a wealthy, urban elderly individual. They each have different medical and social needs (Kohut, Kohut, & Fleishman, 1983, p. 21). Thus, socio-economic status may also affect the quality of life of an elderly person.

Lifestyle behavior such as **smoking, alcohol consumption, poor nutrition, lack of exercise**, and **oral health care** affects our health status. Research has linked smoking to all three major causes of death (heart attack, cancer, and stroke). Smoking not only shortens life, but it reduces the quality of life and causes disability.⁵² Although alcohol consumption can have both positive and negative effects on health and longevity, heavy drinkers, defined as someone who consumes more than 14 drinks per week, are more likely to suffer from cirrhosis of the liver, certain cancers, and hypertension (Quadagno, 1999, p. 265).

Proper nutrition lowers the risk of many chronic diseases, including heart disease, stroke, some type of cancer, diabetes, and osteoporosis, however, elderly Texans do not consume an appropriate and balanced diet.⁵³ To alleviate some of this unmet need among the elderly population, the 1973 Amendment of the OAA provided for the distribution of at least one hot meal per day to low income elderly people 60 or older, initially in a congregate setting. **Congregate meals** are meals prepared meeting the USDA dietary guidelines and are served in locations such as senior centers or adult day cares. **Home Delivered Meals** (“Meals on Wheels”) are provided to homebound persons,

⁵² See Hobbes and Damon, 1996.

⁵³ See TDoA, Physical Health (2002).

and allow them to have good nutritional intake of food on regular basis. Approximately 90% of all those receiving these meals are aged 60 and over. The purpose of the program is to assist individuals who are unable to cook to remain in the community (Gelfand, 1999, pp. 123-129).

Exercise is an important lifestyle activity that influences the well-being of the elderly person. Elderly people who exercise routinely are more able to keep their weight under control, and more likely to have fewer backaches and joint problems than those who are sedentary (Quadagno, 1999, p. 264). People who exercise regularly show improved cardiovascular function, better long-term and short-term memory, and less disability than sedentary people (Hill, Storandt, & Malley, 1993 pp. 12-17). Despite of the benefits of exercising, national trends show that individuals of all ages are involved in less and less activity. More than 60% of Americans are not regularly active; 25% of Americans are not active at all; older Americans are the least likely to participate in any type of physical activity. Approximately 34% of the population age 50 and older are sedentary (Stalvey, 2002, p.1). In Texas, 33% of those age 55-64 and 37% of those over age 65 reported no physical activity in previous month (TDH, 2003).

Factors such as poor **oral health care** and difficulty in eating can lead to malnutrition. Oral health care prevention and treatment can improve the dental health. Oral cancers, tooth decay, and periodontal disease are still serious problems (TDoA, 2002, p. 111).

Older adults who have chronic conditions (heart disease, diabetes, arthritis, heart attack, high blood pressure, and stroke) eventually face diminished quality of life, increase health care cost, and difficulties conducting **activities of daily living**, such as

shopping, dressing, preparing meals, cleaning, walking, dressing, bathing, etc. The majority of them rely on others for **transportation**, because of their declined physical condition and inability to see clearly. Adaptive equipment, **adaptive aids** and **medical supplies** (walkers, hand rails, high rise toilet seat, diapers) may improve mobility and adaptability.⁵⁴

5.2 Medical Health

Chronic conditions also place a financial burden on the elderly. As the older population becomes larger, health care costs are also projected to increase. This is because, on average, the elderly uses more health services and spends more on care than younger people. Many elderly people do not receive the needed **medical care**, because they lack the financial resources to see a doctor (GAO, 1986, p.4). Low income people relies on Medicaid to pay for **prescription drugs**; however, those who live in the community are only allowed to fill three prescriptions per month.⁵⁵ Medicare does not pay for prescription drugs. Medicare's assistance is limited to diabetic supplies only. Some financial relief may be available through the local AAA, the Texas Department of Protective and Regulatory Services, or local community agencies such as the Salvation Army. In Guadalupe County, assistance with medications is available through the prescription assistance program, sponsored by Guadalupe Valley Hospital. Only those

⁵⁴ Interview with M. Wilson, AACOG

⁵⁵ Tommy G. Thompson, HH Services Secretary (2002) reported the cost of prescription drugs increased 15% a year from 1995 to 2,000 (faster than any other category of spending). Thompson also reported that hospital stays are getting shorter. Twenty years ago patients were spending 7 days or more in the hospital. In 2000, the average was 4.9 days. Sixty three percent of all surgeries now are performed as outpatients procedures, with patients being sent home after a short stay in a recovery room.

individuals with low income, and who lack any type of health insurance, are eligible for the assistance. Thus, Medicaid recipients would not qualify.⁵⁶

5.3 Mental Health

Mental illness affects all people, the old and the young. Emotional distress such as schizophrenia is joined by problems more common in later life: depression and dementia. Emotional problems such as depression may be more common as older people are forced to adapt to losses in later life: loss of spouse, income, status, companionship, and health. Those who lose their social support network may be vulnerable. Dementia is a condition that people fear the most (Thorson, 2002, p.202). Dementia includes, but is not limited to, loss of memory, reduced motor skills and judgment, disorientation, and sometimes significant behavioral changes. **Alzheimer's** is the most prevalent condition associated with dementia. Infectious diseases, high blood pressure, diabetes, and high cholesterol are also contributing factors (Bettelheim, 2001, p.52).

Stalvey (2002, p.3) explains that prevalence of mental illness is greater among older adults than in other age group. According to the American Psychiatric Association, approximately 15 to 25 percent of older adults in the United States suffer from significant symptoms of mental illness which can result in outcomes such as suicide.

Abuse of alcohol or crack cocaine, or misuse of medications are inevitably dementing over time. Affective disorders such as **major depression** and **bipolar disorder** can lead to this dementia as well. Sometimes community mental health cannot longer assist these individuals to live safely in their homes; eventually their social

⁵⁶ Interview Yolanda Griffith November 11, 2002.

network and support breaks down. Then, institutional care is the next safe place for them (ADI, 2000).

According to Stalvey (2002, p.3) the manifestation of mental health disorders are often very unique among the older population. The Surgeon General's Report of Mental Health states that progress has been made in the field of geriatrics to differentiate mental disorders related to normal aging. Many older adults have mental disorders that exist simultaneously with other chronic diseases, making it difficult to ascertain a specific diagnosis or treatment. Social stigmas often cause health care professionals, as well as patients and families, to inaccurately attribute unusual behavior to the "aging process" instead of recognizing and treating the problem. Other barriers such as the lack of available services, lack of cultural competence, and limited financial reimbursement further contribute to this problem.

Category 6. Protection

Older adults deserve protection from **abuse, neglect or exploitation**. Mistreatment of the elderly may be physical, emotional, or in the form of financial exploitation. Domestic elder abuse refers to the maltreatment of an older person by someone who has a relationship with the older adult (a spouse, sibling, child, friend, or caregiver). Institutional abuse occurs in residential facilities (nursing homes, group homes, assisted living) by people who have a legal or contractual obligation to care for

the elderly.⁵⁷ **Neglect** means the “failure to provide for one’s self the necessary goods and services, including medical services, which are necessary to avoid physical or **emotional harm** or pain or the failure of a caretaker to provide the goods and services.”⁵⁸

Self-neglect is the most common form of abuse among older adults. It occurs when individuals are unable to meet their own basic needs (nutrition, hygiene, finances, medical care, shelter) due to poverty and or mental impairment (Duke, 1996, pp. 42-43). Financial or material exploitation occurs when an individual without the older person’s knowledge or consent, uses his or her income and resources for own personal gain (THRC §48.002).

There have not been enough studies to determine the prevalence of elder abuse in this country. The 1996 National Elder Abuse Incidence Study was the first attempt to quantify the number of elder abuse in the United States. This study reveals that almost half a million people 60 and over experienced abuse and/or neglect in domestic settings. Of this total, only 16% were reported to state protective and regulatory agencies (NCEA, 1998).

During the past decade, studies and research have increased toward understanding the nature or causes of elder abuse. Studies show that in cases of physical, emotional, and financial abuse (community), the perpetrators were more than likely to have a history of mental illness and tended to be financially dependent on the victim. In cases of self-neglect, the victim/perpetrator was more likely to be older, widowed, and cognitively or physical impaired, or both, with very limited social contacts. (Wolf, 1996, pp. 4-9).

⁵⁷ See NCEA, 1998. Abuse in nursing home or institutional setting not discussed, considering the scope and nature of this paper.

⁵⁸ See Texas Human Resources Code §48.002 (a)(4).

In consideration of our frail elderly population neglected, abused, and exploited, federal support was expanded under the Title VII of the OAA (1992) that created the Vulnerable Elder Rights. This title helps to focus programs designed to protect the right of vulnerable older people, including those who are victims of elder abuse. The federal government has tried to consolidate a variety of programs throughout the Act into one title in an effort to strengthen them. The main point of Title VII is to engage in aggressive efforts to make sure that rights of older people are protected. The elder abuse provisions, the ombudsman provision, and the elder rights have received increasing funding.

As commented earlier in the Institutional Chapter, this legislation (Title VII OAA) was crafted in a way that it was treated as a grant program to states in order to take the lead in activities to identify and prevent abuse. Unfortunately, this legislation has caused tension between state agencies where Adult Protective Services are not part of the Aging Department (Benson, 1998, p. 25). For example, the Texas Department of Protective and Regulatory Services (TDPRS) is the agency authorized by law to protect vulnerable adults (elderly and disabled adults). Funding for the program comes from Title XX of the Social Security Act, not from Title VII of the OAA.⁵⁹

Recent legislation to protect elderly Americans was enacted by the 107th Congress, The Elder Justice Act (2002). This is the first ever comprehensive federal effort to address elder abuse and crimes against senior citizens and to guarantee protection for every older American. The Act would create a federal office of elder justice, both in the Department of Justice and the Department of Health and Human Services.

⁵⁹ See TDPRS Appropriation Budget 2002-2003.

Major provisions of the Act include Prevention, Detection, Treatment, Collaboration, Prosecution, and Consumers. *Prevention* focuses on making older adults safe in their homes and neighborhoods by enhancing long-term care staffing, and stopping financial fraud. *Detection* refers to the creating of forensic centers to enhance detection problems. *Treatment* addresses the improvement of investigations in a way that diminishes the consequences of abuse and meeting the complex needs of the victims. *Collaboration* is an effort in coordinate federal, state, local and private entities, law enforcement, long-term care facilities, consumer, advocates, and family through mechanisms such as multi-disciplinary response teams. *Prosecution* provides for holding the perpetrator accountable for his or her acts, by giving more support to law enforcement personnel and prosecutors. Finally, *Consumers* refers to creating a resource center to help older adults and family make choices about personal care options and receive training in prevention of abuse, neglect and exploitation (Breau, 2002).

Category 7. Social Engagement

Social engagement includes socialization and interaction with others. Social participation helps elderly individuals to be involved in their community. Elderly, regardless of their economic status, may become isolated. Factors that contribute to withdrawal from others include loss of spouse, family, or friend; problems with mobility; disability; sensory loss; illness; lack of income; or cognitive dysfunction (TDoA, 2002, p. 95).

Poor physical and mental health problems are associated with lack of community interaction. Isolation often creates feelings of loneliness and depression. Providing adequate **social support** may prevent withdrawal and improve quality of life. Social support systems contribute to health (Gilles, Metcalf, Anderson, & Andrews, 2001, pp. 10-13). Research suggests that daily contact with a family member or friend may make a difference between living independently in the community or in an institution (Bennett, 1980, p. 3). Routine weekly or bi-weekly visits from children help, but do not fully satisfy an older persons' need for socialization (Bennett, 1980, p. 137). Thus, friends and neighbors are important elements in a person's life.

There are many opportunities for elderly persons to remain socially active. Participation in **recreational activities** allows social interaction by creating a common bond of interest among participants (Siegenthaler, 1996, pp. 18-21). **Volunteerism** creates opportunities for older adults to participate in unpaid activities after retirement, providing a positive impact and sense of usefulness in the individual (Wheeler, 1998, p. 69). Employment opportunities and subsidized part-time community jobs can help older adults to stay active in their communities. Involvement in spiritual and religious organizations allows many seniors to be connected and bring meaning to their lives. **Escorts** can also promote independence and self-confidence to improve access and participation in the community (TDoA, 2002, p. 95-97).

Conceptual Framework Summary

As stated at the beginning of chapter four, the conceptual framework for this research is a "Model-Framework" that will be used to develop the handbook that

connects the services to the needs identified in the literature. The type of conceptual framework is descriptive categories.

Categories are best used when the researcher wants to classify and analyze things that are grouped together, because they are similar or make sense (Kaplan, 1964, p. 50). Sorting, labeling, creating bins, and doing a natural classification instead of an artificial one are techniques to use in this process (Shields, 1998, p. 59-60).⁶⁰ Categories and subcategories are developed to describe the needs of the elderly population. There are seven major categories, five minor categories, and forty-five subcategories.

Table 4.1 Summary of Needs Model-Framework

Categories	Sources
<p>1. Employment and Education</p> <p>1.1. <u>Employment</u></p> <p> Counseling</p> <p> Employment</p> <p> Employment Services</p> <p> Job Training</p> <p> Volunteer Activities</p> <p>1.2 <u>Education</u></p> <p> Educational Programs</p>	<p>Gelfand (1999)</p> <p>Thorson (2000), US FC §42</p> <p>Thorson (2000), US FC §42</p> <p>US FC § 42</p> <p>Thorson (2000)</p> <p>Scharlach & Robinson (2000)</p>
<p>2. Financial Assistance</p> <p> Federal Income Tax Relief</p> <p> Income Assistance</p> <p> Money Management</p> <p> Property Tax Exemption</p>	<p>Anderson (2001)</p> <p>Hudson (2002)</p> <p>Family Elder Care (2003)</p> <p>Anderson (2001)</p>

⁶⁰ Also see Kaplan (1964), Hickman (1990).

Social Security Benefits Tax Benefits	GAO (2001) Anderson (2001)
3. Housing Accessibility Improvement Adult Foster Care Energy Assistance Home Improvement Home Repairs and Rehabilitation Intermediate Care Facilities Nursing Homes Personal Care Homes Intermediate Care Facilities Retirement Communities Weatherization	TDoA (2002) D'Laine Haggan (2002) TDoA (2002) TDoA (2002) HUD (1999) Lustbader & Hooyman (1994), Thorson (2000) Lustbader & Hooyman (1994), Thorson (2000) Thorson (2000) HUD (1999)
4. Legal Durable Power of Attorney Durable Power of Attorney for Health Care Living Will Out of Hospital Do Not Resuscitate Revocable Living Trust Will	Family Caregiver Alliance (2001), Clifford (1996), Cane (1995) ABA (2003)
5. Physical, Medical, and Mental Health 5.1. <u>Physical Health</u> Assistance with Personal Care Assistance with Activities of Daily Living Adaptive Aids and Medical Supplies Alcohol and Drug Treatment Exercise Meals(congregate/home delivered) Oral Health Care Transportation Smoking Treatment 5.2. <u>Medical Health</u> Medical Care Prescription drugs 5.3. <u>Mental Health</u> Mental Health Services	Wilson (2002) Wilson (2002) Wilson (2002) Hobbes and Damon (1996), Quadagno (1999). Hill, Storandt & Malley (1993) Gelfand (1999) TDoA (2002) Wilson (2002) Hobbes and Damon (1996) GAO (1986) Thompson (2002) Thorson (2002), Bettelheim (2001), Stalvey (2002)
6. Protection Elderly Abuse Protection	Duke (1996), THCR §48.002. NCEA (1998), Wolf (1996), Benson (1998), Breaux (2002).
7. Social Engagement Recreational Activities Social Support Volunteerism	TDoA (2002), Gilles, Metcalf, Anderson & Andrews (2001), Bennett (1980), Siegenthaler (1996), Wheeler (1998)

Chapter Five

Research Methodology

Introduction

This chapter explains the research methodology used in this study to collect data that would be incorporated in the handbook. The use of document analysis, field trips, and informal interviews operationalizes the conceptual framework.

Research Design

A case study is selected as the research design for this paper. Babbie (1998) refers to a case study as the focus of attention “on one or a few instances of some social phenomenon, such as village, a family or a juvenile gang” (p.285). This particular study centers in Guadalupe County, Texas. The purpose of the case study is descriptive, since the researcher is identifying and describing the services available in a particular county to meet the needs of the elderly identified in the literature. These services are incorporated into the Needs-Model Framework to develop the handbook. Yin (1994) explains that the scope of a case study involves the investigation of a current phenomenon within “its real-life context.” This applies to this study since this paper describes what services are currently available to the elderly in the fiscal year 2003-2004, based in the scope of a real institutional setting (federal, state, and local agencies and providers in Guadalupe County).

Appropriateness of a Case Study for This Research

To meet the purpose of this research a case study is preferred, because the researcher has little control over events (Yin, 1994, p.1, 6). An in-depth investigation is needed to describe the services available for the elderly in Guadalupe County. A case study also brings details by using multiple sources of data (Tellis, 1997, p. 1).⁶¹ A case study should demonstrate that the researcher spent extended effort in collecting relevant data (Yin, 1994, p. 148). Based in this principle, the appropriate techniques are selected to gather the evidence (document analysis, field trips, and informal interviews). Cases

⁶¹ Also see Feagin, Orum, & Sjober, 1991

studies are known to take too much time. This is why this study covered three academic semesters. A case study is not completed if the research ended because the “investigator ran out of time (when the semester ended),” (Yin, 1994, p. 149).

Some disadvantage of the case study is that the observer can be biased in reporting the findings. This particular research bias does not play a role, since the researcher does not make a subjective judgment in the information gathered. Another concern is that case studies provide little results for scientific generalization. The problem with generalization does not apply to this paper. On the contrary, the lack of generalization is considered an advantage, because the goal is to provide a description of services in Guadalupe County only.

Perhaps the most important observation is that there is not enough testing to screen the researcher’s ability to do case studies (Yin, 1994, pp. 10-11). But, the technique used in collecting data, analysis of documents such as handbooks, state laws and agency rules can eliminate some of this problem (Cordova, 2001, p.35).

Unit of Analysis

The unit of analysis in this research regards the services available to the elderly. Descriptive categories of services are collected from the literature review, sorted and classified. Units of analysis consist of things the researcher examines in order to create a summary description of all such units and to explain differences among them (Babbie, 2001, p.94). Services are sorted and placed into different categories according to needs.

The sources of evidence for this research are document analysis, field trips, and informal interviews.

Operationalization of the Conceptual Framework

Operationalization refers to those activities that precede the collection and analysis of data (Babbie, 1998, p. 139). For example, the collection of documentation from federal, state, and local agencies, field trips, and informal interviews are the operationalization techniques of this research.

Document Analysis

Document analysis is chosen to analyze data and sort out information relevant to this research. Some of the strengths are that documents can be reviewed repeatedly; they are unobtrusive (not created as result of the study), and information on the documentation remains the same. Another advantage is that documentation has a broad coverage of numerous events and settings (Yin, 1994, p.80).

The weakness in this type of source of evidence is that retrieving documentation can be a slow process and access may be blocked deliberately (Yin, 1994, p.80). Retrieving and accessing documentation is not a problem in this study, since it is mandated by law that information about services must be provided at request. The data gathering process slowed down at times not because of the selection of document analysis as a source, but because of shortage in agency staff. However, time consuming is expected in this type of research.

Field Trips

The strength of field trips as a source of evidence is that it focuses in a target population and covers context of the event. The disadvantage is that is time consuming and costly (Yin, 1994, p. 80, 86, 87); however, in combination with document analysis and informal interviews, field trips are appropriate, because they provide a more in depth study of the unit of analysis. Field trips give more predictability when gathering data versus other sources such as surveys. For example, the researcher can prepare an agenda when going to a field trip. On the other hand, when using surveys, the researcher lacks control on the predictability of the response.

Informal Interviews

Informal interviews are also used in this study. Interviews play a significant role in complementing the document analysis, because through informal interviews, the researcher gets information about which services area available to Guadalupe residents. It also provides additional information such as, length and accessibility of services in the near future. The researcher uses the data to determine and sort which services must be incorporated in the handbook. Interviews are essential sources of case study information. Informal interviews also assist in clarifying information (Yin, 1994, p. 84). Table 5.1 Shows the other components of the Needs-Model Framework.

Table 5.1 Operationalization of the Needs Model-Framework

Categories	Agency/Organization	Source
1. Employment and Education 1.1. <u>Employment</u> Counseling Employment Employment Services Job Training	1.0. BluebonnetTrails Community MHMR Texas Commission for The Blind Texas Rehabilitation Commission Texas Workforce Commission Retired Seniors Volunteer Program	Document Analysis Informal interview

<p>Volunteer Activities</p> <p>1.2 <u>Education</u> Educational Programs</p>	<p>1.2 Adult Education Seguin-Guadalupe Public Library Seguin Independent School District Texas Lutheran University</p>	<p>Field Trips</p>
<p>2. Financial Assistance Federal Income Tax Relief Income Assistance Money Management Property Tax Exemption Social Security Benefits Tax Benefits</p>	<p>2. Alamo Area Council of Governments Consumer Credit Counseling Services Greater Randolph Area Service Prog. Guadalupe County Appraisal District Internal Revenue Services Randolph Area Christian Assist. Prog. Salvation Army Seguin Ministerial Alliance Social Security Administration Veterans Service Office</p>	<p>Document Analysis</p> <p>Informal interview</p> <p>Field Trips</p>
<p>3. Housing Accessibility Improvement Adult Foster Care Energy Assistance Home Improvement Home Repairs and Rehabilitation Intermediate Care Facilities Nursing Homes Personal Care Homes Retirement Communities Weatherization</p>	<p>3. Alamo Area Council of Governments Community Council of SC Texas Guadalupe County Habitat for Hum. Home Repairs Ass. Program for Veter. Schertz Housing Authority Seguin Housing Authority TX Dept. of Protect. Regulat. Services US Department of Agriculture (Rural Development Office)</p> <p>Autumn Winds Retirement Lodge Care Inn of Seguin Casa Guadalupe ICF-MR Guadalupe Valley Nursing Center Lee Stevens Country Place Assist. Liv. Martin Luther Homes of Texas Nesbit Nursing Home Our Family Home I & II Seguin Assisted Living Seguin Nursing Home and Rehabil. Texas Department of Human Services</p>	<p>Document Analysis</p> <p>Informal interview</p> <p>Field Trips</p>
<p>4. Legal Durable Power of Attorney Durable Power of Attorney for Health Care Living Will Out of Hospital Do Not Resuscitate Revocable Living Trust Will</p>	<p>4. Alamo Area Council of Government Texas Rural Legal Aid</p>	<p>Document Analysis</p> <p>Informal interview</p> <p>Field Trips</p>
<p>5. Physical, Medical, and Mental Health 5.1. <u>Physical Health</u> Assistance with Personal Care Assistance with Activities of Daily Living Adaptive Aids and Medical Supplies</p> <p>Alcohol and Drug Treatment Exercise</p> <p>Meals(congregate/home delivered)</p> <p>Oral Health Care Transportation Smoking Treatment</p>	<p>1.0 Alamo Area Council of Governments Bluebonnet Trails Community MR Bluebonnet Trails Community MH Alamo Area Council of Governments Texas Department of Human Serv. Texas Commission for the Blind New Vision Program Guadalupe Valley Hospital Silver Center of Seguin Community Council of SC Texas Schertz Sr. Center Hot Meals Christian Cupboard</p> <p>Dental School University of Texas Community Council of SC Texas New Vision Program</p>	<p>Document Analysis</p> <p>Informal interview</p> <p>Field Trips</p>

<p>5.2. <u>Medical Health</u> Medical Care Prescription drugs</p> <p>5.3. <u>Mental Health</u> Mental Retardation Services Mental Health Services Counseling</p>	<p>2.0 Christian Free Clinic Guadalupe Valley Hospital (GVH) GVH- Home Health Care GVH - Hospice GVH - Prescription Assistance Prog. Kidney Disease Clinic of Seguin</p> <p>3.0 Bluebonnet Trails MR Services Bluebonnet Trails MH Services Heritage Program for Seniors NIX Health Care Systems NE Methodist Hospital</p>	
<p>6. Protection Elderly Abuse Protection</p>	<p>6. Alamo Area Council of Governments TX Dept. Protective and Regul. Serv.</p>	<p>Document Analysis</p> <p>Informal interview</p> <p>Field Trips</p>
<p>7. Social Engagement Recreational Activities Social Support Spiritual and Religious Organizations Volunteerism</p>	<p>7. Adult Care Centers of America CCSCT Aging Program Retired Volunteer Program Schertz Senior Citizens Program Silver Center of Seguin</p>	<p>Document Analysis</p> <p>Informal interview</p> <p>Field Trips</p>

The Handbook of Community Services for the Elderly in Guadalupe County is developed based on the above Model Needs-Framework. The Handbook is incorporated in this research as Appendix A.

The following chapter summarizes the services available for elderly based on identified needs and provides the link to the appropriate section of The Handbook.

Chapter Six

Conclusion

Introduction

This chapter presents an overview of services available to elderly residents in Guadalupe county. Raw data was collected through document analysis, field trips, and informal interviews. A table at the end of each category summarizes the needs identified in the literature, the agency that provides services, and the appropriate page of The Handbook. Please refer to the Handbook for details on particular services.

Overview of Data Collection

Data to organize the handbook was collected from January to April 2003. Based in the institutional setting chapter, a list of federal, state, and local agencies was prepared. Phone calls were made to the aging network staff to coordinate field trips and accessibility to document analysis.

Once all services were clearly defined, they were sorted and classified into their corresponding categories to match each need identified in chapter four (Conceptual Framework). The majority of services in The Handbook do not provide detail information about income and resource limits, as these vary between programs and agencies. Thus, the most reliable and update information is made when the elderly or interested person contacts the agency that provides a particular service.

Category 1. Employment and Education

1.1. Employment. Texas Rehabilitation Commission (TRC) and the Texas Commission for the Blind (TCB) offer rehabilitative and vocational services to elderly persons who want to obtain and maintain employment. Services are based in individual

needs. Bluebonnet Trails Community Mental Retardation also provides vocational training through its workshop center located in Seguin; these services, however, are limited to individuals with mental retardation. While TRC allows the person to obtain a gainful employment, TCB only offers job opportunities to qualified Guadalupe elderly residents in San Antonio area.

The Texas Workforce Commission through their Employment Service (ES), Senior Texas Employment Program (STEP), and Food Stamps Employment and Training (FSE&T) assists individuals in finding employment. The ES is available to the general public. The STEP provides part-time employment to poor elderly Texans. The FSE&T helps individuals not eligible for cash assistance to become self supporting through participation in employment and training activities.

The Retired Senior Volunteer Program (RSVP), non-profit organization, offers volunteer placement services for individuals 55 or older. There is limited travel reimbursement for volunteers who drive their own vehicle.

2.2. Education

Adult Education to elderly individuals is provided through the Seguin Independent School District, and Texas Lutheran University (TLU). The Seguin

Independent School District sponsors the Even Start Program. Services include literacy training, GED classes, computer access, and general education training. The TLU through its Center for Professional Development offers continuing education classes open to all interested adults at modest fees. Another non-profit organization is the Adult Education program located in Schertz. Services include, GED preparation, English as a Second Language, Amnesty Classes. Table 6.1 shows the identified needs, the agency that provides services and the corresponding page of The Handbook.

Table 6.1 Category: Employment and Education

Categories	Agency/Organization	Handbook
<p>1. Employment and Education</p> <p>1.1. <u>Employment</u></p> <p>Counseling</p> <p>Employment</p> <p>Employment Services</p> <p>Job Training</p> <p>Volunteer Activities</p> <p>1.2 <u>Education</u></p> <p>Educational Programs</p>	<p>1.0. BluebonnetTrailsCommunity MHMR</p> <p>Texas Commission for The Blind</p> <p>Texas Rehabilitation Commission</p> <p>Texas Workforce Commission</p> <p>Retired Seniors Volunteer Program</p> <p>1.2 Adult Education</p> <p>Seguin-Guadalupe Public Library</p> <p>Seguin Independent School District</p> <p>Texas Lutheran University</p>	<p>p. 1</p> <p>p. 1</p> <p>p. 2</p> <p>p. 2</p> <p>p. 3</p> <p>p. 3</p> <p>p. 4</p> <p>p. 4</p> <p>p.4</p>

Category 2. Financial Assistance

The Alamo Area Council of Government (AACOG) through their Benefits Counseling Program provides information, counseling, and advocacy to senior citizens and Medicare beneficiaries of any age. Benefits counselors consult on topics such as: Medicare, Medicaid, Supplemental Security Income, Senior Fraud, Advance Directives,

Long-Term Care, Non-covered Health Insurance, Veterans issues, Medicare and Medicaid Appeals, and others.

The Consumer Credit Counseling, located in San Antonio, provides services such as, pre-purchase housing counseling, defaulted mortgage counseling, debt consolidations, and consumer education classes at no fee. They also prepare a debt management plan for \$ 6.00 per month.

The Greater Randolph Area Services Program, the Salvation Army, Randolph Area Christian Assistance Program, and Seguin Ministerial Alliance assist financially toward rent payments, utilities, food or clothes, transportation, meals, gas or prescriptions.

Property Tax Exemptions and information is available through the Guadalupe County Appraisal District. The Social Security Administration provides income assistance to poor elderly persons and processes applications for retirement benefits. The Internal Revenue Services (toll-free number) assists and guides with tax preparation. IRS also distributes information about federal income tax relief. Table 6.2 shows the agencies and organizations that provide services in this category with a link to the appropriate page of the Handbook.

Table 6.2 Category: Financial Assistance

Category	Agency/Organization	Handbook
<p>2. Financial Assistance Federal Income Tax Relief Income Assistance Money Management Property Tax Exemption Social Security Benefits Tax Benefits</p>	<p>2. Alamo Area Council of Governments Consumer Credit Counseling Services Greater Randolph Area Service Program Guadalupe County Appraisal District Internal Revenue Services Randolph Area Christian Assist. Program Salvation Army Seguin Ministerial Alliance Social Security Administration Veterans Service Office</p>	<p>p. 5 p. 5 p. 6 p. 6 p. 6 p. 6 p. 6 p. 7 p. 7 p. 7 p. 8</p>

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Category 3. Housing

Services such as, home improvement, home repairs, weatherization, and energy assistance are provided through a variety of agencies. The Alamo Area Council of Governments (AACOG) administers the weatherization program, residential repairs, and assistance with utilities. Other non-profit organizations such as, Guadalupe County Habitat for Humanity, Home Repair Assistance Programs for Veterans, United States Department of Agriculture also implement home improvement programs. The Community Council of South Central Texas (CCSCT) assists with electric bills and provides energy efficient heaters during winter and fans in the summer. CCSCT administers the Comprehensive Energy Assistance Program and Transportation to and from medical appointments. Services under the CCSCT are based in poverty guidelines. The local Schertz and Seguin Housing Authorities administer the Section 8 Housing Voucher and provide subsidized housing to poor elderly persons.

Intermediate Care Facilities (ICF-MR) for persons with mental retardation such as, Casa Guadalupe I and II and Martin Luther Home of Texas are accessible through private paid or the local mental retardation agency. Nursing homes such as Care Inn of Seguin, Guadalupe Valley Nursing Center, Nesbit Nursing Home, and Seguin Nursing and Rehabilitation Center are available to all individuals who meet medical criteria. Admission can be funded through private-paid, Medicare or Medicaid. Other assisted living settings include Autumn Winds Retirement Lodge, Lee Stevens Country Place Assisted Living, and Seguin Assisted Living.

State agencies such as, the Texas Department of Protective and Regulatory services through its Adult Protective Services Program provides financial emergency assistance to access all services mentioned in the precedent paragraph. The Texas Department of Human Services (TDHS) under its Community Based Alternative Program (CBA) provides home modification to qualified clients. TDHS also has contract with local Adult Foster Care, Residential Care Facilities and Assisted Living Facilities. The problem is that the majority of community living settings administered by TDHS are not immediately available to the needy elderly. Please see Table. 6.3 to match the corresponding need under this category with the appropriate Handbook page.

Table 6.3. Category: Housing.

Category	Agency/Organization	Handbook
<p>3. Housing Accessibility Improvement Adult Foster Care Energy Assistance Home Improvement Home Repairs and Rehabilitation Intermediate Care Facilities Nursing Homes Personal Care Homes Retirement Communities Weatherization</p>	<p>1. Alamo Area Council of Governments Community Council of SC Texas Guadalupe County Habitat for Hum. Home Repairs Ass. Program for Veter. Schertz Housing Authority Seguin Housing Authority TX Dept. of Protect. Regulat. Services US Department of Agriculture (Rural Development Office)</p> <p>Autumn Winds Retirement Lodge Care Inn of Seguin Casa Guadalupe ICF-MR Guadalupe Valley Nursing Center Lee Stevens Country Place Assist. Liv. Martin Luther Homes of Texas Nesbit Nursing Home Our Family Home I & II Seguin Assisted Living Seguin Nursing Home and Rehabilitation Texas Department of Human Services</p>	<p>p. 9 p. 9 p. 10 p. 10 p. 10 p. 11 p. 11 p. 11</p> <p>p. 12 p. 12 p. 12 p. 13 p. 13 p. 13 p. 13 p. 14 p. 14 p. 14 p. 15 p. 15</p>

Category 4. Legal

The Alamo Area Council of Government (AACOG) assists in legal matters and determines need for legal advice or legal action. AACOG draft and implement the

execution of Durable Power of Attorney, Durable Power of Attorney for Health Care, Living Wills, Out of Hospital Do Not Resuscitate, Revocable Living Trust, and Wills.

The Texas Rural Legal Aid (TRLA) is a non-profit law firm that specializes in providing legal services to the indigent residents of South and West Texas along the Mexican border. With staff of approximately 45 lawyers located in ten offices, TRLA services more than 10,000 eligible clients each year with a broad range of legal problems. TRLA recruits bilingual attorneys from law schools throughout the country. For more information refer to Table 6.4 (Handbook page).

Table 6.4 Category: Legal

Category	Agency/Organization	Handbook
<p>4. Legal Durable Power of Attorney Durable Power of Attorney for Health Care Living Will Out of Hospital Do Not Resuscitate Revocable Living Trust Will</p>	<p>2. Alamo Area Council of Government Texas Rural Legal Aid</p>	<p>p. 16 p. 16</p>

Category 5. Physical, Medical, and Mental Health

5.1 Physical Health

For the purpose of The Handbook, Physical Health includes services such as, assistance with personal care, adaptive aids and medical supplies, help with activities of daily living, exercise, meals, congregate meals, oral health care, alcohol and drug treatment, and transportation. The agencies and organizations that provide services are: AACOG, Bluebonnet Trails Community Mental Health and Mental Retardation, TDHS, CCSCT, Christian Cupboard, the Dental School University of Texas in San Antonio,

Schertz Senior Citizens Hot Meals Program, Silver Center, Texas Commission for the Blind, and The New Vision Program Treatment Center.

Provider services are available through the AACOG, Bluebonnet Trails MHMR, and TDHS. These agencies also assist with adaptive aids and medical supplies, health screening, oral health, optical services, and prescription drug assistance. The Guadalupe Valley Hospital has an array of programs such as, hospice, counseling, substance abuse treatment, assistance with prescriptions, and home health care services.

The majority of long-term care community services are provided by the TDHS with the following programs: Community Based Alternatives, Primary Home Care, Family Care, Home Delivered Meals, Day Activity and Health Services, Emergency Response Services, Respite Care, In-Home Family Support, and Program for People who are Deaf-Blind with Multiple Disabilities. Bluebonnet Trails Community MHMR also access similar services to their clients.

The CCSCT administers the congregate and Meals on Wheels Program. It also provides transportation in surrounding counties. Seniors who attend the community program have access to hot noon meals, health information, and nutritional education. Staff also monitor recreation and leisure activities and check participant's blood pressure. Other centers that provide lunch meals are the Schertz Senior Citizens Hot Meals Program, and the Silver Center. The Dental School University of Texas in San Antonio provides dental screenings, assessment and treatment at 30 percent reduced rate than market prices. Table 6.5 shows the needs identified in this sub-category, the provider agency and the corresponding page of the handbook where services are explained in detail.

**Table. 6.5.1 Category: Physical , Medical and Mental Health
Sub-Category: Physical Health**

Category	Agency/Organization	Handbook
<p>5. Physical, Medical, and Mental Health</p> <p>5.1. <u>Physical Health</u></p> <p>Assistance with Personal Care Assistance with Activities of Daily Living Adaptive Aids and Medical Supplies</p> <p>Alcohol and Drug Treatment Exercise</p> <p>Meals(congregate/home delivered)</p> <p>Oral Health Care Transportation Smoking Treatment</p>	<p>4.0</p> <p>Alamo Area Council of Governments Bluebonnet Trails Community MR Bluebonnet Trails Community MH Alamo Area Council of Governments Texas Department of Human Serv. Texas Commission for the Blind New Vision Program Guadalupe Valley Hospital Silver Center of Seguin Community Council of SC Texas Schertz Sr. Ctr. Hot Meals Christian Cupboard</p> <p>Dental School University of Texas Community Council of SC Texas New Vision Program</p>	<p>p. 17 p. 17 p. 18 p. 17 p. 20-21 p. 20 p. 22 p. 22-23 p. 19 p. 18 p. 19 p. 18</p> <p>p. 19 p. 19 p. 22</p>

5.2 Medical Health

The Christian Free Clinic located in Seguin opens on Mondays. It allows residents with chronic conditions, such as Diabetes, Hypertension, Asthma or Epilepsy to continue their care under the supervision of a local physician.

Guadalupe Valley Hospital (GVH) provides general acute inpatient care, outpatient services, home health care, hospice and substance abuse treatment. The Prescription Assistance Program assists residents in general to obtain medications for chronic conditions. This program works with the drug manufacturers, and the medication is shipped to the person’s physician. Assistance is based on income and lack of medical insurance. Those individuals who have Medicaid or private insurance are not allowed to participate.

The GVH Hospice Program provides counseling, nursing care, personal care, physical therapy, medications related to terminal illness, medical supplies and equipment, clergy counseling, and related services to those terminally ill persons who want to die in their home.

The GVH Home Health Services include: physical therapy, speech therapy, occupational therapy, home health aide, social services, and home maker and sitter services. Fees associated to these services are charged to Medicaid, Medicare or private insurance.

The Kidney Disease Clinic provides outpatient hemodialysis service and outpatient kidney treatment. Services include facility, home assisted and peritoneal hemodialysis. Medical staff monitor these services. Table 6.5.2 Summarizes this section and refers to the appropriate page on the Handbook.

**Table. 6.5.2 Category: Physical , Medical and Mental Health
Sub-Category: Medical Health**

Category	Agency/ Organization	Handbook
<p>5. Physical, Medical, and Mental Health</p> <p>5.2. <u>Medical Health</u> Medical Care Prescription drugs</p>	<p>1.0 Christian Free Clinic Guadalupe Valley Hospital (GVH) GVH- Home Health Care GVH - Hospice GVH - Prescription Assistance Prog.</p>	<p>p. 22 p. 23 p. 23 p. 23 p. 24</p>

5.3. Mental Health

For the purpose of the Handbook the sub-category Mental Health includes services to individuals with mental illness (mental health) and mental retardation.

Bluebonnet Trails Community MHMR provides services to people with mental health and mental retardation. Both programs run independently and have their own facilities and staff. Services to individuals with mental retardation include: counseling, financial assistance, placement to residential facilities, job training, advocacy and case management. The mental health program provides assistance with psychotropic medications, psychiatric services, case management, and residential placement locator.

Bluebonnet Trails Mental Health in coordination with the Guadalupe County Court files the necessary documentation for commitment to a psychiatric unit when it is needed to protect the safety of an individual or society.

The NIX Health Care System and the North East Methodist Hospital in San Antonio has specialized units to provide mental health services to those individuals with serious mental health condition. Usually, when Bluebonnet MH files documentation for commitment, the person is transported to one of these hospitals.

The Heritage Program is administered by GVH and consists of intensive outpatient treatment that integrates multi-disciplinary team of health care professionals. Services include: group, family or individual therapy, skills training, medication management, health and wellness training, nutritional information, grief and resolution counseling, etc. Please refer to Table 6.5.2 for location of the appropriate section in The Handbook.

**Table. 6.5.3 Category: Physical , Medical and Mental Health
Sub-Category: Mental Health**

Category	Agency/Organization	Handbook
5. Physical, Medical, and Mental Health		

<p>5.3. <u>Mental Health</u> Mental Retardation Services Mental Health Services Counseling</p>	<p>5.3 Bluebonnet Trails MR Services Bluebonnet Trails MH Services Heritage Program for Seniors NIX Health Care Systems NE Methodist Hospital</p>	<p>p. 25 p. 25 p. 25 p. 25 p. 26</p>
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Category 6. Protection

AACOG through its Ombudsman program provides advocacy services to residents of long-term care facilities by identifying, investigating, and resolving complaints or on behalf of residents.

The Texas Department of Protective and Regulatory Services (TDPRS) investigates cases of abuse, neglect or exploitation to elderly or disabled adults. Services include: immediate intervention to alleviate further abuse, ongoing protective services, financial assistance to alleviate harm (food, shelter, furniture, medication, utilities, rent, medical or mental health services, etc). TDPRS also has the legal authority to file legal actions such as, Emergency Order for Protective Services, Court Authorized Entry to include Application for Guardianship as appropriate. Please refer to Table 6.6.

Table. 6.6 Category: Protection

Category	Agency/ Organization	Handbook
<p>6. Protection Elderly Abuse Protection</p>	<p>6. Alamo Area Council of Governments TX Dept. Protective and Regul. Serv.</p>	<p>p. 26 p. 26</p>

Category 7. Social Engagement

The Adult Day Care Centers of America, Aging Program, and the non-profit organizations such as Retired Seniors Volunteer Program, Schertz Senior Citizens

Program, and the Silver Center of Seguin engage elderly in social and leisure activities. In addition, the Adult Day Care Center provides skilled nursing services to those individuals who meet medical need while encourage them to participate in different programs. For more information please refer to Table 6.7 to the appropriate section of the Handbook.

Table 6.7 Category: Social Engagement

Category	Agency/Organization	Handbook
<p>7. Social Engagement Recreational Activities Social Support Spiritual and Religious Organizations Volunteerism</p>	<p>7. Adult Care Centers of America CCSCT Aging Program Retired Volunteer Program Schertz Senior Citizens Program Silver Center of Seguin</p>	<p>p. 27 p. 27 p. 27 p. 28 p. 28</p>

Comments

Accessibility of services is compromised by the lack of continuous funding for public programs. For instance, income assistance through the Salvation Army is limited to one need per calendar year. Similarly, services from the AACOG have a ceiling of \$1,200.00 per individual. CCSCT Energy Assistance Program follows the same pattern.

Although state agencies have guidelines in the implementation of programs to meet specific needs, sometimes this is not the case. It is odd to believe that an elderly person with vision problems can benefit from the Texas Commission from the Blind Vocational Rehabilitation Program when job opportunities are offered in San Antonio area, and transportation is not provided. The distance between San Antonio and Seguin (main city in Guadalupe County) averages 38 miles.

Transportation is the most crucial need in Guadalupe County. Caseworkers reported clients not meeting appointments or having difficulties accessing services. CCSCT Transportation Services are limited to medical procedures in San Antonio and surrounding cities. If a person has an appointment in Hays or Travis County, services are not provided.

Another important observation is that vacant positions are rarely filled due to budget constraints. This translates into workers having high volume of cases and not enough time to provide quality of services. For example, the Community Care for the Aged and Disabled Program, TDHS, has lost two positions, including a Spanish-speaking one. Thus, clients who only speak this language cannot communicate with their caseworkers.

The findings of this study indicate that the given patchwork system, created by the legislative setting explained in Chapter Two, has a tremendous negative impact in the delivery of services. Many agencies provide similar services, and eligibility for the programs varies significantly. Services and agencies are intertwined and no one knows what the other is doing. In the meantime, the elderly is left with limited information about services available to meet their needs.

The positive aspect of this study, in addition to the comprehensive Handbook, is that professionals who serve the elderly in Guadalupe County are willing to work together and eager to coordinate services, as they are committed to their clients and show high degree of compassion. Nevertheless, as explained in the introduction, no one is responsible for organizing meetings to better coordinate programs among agencies.

I believe that this study has met its double-fold purpose, (1) Develop The Need-Model Framework, and (2) provide A Comprehensive Handbook of Community Services for the Elderly in Guadalupe County. The Handbook (Appendix A) narrows the gap that exists between the need and the services. The Handbook is the bridge that facilitates this transition. The classified system into categories is flexible. The Needs-Model Framework can be used to organize community services in other counties, based on the needs of their population.

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