State-wide Assessment of Alabama Women 65+: Organizations, Practices, and Participant Perspectives

Final Report to the Alabama Women's Commission

November 2011

Mitchell Brown, Ph.D.
Associate Professor
Department of Political Science
Auburn University

Kathleen Hale, J.D., Ph.D.
Associate Professor
Department of Political Science
Auburn University

Acknowledgements

This study was made possible by the support of several organizations and individuals. Funding for the project was provided by the Alabama Women's Commission and the Department of Political Science at Auburn University. Political Science Department administrators Phillis Hodge and Denise Smith provided staff support for recordkeeping and mailing. MPA graduate student Kellie Cosby provided support for development of the internet list of organizations, demographic research, data coding and production of state-level maps. Ph.D. student Jessica Gratz provided support for recordkeeping, mailing, coding, development of the statewide list of organizations, and coding and data entry for organization surveys and personal interviews. Our Political Science colleagues Rene' McEldowney, Cathleen Erwin, and Jennifer Johnson shared their knowledge of Alabama's health care system. Jan Widell, now retired from the faculty at Troy University, shared her extensive experience in nursing and nursing education across Alabama and pre-tested our instruments. We also acknowledge the time and attention provided us by countless individuals serving the women of Alabama who took time to respond to the survey as well as all those who opened their doors to us during our site visits and interviews. Most of all, we thank the women of Alabama for sharing their lives and stories with us. We hope that our report gives voice to a small portion of the worlds that you described.

Table of Contents

Table of Tables

Table of Figures

Executive Summary

In the spring of 2010, the Alabama Women's Commission issued a Request for Proposals (RFP) for a study of the status of senior women in our state (those women approximately age 65+). The Commission sought to better understand the issues facing this age population and best practices for serving the needs of these women. In response to this RFP, we proposed a study to identify services available for Alabama women aged 65 and older; identify participant perceptions of these services; and identify best practices for serving the needs of these women. Our corresponding research design included a survey of all potential organizations (non-profits, for-profit and government agencies) serving women 65 and older across the state, and individual interviews with a sample of Alabama women 65 and older to hear about needs through the voice of these women.

This report details our efforts, including: a discussion of needs of the population more generally; useful demographic information about women in this age group in the state of Alabama; a description of available services; a discussion of typical needs women in this group face across Alabama; an analysis of organizational capacity based upon the state-wide survey; a discussion of best practices; and identification of future trends and challenges.

Key Findings: Alabama Organizations

Most organizations are well-established, local area service providers serving a single county or a several-county area.

A significant number of organizations are both very large and very small. Approximately 50% have budgets under $500,000, 5 or fewer staff, and few volunteers, if any. The top 10% of organizations have annual budgets in excess of $10 million and hundreds of staff and volunteers.

Government does not deliver most of the services provided to women aged 65 and older. Half the organizations serving this population are nonprofits and one-quarter are private for-profit companies.

Larger organizations are significantly invested in licensure, accreditation, and certification for staff and programs serving women aged 65 and older.

Overall, Alabama organizations serving women aged 65 and older are involved in a wealth of formal and informal collaborations with government agencies and with the nonprofit community both within and outside Alabama. These collaborations may hold potential for an exchange of ideas that can foster innovation.

Key Findings: Alabama Services and Best Practice Settings

From the perspective of organizations providing services to women aged 65 and older, the most beneficial services are medical care, nutrition, assistance necessary to remain in one's own home, educational programs, and assistance with housing, prescription drug expenses, and transportation.

Best practices for delivering services are found in urban and rural settings.

Best practice facilities typically, but not always, are seen in areas with significant public and/or private philanthropic resources and support.

In the case of areas with minimal resources, best practice facilities exhibit two important characteristics. First, they develop around another existing service area in which resources are relatively more available, and second, they are run by skilled and impassioned directors.

Key Findings: Alabama Women Participating in Programs and Services

Personal needs vary widely based on income, and private retirement benefits are rare outside major cities.

Quality of life is influenced directly through the interaction of health, personal wealth, and family wealth (typically of the spouse). Needs are extensive and rarely met for women with few resources and poor health.

Quality of life is influenced indirectly by race, education, and previous employment status.

Private retirement benefits beyond Social Security are relatively rare among women interviewed in locations other than major metropolitan areas.

Key Findings: Future Challenges

Lack of resources will be the greatest future challenge as this population grows, both in terms of funding support, paid staff, and volunteers. Affordable home services are a particular concern.

Broad systemic concerns also exist regarding future national and/or state policy changes and available resources around income security and health care.

Part 1: Purpose

In the spring of 2010, the Alabama Women's Commission issued a Request for Proposals (RFP) for a study of the status of senior women in our state (those women approximately age 65+). The Commission sought to better understand the issues facing this age population and best practices for serving the needs of these women. In response to this RFP, we proposed a study to identify services available for Alabama women aged 65 and older; identify participant perceptions of these services; and identify best practices for serving the needs of these women. Our corresponding research design included a survey of all potential organizations (non-profits, for-profit and government agencies) serving women 65 and older across the state, and individual interviews with a sample of Alabama women 65 and older to hear about needs through the voice of these women. This report details our efforts, including: a discussion of needs of the population more generally; useful demographic information about Alabama women in this age group; a description of available services; a discussion of typical needs women in this group face across Alabama; an analysis of organizational capacity based upon the state-wide survey; a discussion of best practices; and identification of futures trends and challenges.

The physical, financial, social, and emotional well-being of women aged 65 and older pose growing challenges to policymakers across America as Baby Boomers continue to age. Women 65 years of age and older are more likely to be widowed, more likely to live alone, and more likely to face income insecurity, poverty, and potential homelessness than males of the same age (He et al. 2005). Women in this age group are also at risk of depression (Federal Interagency Forum on Aging Related Statistics 2006) and abuse (Albright et al. 2004; Anthony et al. 2009). These problems will only expand over the coming decades. The American population over age 65 will double from 2000 to reach 72 million in 2030 and increase from

approximately 12% to at least 20% of the total; the vast majority of the oldest old (age 85 and older) are expected to be female (He et al. 2005).

Alabama has a significant stake in meeting these emerging needs. Census data indicate that Alabama's proportion of adults aged 65 and older (13.8% in 2009) exceeds the national average (12.4%). Today more than 380,000 Alabama women are aged 65 or older and represent approximately 60% of that age group. By 2025, the total Alabama population aged 65 and older is expected to exceed 1 million and will include more than 600,000 women (He et al. 2005; U.S. Census Bureau. 2009).

To meet the needs of this growing population, policymakers will be challenged to increase availability, accessibility, and adequacy of services. In the contemporary environment of American public administration, these services will be delivered via a combination of providers including public agencies at different levels of government alongside nonprofit organizations and for-profit service providers. The dominant organizational arrangement for providing public social services and other public programs is an intergovernmental network that crosses boundaries between public, nonprofit, and for-profit sectors (Agranoff 2007; Agranoff and McGuire 2003; Brown 2008; Hale 2011). A growing concern is that communities lack capacity to meet the needs that will occur as this demographic inevitably increases, both in terms of sufficient organizations and sufficient inter-organizational frameworks to bring services together in meaningful ways (Ivery, Akstein-Kahan and Murphy 2010; Mulroy 2003). The interaction of these organizations together with human initiative and leadership form an essential foundation for building community capacity that reaches across disciplines and professions and that integrates the work of nonprofit and private organizations with the role of government (Chaskin et al. 2001; Tiamiyu and Bailey 2001). However, the ability to measure the capacity of a network

to provide services, or the effectiveness of that network in doing so, presents numerous challenges. A common coordinating mechanism which may improve provider network effectiveness is the presence of an organization that functions as a central clearinghouse for funding and fiscal matters across network constituents (Provan and Milward 2001); this is a common approach taken by government agencies at all levels of government across many policy domains. However, special concerns face groups that partner with, or share information with, government agencies. Faith-based and community organizations often face special challenges in sustaining capacity building efforts prompted by government financial support (Brown 2008). Information generated by nonprofit organizations and the information relationships between these groups and public agencies play a vital role in generating policy innovation and institutionalizing tools that can be used to build new capacity that is sustainable beyond preliminary funding initiatives (Hale 2011).

Within this framework of networked relationships directed at meeting public needs, the purpose of our research project is to gain a better understanding of the status of Alabama women aged 65 and older. A critical first step in meeting the needs of this growing population is to capture a snapshot of current organizational services and data from participants about their perceptions of these services. We have undertaken this snapshot in the form of a pilot study of Alabama, funded by the Alabama Women's Commission in response to their request for proposals to look at the needs of Alabama women aged 65 and older. In furtherance of the focus of the funder, our specific research objectives are: (1) to identify services available for Alabama women aged 65 and older; (2) to identify participant perceptions of these services; and (3) to identify best practices for serving the needs of these women. Our examination focuses on Alabama county level data, as county government is a common method of organizing

government services for this population. In addition, we also examine these counties in terms of Congressional districts to look at possible funding and infrastructure effects of representation.

Literature and Background on Needs of Women Aged 65 and Older

The literature suggests a wide range of needs for women in this age group. We examine services across a range of categories supported by the literature on needs of women in this age group. In Alabama, the needs of this growing population range broadly across the activities that constitute daily life and include food, clothing, shelter, transportation, and the resources to maintain a safe and healthy environment. Some of these needs have been recognized through federal or state policy initiatives that address some portion of this population under various conditions and circumstances. A list of the services provided by or through the Alabama government for women in this age group is located in Appendix A; some programs are funded primarily by the federal government and some are funded primarily by state sources. It is important to note that age 65 is not an eligibility point for these services although some services are means-tested; many services are provided to women and men aged 60 and older.

Food and nutrition assistance for qualifying citizens aged 60 and older are recognized dimensions of the Older Americans Food and Nutrition Programs. However, access to appropriate nutrition can be confounded by lack of access to transportation. Nationally, three fourths of those over age 65 live in suburban or rural areas where transit options are limited or costly. This is especially significant in Alabama where 55 of its 67 counties are classified as "rural" according to U. S. Census data. Across the United States, more than 1.6 million rural households do not have cars and the highest proportion of carless households is in the South. Twenty-seven rural Alabama counties receive grant funding to institute public transportation

programs; operating details vary and include fees for service ranging from $1.00 to $9.00 per trip (Foote, Guiliano and Harris 2000; O'Shaughnessey 2002; Sharkey 2003).

Women aged 65 and older may also experience a need for assistance with the instrumental activities of daily living (IDAL) such as housework, using the phone, preparing meals, managing transportation, and shopping. Because of higher rates of isolation, elderly women are more likely to have deteriorating IDALs progress without notice by anyone (Foundation for Health and Aging 2005; Ward, Jagger and Harper 1998). Services for these needs may be combined with housing options through congregate communities (independent living in private apartments and the opportunity to share daily living activities with other residents), assisted living (help with non-medical aspects of daily activities), and skilled nursing facilities (nursing homes with nursing staff). Housing for this population also includes private homes and rental units that exist independently of any IDAL services or other supportive services. Public housing residents may be more isolated, poorer, and frailer than those living in other settings (Golant 2006; Lisbon 2006; Smith, Rayer and Smith 2008).

Studies show that socially isolated elderly people who increase their social interaction through clubs, support groups, and senior centers experience better mental health, and experience increased actual and perceived physical health (Aday, Kehoe and Farney 2006; Carstensen and Fremouw 1988; Sorkin and Rook 2002). Volunteering also can be an empowering activity for older adults, although the rate of volunteering appears to decline after age 44 and may be related to a need to delay retirement (Butrica, Johnson and Zedlewski 2007; Volunteering in Alabama 2009).

The elderly population faces unique legal circumstances associated with end of life that have been addressed by a range of tools for estate management and physical care including

advanced health care directives, living wills, and health care powers of attorney; however, studies suggest that these instruments cannot fully protect all elderly women from victimization or exploitation (Kayser-Jones n.d.; American Bar Association 2009). Victimization may include physical danger. The typical victim of elder abuse in Alabama is female, 75 years of age or older, and has one or more disabilities (Alabama Department of Human Resources 2010). Accusations of abuse and/or neglect of the elderly most commonly fall upon employees of senior living facilities, followed by residents of those facilities (Administration on Aging 2010; All 1998).

The population studied in this project also encounters more out-of-pocket health care expenses than any other demographic. Longer life expectancy creates the need for increased resources to cover health care expenses. Nationally, woman comprise 57% of the Medicare population and spend a greater share of their income on prescription drugs and other health care expenses than men (Duggleby, Addullah and Bateman 2004; Jacobs-Lawson, Schumacher and Webb 2007; Kaiser Family Foundation 2001). Health issues related to sedentary lifestyle are also a part of this mix. According to the Alabama Department of Public Health, heart disease is the leading cause of death for Alabama women. The major risk factors include physical inactivity, high blood pressure, and obesity. Active lifestyle is a fundamental prevention strategy; evidence indicates that older adults can maintain vigorous and high functioning physical activity at advanced ages (Alabama Department of Public Health 2011; Cardenas, Henderson, and Wilson 2009; Yaffe 2001). Literacy about health care itself is also a dimension of the issues facing women aged 65 and older. Health care literacy encompasses the ability to obtain, process, and understand basic health information including the information needed to make basic health decisions; it includes the language of medical care, prescription drugs, and insurance programs. Generally, studies indicate that these abilities improve with educational programs and decline

with aging or with ailments that impair cognition; low health care literacy is associated with poorer health and higher rates of hospitalization and may be complicated by chronic disease and increased responsibility for adherence to medical regimens (Baker 2006; Barker et al. 2007; Cho et al. 2008; Iosifesco et al. 2008).

Information needs are not limited to health care information. Financial literacy, or the ability to make informed decisions and judgments about the use of money and other resources, can provide a sense of control and psychological well-being related to an increased quality of life (Glass and Kilpatrick 1998; Into 2003; U. S. Department of Labor n.d.). Increasingly, access to information of any kind can be enhanced by the ability to use computers and related electronic technology. Although increases continue in the number of households that own a computer and that have home Internet access, demographic differences are related to a digital divide (Mossberger, Tolbert and Stanley 2003) that persists in spite of the obvious growth of electronic access through hand-held computers and smart phones (Hale and McNeal 2011; McNeal, Hale and Dotterweich 2008); the elderly as a whole, African-Americans, and rural households continue to lack viable access to computers and Internet service. Among the elderly, barriers include affordability or hardware, software or access as well as lack of confidence in learning new technology and lack of understanding of the benefits that connectivity might provide (Gatto and Tak 2008: Laguna 2008; Rosenthal 2008; Saunders 2004).

Part 2: Design and Approach

To address our research questions, we undertook a two-part research strategy to capture non-profit organizations, for-profit organizations, and government agencies serving women 65 and older across the state, and the perceptions of women about the services that they receive, as well as their other needs, if any.

First, the population of potential organizations was developed in two ways: 1) through an internet search (a total of 438 organizations across the state were identified), and 2) through a list of organizations on file with Area Agencies on Aging as providing services to seniors and disabled adults (a total of 3,019 organizations across the state were identified).

Second, we developed a survey of organizations that includes questions about the issues facing this population, services provided to the population, and to the extent the organizations know, outcomes of these services and how organization leaders knew this (what methods did they use). The survey was fielded as a Web-based survey using Qualtrics online survey software and a link was sent to all potential organization heads from the first list for those organizations that had an e-mail address listed on the Internet with two follow-up reminders spaced two weeks apart. The organizations that did not respond to this survey after three attempts were contacted by telephone and asked to participate in the study. Our response rate for this portion of the survey was 7%. We then sent a paper-based survey by mail to all of the organizations, and our response rate was 6%. The analysis presented in this report includes descriptive and bivariate relationships.[1]

[1] A critical gap in our study may exist around churches and faith-based groups. While both lists capture these types of organizations to an extent, we believe that these groups are nonetheless underrepresented in this research. From personal experience, we know that there are many churches and faith-based groups that do this work. In addition, we made a real attempt to reach out to these organizations. To develop the first list, we sent e-mail requests to all church and faith-based groups listed in a statewide directory of Episcopal AME churches (275 total). However, we received replies from fewer than 10 churches and all that indicated that they provide services for our population were

Third, we interviewed Alabama women 65 and older to hear about needs through the voice of these women. Participant experience provides an essential ingredient for connecting theory about services to actual practice within communities (Dabelko-Schoeny and King 2010; Tiamiyu and Bailey 2001).The interviews were designed to be stratified by age (3 groups—age 65-74, 75-84, and 85+), Social Security beneficiary status (2 categories—individual or dependent recipient), race (white, black)[2], region of state and urban/suburban/rural (3 groups). We deliberately sought women receiving some type of service through an organization on one of our lists. As such, we did not collect data from women not participating in these organizations, nor did we interview women whose needs were so great that they could not provide their own consent to be interviewed. As such, we missed the very frail, the very wealthy, those with sufficient resources that they did not need free services such as those provided by Day Centers and similar programs, and likely some portion of the poorest poor facing complete isolation or who were homeless.

We completed a total of 58 interviews from 15 centers across the state located in or near Auburn; Alexander City, Bay Minette, Birmingham, Demopolis, Hunstville, Madison, Mobile, Montgomery, Prattville, Smiths Station; Sylacauga, and Tallassee. In addition to the completed interviews, we initiated 10 interviews that terminated with participant refusals that came at various points during the consent process. Appointments scheduled at 5 centers (which would have resulted in 15-25 additional interviews) were cancelled because of the tornado damage in northern Alabama (4 centers) and a family emergency (1 center).

---

included on our list. This may be an important area for future research on the topic of service availability for this population and the topic of integration of faith-based support with government and nonprofit service networks.

[2] We had intended to also include a representative group of American Indian and Hispanic women. However, to date no women at the centers in which the interviews have been conducted have self-identified with these categories.

Interviews asked about what the women's everyday lives are like, needs, the extent to which programs exist that would meet those needs, whether they are they utilizing these programs (why or why not), how useful they find the programs that they access, and what else would they like. The interview instrument starts with a follow-back calendar, a method typically used to track alcohol or drug consumption, though sometimes can also applied to other cases, for example anxiety disorders and eating disorders (Sobell and Sobell 1992. This data collection effort is designed to be comprehensive, and not a medical study. As such, beyond determining whether or not women could legally provide their own consent to participate, we did not screen for particular illnesses, including depression. Qualitative pattern matching was used for analysis, as well as descriptive and bivariate statistics.

Part 3: Overview of Need and Service Availability

Before beginning data collection, we identified needs in the state and service availability. This section provides a county-level overview of demographic data for the State of Alabama. We then discuss service availability to meet this need in two parts, those organizations identified through an internet search and those organizations identified on file with Area Agencies on Aging. This division is important as one's sense of resources will be determined in part by the path they take in obtaining information (an internet search versus going to a state official).

Demographics

This section begins with a county-level demographic scan of Alabama's sixty-seven counties. Figure 1 illustrates the proportion of women aged 65 and older as a percentage of county population as a gradient across four ordered ranges (0-10%, 10.1%-14%, 14.1%, and 17.1%-21%). The darker the shading, the higher the proportion of women aged 65 and older in the county. At 8.0% statewide, the proportion of Alabama women aged 65 and older is slightly higher than the national average of 7.3%. Compared to the nation as a whole, Alabama women aged 65 and older are slightly more concentrated at the lower age range of this group (65-74) and a slightly less so at the oldest end of the age spectrum (85+). In Alabama, 52.9% of the women aged 65 and older are between the ages of 65 and 74, compared to 50.7% nationally; 13.9% of Alabama women aged 65 and older are 85 years or older, compared to 16.2% nationally. Figure 2 illustrates the dispersion of women aged 65 and older by county where counties are classified by Census designation as rural counties (shaded) or urban counties (unshaded).

[Figure 1 about here]

[Figure 2 about here]

Together, these maps suggest that the highest numbers of women aged 65 and older in are in Alabama's rural counties.

Figure 3 illustrates the distribution of Alabama women aged 65 and older by race across the sixty-seven counties. Each dot represents 500 women in this age group. Lighter dots (green) indicate White women. Darker dots (blue and red) indicate non-White minorities. Blue dots indicate African-Americans and red dots indicate other minorities. African-American women in this age group are concentrated in three of the states four most populous urban counties: Jefferson (Birmingham); Montgomery, and Mobile. Jefferson County, located in the northern middle of the state, is the most populous county in the state with more than 650,000 residents. Mobile County, on the Gulf Coast, has more than 400,000 residents as the state's second most populous county. Montgomery County (home of the state capital city of the same name) is in the eastern middle of the state and is the fourth most populous, with nearly 225,000 residents. Of these three counties, only Montgomery falls nominally within the Black Belt region, where African-American residents make up more than 50% of the population; the proportion of African-American residents in most Black Belt counties ranges from 67-82% or more. In comparison, Census 2009 Population Estimates expect approximately 8.3% of the population aged 65 and older are African American. White women aged 65 and older are concentrated in two northern counties: Jackson (Scottsboro) and Marshall (Guntersville). These counties are two of the northernmost counties in the state; Jackson County borders Tennessee and Georgia, and Marshall County is immediately adjacent to the southwest. In both Jackson and Marshall counties, the African-American population is less than 2% of the total. Minority, non-African-American women are few; only three red dots exist on the map to indicate non-African-American, minority women in Jefferson, Madison, and Mobile counties.

[Figure 3 about here]

Educational attainment of women aged 65 and older is illustrated in figure 4 across seven ordered categories (less than 9th grade, 9th-12th grade without diploma, high school graduate including equivalency, some college no degree, associate degree, bachelors degree, and graduate or professional degree) Each dot represents 500 women in this age group. Education above high school is concentrated in the four most populous counties, which also include universities and colleges. Other counties with women in this age group educated beyond high school are also locations with universities (University of Alabama in Tuscaloosa County and Auburn University in Lee County), military installations (Anniston Army Depot in Calhoun County), or multinational employers (Goodyear Tire& Rubber Company in Etowah County). Educational attainment below high school for women in this age group is quite common across the state as indicated by the number of women who have not completed education beyond the 9th grade. Alabama as a whole falls behind the national average in attainment of a high school degree or higher (including equivalency) at 80.8% compared to the national average of 84.6%. In Alabama, 21.5% of the population aged 25 and older has earned a bachelor's degree or higher compared to the national average of 27.5%. Statewide, the proportion of Alabamians attaining some college but no degree (20.7%) is on par with the national average (20.3%).

[Figure 4 about here]

The income distribution for women aged 65 and older is depicted in figures 5 and 6. Figure 5 depicts median income by county for women living with at least one other person. Figure 6 depicts median income by county for women living alone. In each figure, the range of median income is shown as a gradient across four ordered ranges; the darker the shading, the

higher the range of median income. Break points between ranges were determined by the natural breaks in the data for each group of women.

[Figure 5 about here]

[Figure 6 about here]

The highest income counties are Shelby and Saint Clair, in which women in this age group are predominantly white. Shelby County is an urban county and St. Clair is a rural county. Both are adjacent to Jefferson County (Birmingham), in which women in this age group are predominantly African-American. For women living with at least one other person, the four ordered income categories are: $0-11,625, $11,625.01-$26,250, $26,250.01-50,625, and $50,625.01-88,391. The economic picture is vastly different for those who live alone. Median income data for women living alone ranges from $7,131 to $16, 614. For women living alone, the four ordered income categories are: $7,131-9,125, $9,125.01-$11,004, $11,004.01-13,225, $13,225.01-16,614.

The highest median income levels are found in the four largest urban counties that are home to three of Alabama's four largest cities (Jefferson County/Birmingham, Madison County/Huntsville, and Montgomery County/Montgomery. The fourth county, Baldwin, is adjacent to Mobile County and the City of Mobile. Whether living alone or with another, the lowest income women aged 65 and older live in rural Alabama. Nearly all the counties with the lowest median income for women living alone are classified as rural counties and all the counties with the lowest median income for women living with another are classified as rural counties. In 2009, Alabama had a higher proportion (11.3%) of the population aged 65 and older living below the poverty line than the national average (8.9%).

Service Availability

Two organization lists were developed for this study, one based on an internet search, and the list of organizations on file with Area Agencies on Aging. In the sections that follow, we describe what services are available by county and congressional district across the state, dividing the information by the source used to develop the lists.

Internet Search

A total of 438 organizations across the state of Alabama were identified as providing services for women age 65 and older. These organizations fell into 31 different categories for types of service provision, including one "general service" category. Of the five most common types of organizations, those that provided volunteer services were the most common, accounting for 12.6% of the total. Following these were advocacy organizations and assisted living facilities, at 10.3% each. The fourth most common are nutrition and meals programs (7.8%), and then general or comprehensive programs (6.4%).

Services are most numerous in Jefferson County, the largest Alabama County, and in Montgomery County, home of the state capital. The range of services available across the various service categories is also the greatest in these counties. Organizational density varies across the counties and congressional districts. While there are organizations in all congressional districts, there are organizations in only 57 of the 67 counties. Congressional District 1, home of Mobile and Alabama's coastal area and represented by Jo Bonner (R), accounts for almost a quarter of all of the organizations. The congressional district with the least organizations is District 5, located in northern Alabama, home to Huntsville, and represented by Mo Brooks (R).

In examining counties and types of available services, there are some notable relationships (overall χ^2=3,100, p<.000). Escambia County is home to the most food/nutrition

services (7 organizations); Mobile County has the most home health services (12 organizations); Birmingham County has the most adult daycare services (6 organizations); Autauga County has the most case management/referral services; Montgomery County has the most assisted living programs (6 organizations). Note that the modal number of services available in each category by county is 0, with 10 counties home to none at all.

Related, there is a relationship by density of types of service organizations and congressional district (χ^2=537.22, p<.000). District 1, home to a plurality of organizations, has the most in each service category. One the other extreme, District 5, home of the least organizations, has the most general/comprehensive service organizations (13 total). District 3 (east Alabama) has the most volunteer organizations (20), while Districts 4 and 7 (contiguous districts in west Alabama on the Mississippi border) have competing numbers of advocacy organizations (13 and 12 respectively).

In developing our population list, we also took note of easily accessible and publicly available websites and e-mail addresses. Of the 438 organizations, only 87, or 19.9%, had readily available e-mail addresses. Slightly more, 23.7% (104) had easily accessible websites. While most organizations that have websites also have e-mail (and vice versa), this is not always the case (χ^2=50.88, p<.000).

There is also a statistically significant relationship between e-mail access and service type—meaning that some types of service organizations are likely to not have access while others are likely to have access (χ^2=62.4, p<.000). Those types least likely include assisted living facilities (40 without, 7 with), advocacy organizations (40 without, 5 with), meal and nutrition programs (31 without, 3 with) and adult daycare and comprehensive service organizations (25 without, 1 with and 25 without, 3 with respectively). Conversely, those type of service

organizations with more e-mail access than without by category include only leisure and recreation and support groups. Similar relationships exist for websistes for the without to with organizations, but there are some differences for those that are more likely than not to have websites. These include prescription drug providers, homemaker services, mental health service, abuse and neglect programs, and SSI/income security organizations. (Overall χ^2=87.77, p<.000.)

Easily accessible and publicly available internet technology is significantly related to congressional district (χ^2=194.53, p<.000 for e-mail and χ^2=112.78, p<.000 for websites). District 3 is the most likely to have e-mail access, while District 1 is most likely to have websites.

[Table 1 about here]

State List

A total of 3,019 organizations across the state of Alabama were identified as providing services for women age 65 and older and for the adult disable population. These organizations fall into 33 different categories for types of service provision, including one "general service" category (see Table 2). The most common types of services available include geriatric assessment, followed by medical care, educational programs, leisure and recreation, wellness programs, and sitter/ companion services. Several categories of services were not identified by any of the organizations. These include providing clothing, emergency financial assistance, financial counseling, friendly visit, grocery shopping/delivery, home repairs, income security, and lawn care. This suggests that as a comprehensive list of organizations that provide services to the population, the state list is also incomplete, as the data we collected (see Parts 4 & 5) point to the fact that women in the state do in fact get these services from somewhere.

The organizations that provide services to this population vary by type, but the most common type is nonprofit groups, comprising 42.1% of the organizations in the list. This is followed by for-profit groups which comprise 34.8% of the organizations, and lastly by government agencies, which comprise 23.1% of the organizations.

Services are available in every county, though availability varies across counties, with a mean of 37 organizations. Services are most numerous in Jefferson County (comprising 10.6% of all service organizations), Madison County (with 6.2% of organizations), and Mobile county (with 5.9% of the organizations). Services are least numerous in Coosa County (comprising 0.28% of the organizations), followed closely by Perry and Sumter Counties (with 0.3% of organizations and 0.4% of organizations respectively).

Organizational density also varies across the congressional districts, with the greatest number of organizations available in District 2 (represented by Jo Bonner and home to Mobile), and the least available in District 6 (represented by Spencer Bachus). An interesting disparity between the two lists is seen at the Congressional district level. While the most services in both lists are concentrated in District 2, the state list shows the least in District 6 while the internet search indicated the least in District 5. In the state list, District 5 boasts 466 organizations, a significantly higher portion of the total organizations than in the internet list.

In examining counties and types of available services, there are some notable relationships (see Table 3). There are statistically significant relationships between county and 5 service types, including employment (χ^2=128.8, p<.000), home delivered meals (χ^2=106.9, p<.001), information referral (χ^2=106.9, p<.001), medical care (χ^2=82.6, p<.08), and volunteer services (χ^2=106.9, p<.001). In almost all of these cases, this is driven by disproportionate

numbers of organizations in each of these service areas in Jefferson, Madison and Mobile counties.

Finally, there is a statistically significant relationship between type of organization and service type. Non-profit organizations are much more likely to provide advocacy assistance than other types of groups (χ^2=545.4, p<.000), educational programs (χ^2=261.1, p<.000), food stamp assistance (χ^2=17.9, p<.000), health insurance counseling (χ^2=17.9, p<.000), home delivered meals (χ^2=545.4, p<.000), information referral (χ^2=545.4, p<.000), legal services (χ^2=19.6, p<.000), prescription expense assistance (χ^2=17.9, p<.000), volunteer services (χ^2=545.4, p<.000), and mental health services (χ^2=135.4, p<.000). For profit groups are more likely to provide case management (χ^2=969.5, p<.000), comprehensive services (χ^2=959.5, p<.000), elder abuse and neglect (χ^2=607.4, p<.000), geriatric assessment (χ^2=737.2, p<.000), homemaker services (χ^2=969.5, p<.000), housing options services (χ^2=579.1, p<.000), medical care (χ^2=605.9, p<.000), sitter companion services (χ^2=989.3, p<.000), and wellness programs (χ^2=276.0, p<.000).

[Table 2 about here]

[Table 3 about here]

Part 4: Lives and Needs

While the women with whom we spoke cannot be said to be representative of all women 65 and over in Alabama, they do represent an important sub-group of women, and useful themes have emerged from the conversations we have held to date. As such, the material that follows is written in terms of generalizations based upon the completed interviews, but should not be used for making generalizations beyond this group.

The year born of the women we spoke with ranges from 1915 to 1946, with a mean year of 1934 (st. dev.=6.9). Slightly over half of the women are white, and the others African American (we have neither spoken to nor seen any Hispanic/Latinas, Asian, or American Indian women at the centers we have visited to date).

Of the 58 women, 3 were never married, 10 are currently married, 38 are widowed, and 4 are divorced. The range of live births among the women is none to 8, with a median of 2 children. The median number of grandchildren is 4 (range is 0-21), and the median number of great grandchildren is 1 (range is 0-35). The most typical response from the women is that they see at least one of their children or grandchildren weekly, though this ranges from daily to not at all.

Most of the women (41) with whom we spoke currently reside in a private residence, and most of these alone. All of the women who live with someone else live with a family member. Of the women in private homes, an overwhelming majority own their homes, though a few own them with a younger family member.

Of those that answered the question, the typical woman has a high school diploma, though educational attainment ranged from completion of the 5th grade at the lowest to graduate work. There was a range of occupations the women held in their younger years, from

homemaker to nurse (this information was not a part of the semi-structured protocol, but came up in the interviews nonetheless).

Income levels for these women (only 64% of respondents were willing to divulge this information) was low, ranging from $1,800 to $60,000 per year (mean=$17,055, st. dev.=$13,100, median=$12,967). All of the women who responded receive income from social security, and for most this was their only source of income. Other sources noted include personal retirement, husband's retirement, interest income, rental income, and current employment. None of the women reported receiving money from family and friends.

Finally, we ran a basic analysis of the data by age cohorts (decade groupings). Thirty-eight percent of women interviewed were between the ages of 65-74, 50% between 75-84, and 12% 85 or above. While there were no statistically significant relationships between income levels, sources of income, race, marital status, housing type or general (not familial) social contact, there were two significant demographic relationships. First, as age increases, so does the average number of grandchildren a woman has (pairwise correlation=.243, $p<.10$ using a two-tailed test), though not to the number of children a woman has. Second, there was a statistically significant and inverse relationship to how often the women see their family members (pairwise correlation= -.322, $p<.05$ using a two-tailed test). That is, as decade increases, women are less likely to see their family members.

Life in a "typical" week

The follow-back calendar we used was designed to record information about what a typical week is like, from the mundane to the unusual. We collected data on sleeping patterns, eating patterns, social isolation, and activities. It is not a perfect instrument, and the results are only as good as the memories of the respondents and prodding of the researchers. As such, the following findings should be through of as illustrative of the lives of these women, but not exhaustive nor precise recordings of their days.

Meals

The women reported eating one to three meals per day, and for most this was three meals a day. When asked, 36% noted that they needed assistance with meals (this included money for purchasing food and someone to prepare it for them). One stated that she purchases food with her credit card because she doesn't have enough cash to pay for it (she did not say whether and to what level she pays off this card each month). Another woman noted that she "needs help lifting pots and pans. [And] going to the store every day is tiring on the body." When we followed up with questions about whether or not they receive any help with meals, a third of the women said they got no help whatsoever; the irony of this is that all of the interviews took place in centers in which the women were served lunch shortly after the interviews ended. Of those that said they received help, this help came from a variety of sources, including family, friends, non-profit organizations, government, and churches.

Sleep Patterns

Sleep patterns ranged for the women. Some work as early as 2:30 am each morning, while others woke as late as 8:00 am. The modal time is 5:00 am, and the median 6:00 am.

Similarly, the times the women went to bed (note that for many this meant laying down, not going to sleep) ranged from mid-afternoon to 11:00 pm. The typical time (modal and median) is 8:30 pm. A few mentioned experiencing problems sleeping and frequent urination through the night. Few of the women mentioned napping.

Medical Visits & Prescription Medication

In the Follow-back Calendar portion of the interview, one third of the women mentioned taking medication, and when they did this was only with prompting from the interviewer, while a quarter of the women mentioned having been to see a doctor at some point in the week preceding the interview. However, many more of the women (one third) noted needing helping affording co-pays for medication. Two women noted that they do not take their prescription medication because they cannot afford it, and several others noted that it would help if these bills weren't so high so they could use that money for other items. A few mentioned needing other types of help with their healthcare—in one case this was paying for the co-pay to see the doctor, but the other needs mentioned were either transportation to their appointments or help understanding changes in the government sponsored health plan. Half of the women noted that they receive help with healthcare. This ranged from information sessions sponsored by local Council of Governments (COGs) to financial donations received for medical payments to other government sponsored health programs.

Housework

Sixty-nine percent of the women noted that they performed some type of housework in the week prior to the interviews, and 12% some type of yard work. Twenty-six percent of the women stated that they needed help with housework, and this ranged from needing help with

laundry, to repairs, to needing a housekeeper. Almost half of the women noted that they need help with repairs to their homes, and a third need help with yard work. These needs ranged from raking and mowing to replacing roofs, windows, and doors to patching holes in floors. When asked, almost a third of women stated that they receive help with housework, and this was typically from family members. Over half noted that they currently receive help with yard work, and again this was typically from family members, though a few paid other people for this and in one case the Home Healthcare provider helped with this. Even more noted receiving help with repairs to their home, and this help came from family, fee-for-service, and community groups. The most common community group noted was Community Action, though in most cases the women felt that they needed more help than they received, or in some cases asked for specific types of help but were given other help instead.

Only two women noted needing help with actual housing. In one case, she was a resident of public housing and felt that her unit was in disrepair and that her requests for improvements were going unheeded. In the other, her home had burned seven years prior and had been living in a mobile home since.

Transportation

Almost half of the women interviewed mentioned needing help with transportation of some sort. More than half of the women noted receiving help with transportation, often from family members. Many others use municipal transportation, though a few noted having difficulty paying for it (the availability of municipal transportation varied across the communities we visited, as did fees for use). In a few cases, women owned cars but could no longer drive or could not afford insurance or repairs for their vehicles.

Regular Activities Outside the Home

Over half of the women with whom we spoke noted running errands of some type in the week before the interview, typically grocery shopping and going to the drug store.

While only two of the women had regular jobs, more did odd jobs for pay (like hemming). Almost one third of the women noted doing volunteer work of some sort at least once a week. This work ranged from visiting with people in nursing homes, to delivering meals, to phone counseling, to volunteering at church. Just as many women mentioned helping other people outside of a formal volunteering structure.

Only two-thirds of the women noted going to some type of day center in the previous week, though all of the women were interviewed at a day center or retirement community. One third of the women mentioned exercising, and frequently (though not always) this was through exercise classes at the day centers or at rehabilitation facilities.

Over two thirds of the women whom we interviewed attended a church service, and a third attended additional church groups. A few of the women noted teaching Sunday school, and several also noted going to church for other social activities or for choir practice.

Entertainment

Only a few of the women we talked with noted going out for entertainment in the week prior to our interviews (in this analysis, entertainment is distinct from all of the other activities in the follow-back calendar like going to church, visiting family, etc.). Instead, their "entertainment" largely consisted of watching television, followed by talking on the telephone and then reading. One mentioned listening to music. Several mentioned transportation as a barrier to getting out, though others noted that they have friends who will take them out when

asked. Two women mentioned that it would be nice to have more access to the internet in the day facility they attended, and one noted it would be nice to have a personal computer.

Visiting, Companionship & Social Isolation

Over three fourths of the women with whom we spoke noted having received some type of social visit in their home at least once in the previous week. Most of these visits were by family members, though friends and members from church were also mentioned. A few women noted that they were lonely and needed more time with others, in some cases because spouses and siblings had predeceased them or children moved away. Many noted the importance of visiting with other people at the day centers, but particularly desired visits to their home.

Finances, Expenses, Taxes and Legal Aid

Very few of the women noted needing help with paying for regular items, though many mentioned that a little extra income would be "nice." Some noted needing help paying for excess water or electric bills.

Many of the women mentioned that they no longer have to file taxes, though a quarter of the women did and most need help with that. This help primarily comes from family, friends, fee-for-service tax preparers, and a few senior outreach volunteer programs.

Clothing was not a need for most women (only two said they needed extra clothes). In fact, many noted that they had too many clothes, and spent time sorting through them trying to get rid of excess. When receiving clothes was mentioned, most said their children (particularly daughters) gave them clothes as presents, and a couple mentioned the Clothes Closet and another unnamed community organization.

About 20% of the women mentioned needing legal help, and some had received it recently (using a fee-for-service attorney). Examples of legal problems included a questions about wills and leaving property to children, the desire to force the housing authority to repair her apartment, and a lingering problem with a ticket issued because a relative had taken her car without permission, been ticketed out of state, and never paid the ticket.

Social Contact

In an attempt to understand social contact levels, and its converse, isolation, we created a 13-point additive scale (0-12) out of several of the indicators in the follow-back calendar, including: running errands (grocery shopping, drug store, etc.), attending church services, attending church groups (like bible study), volunteering, attending the day center, employment, taking a class, visiting with other people, talking on the phone, travelling (both in and out of the area), and going for doctor visits. The actual range of recorded social contact scores is 0-10, with a mean of 5.9 types of contacts per week (95% confidence interval 5.398-6.379). There were no statistically significant relationships between social contact and any of the demographic variables.

We ran the same analyses replacing social contacts with seeing family (children, grandchildren and great-grandchildren). This variable is a 9-point ordinal scale that ranges from daily (given a score of 1) to rarely or never (given a score of 9). There was only one statistically significant relationship between seeing children and the demographic variables, income. As income levels rise, the frequency with which the women see their family members decreases (pairwise correlation = .279, significant at $p<.10$ using a one-tailed test).

Other

One woman with whom we spoke had spent the previous week institutionalized for severe depression, and our interview was her first social interaction outside of her doctors or family in that week. Though having been released from the hospital, she was still visibly depressed. While we did not screen for depression in the interviews, many of the women noted being depressed. As we talked with them, the sources of their depression ranged from isolation and loneliness to frustration over limited mobility and activity. Related, another woman noted that her "husband's ill health leaves me exhausted and in need of help." Finally, another mentioned that because of her walker and health problems it was difficult to dress herself.

Bivariate relationships

Examining bivariate relationships in the interview data, some telling statistically significant relationships and patterns emerge in terms of race, age, income and social contact (see Table 4). The African American women interviewed are less likely the white women to have education past high school, and more likely to not complete high school (χ^2=4.929, p<.10). African American women are also more likely than white women to attend a church group meeting during the week (outside of weekly services), including bible study or Sunday school (χ^2=2.725, p<.10). African American women also systematically have different needs than white women with cooking for themselves (χ^2=3.253, p<.10), help with transportation (χ^2=6.969, p<.001), and paying for prescription medication (χ^2=2.891, p<.10).

With respect to age cohorts, 7 relationships are seen. The youngest age group is more likely to discuss sleep problems (χ^2=4.597, p<.10), be unable to perform housework (χ^2=6.052, p<.05) and state that they need help with housework (χ^2=5.937, p<.10), have needs preparing meals and purchasing food (χ^2=5.553, p<.10), need legal help (χ^2=6.295, p<.05), and need help

accessing and navigating the healthcare system (χ^2=5.486, p<.10). Meanwhile, the very elderly are less likely to attend church services (χ^2=7.191, p<.05). These findings underscore an important emerging change in policy for the elderly. While in interviews the very oldest women frequently stated that they had no needs because no matter how deprived they are now, they still have more than they had as children during the Depression; the younger elderly women expressed much greater expectations for support. These younger elderly are the oldest of the Boomer generation, and are behaving in accordance with expectations from literature on this age cohort. The implications for policy are clear: they will have a louder voice and in expressing demands than their older counterparts, placing new or growing pressures for services.

Four relationships emerged with education level. Women with lower educational attainment had greater needs than other women paying for gas, repairs and insurance when they own their own vehicles (χ^2=6.519, p<.05). These women also have greater needs paying for prescription medication (χ^2=5.489, p<.10) and with housing (often public housing or home repairs) (χ^2=9.334, p<.01). Similar relationships emerge for women in different income cohorts.[3] Lower income women reported needing more help paying for prescriptions (χ^2=6.188, p<.05) and paying for home repairs (χ^2=7.824, p<.05). However, wealthier women spend more time listening to music than those women with lower incomes (χ^2=4.862, p<.01).

Finally, we looked at relationships by social contact using two variables, first living alone, and second, the social contact scale discussed above. Women who live alone are less likely to leave the house to run errands (χ^2=4.629, p<.10) and more likely to report spending time talking on the telephone (χ^2=7.400, p<.05). Simultaneously, watching television does not drive down social activities, nor the reverse. In fact, the only significant relationships between

[3] The relationship between education cohort and income cohort is χ^2=6.195 but is not statistically significant, and the correlation between actual income and years of school completed is .506, p<.01.

cumulative social contacts and solitary activities (watching television, listening to music, and reading) shows that people who do more, do more (χ^2=16.446, p<.05, χ^2=25.412, p<.01, and χ^2=14.477, p<.10, respectively).

[Table 4 about here]

Facilities

While we did not conduct formal site visits of the facilities where we conducted interviews, we did take notes on many factors related to ambience and facility upkeep, available activities, staffing, and the surrounding communities (for pictures of select facilities, see figure 7).

[Figure 7 about here]

Information on these factors is captured in Tables 5, 6 and 7. We conducted the interviews in a wide range of facilities, from stand-alone programs housed in their own buildings, to programs that are part of municipal facilities, to others that are part of church facilities. In all, a few trends and patterns were detected.

[Table 5 about here]

Table 5 provides a short description of each of the facilities visited, including information on the types of neighborhoods in which the facilities are located, the programmatic functions immediately available, the "feel" of the facility—whether it is new or old, well-maintained or neglected, and so on. In all, centers in wealthier communities were newer, cleaner and included a larger variety of activities. Wealth, however, did not always have a positive bearing on the "mood" of the participants in the centers.

[Table 6 about here]

Table 6 provides a summary description of the centers with respect to type of service provided, location, hours, race of consumers compared with racial breakdown in the towns (or counties for non-metropolitan areas), and available transportation to the center. The racial composition of the consumers did not always follow the majority composition of the towns and counties in which the centers are located, though with one exception when centers were located in low-income neighborhoods, participants tended to be primarily African American. In addition, most centers had some type of public transportation for the participants, with the only exception being the residential facilities.

[Table 7 about here]

Finally, Table 7 provides descriptive information on the center directors. All were female. The modal age (in terms of decades) for the directors is in the 50s, though there was a spread between the 30s and 60s, though tending to be younger. There was an almost equal split with respect to age. Though not captured on this table, the "feel" of the centers tended to reflect the spirit, enthusiasm and professionalism of the center directors.

In summary, wealthier municipalities are home to centers that are newer, cleaner, offer more services and amenities, and have greater staffing capacity. That being noted, there were clear exceptions. First, poorer areas were home to quality (albeit more limited) facilities in the presence of a dynamic program director and developed programs that reached women aged 65 and older around another program with sufficient resources. Conversely, some relatively wealthy areas host poorly supported facilities.

Part 5: Organizational Capacity

The organizations range widely across nonprofit, public and private service providers. The most common respondents were nonprofit direct service providers (50%), followed by private for-profit service providers (25%) and government direct service providers (22%); the remaining organizations included government and nonprofit grantors to direct services providers.

Length of Time in Operation and Geographic Range of Services

Most of the organizations were local or regional service providers. Services were limited to a single county in 42% of the organizations and 40% of the organizations served a multi-county area (defined as more than one but less than all of Alabama's sixty seven counties). Statewide services were provided by 12% of organizations. A minority of organizations operated across state lines; 7% indicated that they provided services in some part or all of Alabama and in some part of all of at least one other state.

All organizations were relatively well-established in terms of providing services to women aged 65 and older. Most organizations reported that they had been in operation for at least thirty years (mean-34.5); many reported start dates in the 1930s or the 1960s and several noted that they had been providing services for well over 100 years. The number of years of service provision range from 1 year to 176 years. In terms of providing services to women aged 65 and older, these organizations have been serving this population essentially since inception; the average number of years of providing services to women was slightly above 30 years (mean=31.5) and the range of years of service provision was also from 1 year to 176 years.

Budgets

Annual budgets ranged from less than $100,000 to more than $10 million for the organizations that provided budget data (73% of respondents). Organizations are concentrated at the lower end of the budget ranges. More than one-quarter (26.7%) report budgets of less than $100,000 and slightly more than half report budgets of $500,000 or less. At the other end of the spectrum, nearly 10% of organizations report budgets in excess of $10 million. Table 8 presents organizational annual budgets by range.

[Table 8 about here]

About half of the organizations (48%) provided data about the proportion of their annual budgets that were dedicated to serving women aged 65 and older. Within this group, budgetary support for these women ranged from a low of 2% to a high of 100%; the average level of support was 62% of the annual budget. For organizations with the largest budgets ($10 million+) that also reported the proportion of their budget linked to serving women in this age range (6 organizations), the proportion ranged from 20% to 75%. For organizations with the smallest budgets (less than $100,000) that also reported the proportion of their budget linked to serving women in this age range (also 6 organizations), the proportion ranged from 40% to 100% with 100% the most common response (4 organizations). The number of women served by these organizations in a typical year ranges widely, from as few as 15 women to as high as 20,000. Half (50%) of the organizations serve fewer than 100 women per year, and a third (35.7%) served between 100 and 200 women per year. Another third served between 4,000 and 4,500 women per year.[4]

[4] These data are drawn from responses to the survey by organizations located on the internet list.

Staff and Volunteers

The resources of organizations serving Alabama women aged 65 and older also included human capital. For the majority of organizations, staff and/or volunteers were dedicated to providing services for which women in this age group would be eligible. More than 95% of the full time employees of respondent organizations were involved in providing services to women aged 65 and older.

The organizations varied widely in the number of full time staff, as would be expected given the wide range in annual budgets reported. The number of full time staff ranged from 1 to 850; the average number of full time staff was 85 and the most common number reported was 1. Table 9 presents the range of full time staff. Smaller staffs are most common; nearly 60% of the organizations that have staff have 1-20 full time equivalents. Several organizations (4%) have no paid staff and operate entirely with volunteers (3 organizations). Large staff of 100 or more are found in approximately 20% of the organizations.

[Table 9 about here]

Further examination of the upper and lower categories indicates that the staff differential between large and small organizations is concentrated at the extreme high and low ends of the scale. Of the organizations with 20 or fewer full time staff, a bit more than half (53%) have 5 or fewer staff. At the other end of the range, of the organizations with more than 100 full time staff, 6 have more than 250 full time staff and 50% (3 organizations) have 800 or more.

Considerable investment has been made in the education, training, and professionalization of the staff serving women aged 65 and older. About half of the organizations (44%) provided data about staff licensure and certification. Figure 7 presents the array of

licenses and certifications reported. The range of the number of license held by staff in any one organization ranged from 0 to 50, with 3 to 4 as the average (mean=3.8) and 1 as the most common response.

[Figure 8 about here]

The majority of the organizations (65%) also responded to questions about the use of volunteers to deliver services to this group. The range of volunteers utilized by organizations varies from 0 to 2500, with about one-quarter of the organizations (24.7%) not using any volunteer support and nearly one-half one-quarter of the organizations (46.8%) 1 to 20 volunteers to assist in the activities of the organization related to women aged 65 and older. Table xx presents the distribution of volunteer support. Table 4 presents an array of the types of activities that volunteers undertake in working with these organizations to serve this population of women. Most organizations (65%) tracked the hours of volunteer service. Across the organizations, volunteers served on average a bit more than 8 hours per week (mean=8.4); the number of hours per week ranged from 0 to 30 hours and the most common response was 2 hours. Within the group of organizations that rely on between 1 and 20 volunteers, more than half (53%) have 5 or fewer volunteers.

[Table 10 about here]

Volunteer service covers a wide range of activities. These activities include food preparation and clean up; scheduling members of the public to come to the organization and discuss services; in-house entertainment such as quilting, choir, reading, bingo, singing, exercise, arts and crafts, and luncheons; and off-premises entertainment such as day trips. Volunteers also

assist with clerical work in some organizations. Table 11 presents the distribution of volunteer service activities by category. Nearly one-quarter (24%) of the service that volunteers provide is in the area of leisure and recreation. The next most common use of volunteers is in the area of clerical support (10%); these two categories account for one-third of volunteer support. Meals (nutrition, preparation, and home delivery), education, and support with errands and medical visits comprise another one-third of volunteer support. The remaining one-third of volunteer support is distributed broadly across a range of support activities.

[Table 11 about here]

Performance and Oversight

Organizations are also subject to oversight or review from a wide range of organizations that provide accreditation or other similar evaluative information. A list of these organizations noted by survey respondents is reported in figure 8. The array of organizations is heavily populated with departments within Alabama state government (Public Health, Mental Health, Senior Services, Transportation) as well as federal agencies including those most directly responsible for public policy on aging issues and public financial support for medical care generally (Center for Medicaid and Medicare Services, Area Agencies on Aging, Housing and Urban Development). All prominently mentioned was The Joint Commission, which is the accrediting body for wide variety of health care organizations (hospitals, doctor's offices, nursing homes, office-based surgery centers, behavioral health treatment facilities, and providers of home care services).

[Figure 9 about here]

About two-thirds of organizations (64%) reported that they track their performance in some way. Figure 9 presents the range of methods reported. Although the comments provide limited specifics about the program evaluation methods that organizations use, larger organizations were more likely to indicate methods such as accreditation and benchmarking and smaller organizations were more likely to use client counts.

[Figure 10 about here]

Collaborative Arrangements

Collaborative arrangements were identified through survey questions about partnerships, sources of information about various aspects of services and programs, and connections to umbrella organizations. Organizations identified partnerships with government and nonprofit organizations in five program areas including funding, program design, service, delivery, program evaluation, and best practices/model programs. For each of these five program areas, organizations also identified government and nonprofit groups that they used as sources of information about programs and services for women aged 65 and older, and which of these sources of information were the most important. Also, organizations identified any organizations which served as umbrella groups for their programs and services. Table 12 presents the partnership relationships identified by Alabama organizations with various levels of government and types of nonprofit organization in the five different program areas. Table 13 presents the sources of information that organizations use in operating programs for women aged 65 and older in these same program areas. Table 14 presents the most important source of information for each of the five program areas.

[Table 12 about here]

[Table 13 about here]

[Table 14 about here]

Organizations were asked to identify which of the categories of service that they provided were most beneficial; the frequency array of responses is presented in table 15. The most frequently chosen are medical care (12.5%) followed by nutrition (9.4%). The next most frequent selection is "other" (7.5%). Together, these categories of service account for 30% of the responses. Combined with educational programs and assistance with housing, transportation, and prescription drug expenses these services account for slightly more than half (51.9%) of the responses. Of the respondents indicating "other," the most common reason was that the service provided by their organization allowed an individual to remain in their own home longer. Lawn care, legal services, and Medicaid waiver services were not mentioned by any organization. The balance of responses ranged widely over the categories of service with each category mentioned by less than 5% or respondents (1.3%-4.4%).

[Table 15 about here]

Organizations in Alabama serving women aged 65 and older have formed an extensive network of collaborative arrangements with federal, state, and local governments as well as with nonprofit organizations at the state and national level. In particular, Alabama state and local governments are important partners and sources of information for organizations serving this population. The federal government and Alabama state government are the most commonly noted information sources as well as the most important sources of information about program funding for these organizations. Government offices are also important sources of other

information about programs (design, delivery, evaluation, and best practices/model programs) alongside national and Alabama nonprofit professional associations. National and Alabama professional associations are particularly useful to these organizations for information about best practices and model programs. The importance of Alabama government is also highlighted in the array of umbrella organizations cited by survey respondents; Alabama state government figures prominently in the list of groups. Figure 10 presents the list of umbrella organizations identified in the survey.

[Figure 11 about here]

Table 17 lists the range of reasons that organizations felt would challenge their ability to serve Alabama women aged 65 and older.

[Table 17 about here]

Part 6: Findings

We began this research with several objectives: (1) to identify services available for Alabama women aged 65 and older; (2) to identify participant perceptions of these services; and (3) to identify best practices for serving the needs of these women. Overall, we conclude the following:

Alabama Organizations

Most organizations are well-established, local area service providers serving a single county or a several-county area. A significant number of organizations are both very large and very small. Approximately 50% have budgets under $500,000, 5 or fewer staff, and few volunteers, if any. The top 10% of organizations have annual budgets in excess of $10 million and hundreds of staff and volunteers. Government does not deliver most of the services provided to women aged 65 and older. Half the organizations serving this population are nonprofits and one-quarter are private for-profit companies. Larger organizations are significantly invested in licensure, accreditation, and certification for staff and programs serving women aged 65 and older. Overall, Alabama organizations serving women aged 65 and older are involved in a wealth of formal and informal collaborations with government agencies and with the nonprofit community both within and outside Alabama. These collaborations may hold potential for an exchange of ideas that can foster innovation.

Alabama Services and Best Practice Settings

From the perspective of organizations providing services to women aged 65 and older, the most beneficial services are medical care, nutrition, assistance necessary to remain in one's own home, educational programs, and assistance with housing, prescription drug expenses, and

transportation. Best practices for delivering services are found in urban and rural settings. Best practice facilities typically, but not always, are seen in areas with significant public and/or private philanthropic resources and support.In the case of areas with minimal resources, best practice facilities exhibit two important characteristics. First, they develop around another existing service area in which resources are relatively more available, and second, they are run by skilled and impassioned directors.

Alabama Women Participating in Programs and Services

Personal needs vary widely based on income, and private retirement benefits are rare outside major cities. Quality of life is influenced directly through the interaction of health, personal wealth, and family wealth (typically of the spouse). Needs are extensive and rarely met for women with few resources and poor health. Quality of life is influenced indirectly by race, education, and previous employment status. Private retirement benefits beyond Social Security are relatively rare among women interviewed in locations other than major metropolitan areas.

With respect to the individual interviews, a significant number of women did not characterize their circumstances as being in need of anything, despite observational evidence to the contrary. Anecdotally, there are connections between education, income and rural isolation that qualitatively diminish the lives of women in this age group, though the women themselves do not personally acknowledge these conditions as limitations or something for which government help should be provided. It is possible that this disconnect is a function of generation. Over and over we heard women say, “I get by,” and “I make do with what I have.” Simultaneously, some noted that they had less in the Depression, so by comparison they are doing just fine now, despite difficulties with transportation, income, and so on. As Boomers join

this cohort, it is highly possible that they will express greater demands for services than the Depression era generation.

Organizations provided comments that reflect their assessments of the needs encountered by women aged 65 and older and the challenges that they face. The following comments are representative of the remarks provided by survey respondents.

- "Most are solely dependent on social security-which often is inadequate to fund the basic needs. Many have to choose food or medicine."
- "Homebound meals [are important] - some would not see anyone for days [and] also may not have a balanced meal daily what we do] allows clients to stay in their homes."
- "Providing services while navigating the system of regulations/eligibility and coverage requirements and its growing complexity; making resources known to potential customers."

Future Challenges

Lack of resources will be the greatest future challenge as this population grows, both in terms of funding support, paid staff, and volunteers. Affordable home services are a particular concern. Broad systemic concerns also exist regarding future national and/or state policy changes and available resources around income security and health care. In response to questions about the challenges facing women in this age group and future needs, respondents' opinions focused on funding, growing size of the population, rising health care costs, the economic downturn, lack of various services, and lack of affordable in-home services. By far, the greatest future service challenge is the lack of resources to meet a growing population. Nearly half the organizations responding to this question (46.7%) identified funding alone as the most important challenge.

Need for staff (10.7%) was cited next, followed by the increase in the aging population itself (9.8%). No organization cited the potential physical limitations of women aged 65 and older as a challenge for future service provision.

Organizations also noted and the need to rely on networks of volunteer and community service providers in addition to traditional government services. The following comments are representative of the remarks about challenges facing women aged 65 and older and the reasons behind these challenges.

- "Funding from the State, budget cuts."
- "Paying for existing care needs of our increasingly dependent population, Medicaid only pays for basic needs."
- "Continuing to provide medical care to those without insurance."
- "[Need] private practice physicians who take Medicare/Medicaid."
- "Financial security-if living on social security, they live in poverty."

Reasons for future challenges varied but a few key factors stood out for the majority of organizations. Rising costs of health care, the income security needs of women in this age group, the lack of funding for services, and the lack of affordable home services accounted for slightly more than half (55%) of the responses. Together with these factors, the general growth of the population and the lack of housing and transportation account for more than three-quarters of the responses.

Part 7: Looking to the Future

Across the network of organizations providing programs and services that touch the lives of women aged 65 and older in Alabama, the need for resources is clear, as is the need to direct resources to meet needs in and outside of institutional settings. There would be utility for the development of more organizations outside of government proper to meet these needs, as the resource challenges may be so severe that government programs will be unable to meet the demands of this group in the future. This is a particularly precarious time to be aging, as the size of the population is increasing dramatically while state and federal budgets are simultaneously decreasing.

All of this suggests that in looking to the future and identifying best practices for providing for this population, there is simultaneously a need for government involvement as well as involvement of organizations outside of government. We visited different, successful model programs that were government run and privately run. Government models make sense under two conditions: 1) in the presence of general will and a significant tax base, and 2) in the presence of significant need and a lower tax base and where multiple government services can be combined together. We saw two potential best practice models—one where facilities were stand-alone and restricted to people in a certain age range (here, age 55 and older), and the other where facilities were a part of a broader community center, providing services to all age groups. In the face of more limited resources, the second of these two approaches to the public provision of services to this population would allow for greater breadth of program offering and simultaneously would provide increased public awareness to build support for programs for this population. Private and not-for-profit models make sense in the case where there is not

necessarily the will of the general public, but there are significant private resources (both financial and skill) to develop programs.

This also begs questions about capacity. Is it really just the places with resources (time, money and staff) that can investigate what ought to be done and then can build and provide those programs? Or is it possible, even without significant resources, to develop model programs. Our experience in visiting programs across the state suggests that in the face of limited resources, best practice facilities exhibited two important characteristics. First, they developed around another existing service area in which resources were high (or perhaps simply available in comparison to resources for other programs), and second, they were run by skilled and impassioned directors.

It is beyond the scope of this research study to design or recommend a systematic, structured approach to developing new capacity to meet the needs of Alabama women aged 65 and older. Themes that emerge from this research suggest that it is important to consider collaborative approaches that leverage resources across sectors and that engage the community more broadly beyond "seniors." It is also important to consider developing capacity around programs that already exist to address other needs, such as transportation, nutrition, exercise, and social interaction. Programs that "work" will be those that reflect the desires and interests of the community and that engage the community in design and development. As in any successful program, expertise and enthusiasm for the work are crucial ingredients.

Table 1. Bivariate Relationships in State Level Organization List (Web-based)

Relationships		χ^2
Service type and		
	County	3,100***
	Congressional district	537.22***
	E-mail	62.4***
	Websites	87.77***
IT and		
	Types	50.88***
	Congressional district (w/ e-mail)	194.53***
	Congressional district (w/ websites)	112.78***

* p<.10
** p<.05
*** p<.01

NOTE: Because of the large number of variables, only significant relationships are reported. All non-reported pairings do not have a statistically significant relationship.

Table 2. Distribution of Service Availability

Service Type	Percentage of Organizations
1. Advocacy Assistance	11.7
2. Alzheimer Support	1.5
3. Case Management	25.9
4. Clothing	0
5. Comprehensive Services	25.9
6. Educational Programs	28.3
7. Elder Abuse/Neglect Prevention	15.5
8. Emergency Financial Assistance	0
9. Employment Services	0.4
10. Financial Counseling	0.0
11. Food Stamps	0.4
12. Friendly Visiting	0
13. Geriatric Assessment	33.3
14. Grocery Shopping/Delivery	0
15. Health Insurance Counseling	0.4
16. Home Delivered Meals	11.7
17. Home Repairs	0
18. Homemaker Services	25.9
19. Housing Options/Services	21.2
20. Income Security	0
21. Information/Referral	11.7
22. Lawn Care	0
23. Legal Services	0.9
24. Leisure/Recreational	28.2
25. Medicaid Waiver	0.4
26. Medical Care	28.5
27. Nutrition Services/Meals	28.2
28. Prescription Expense Assistance	0.4
29. Sitter/Companion Services	27.4
30. Transportation Assistance	26.8
31. Volunteer Services	11.7
32. Wellness Programs	28.2
33. Mental Health Services	3.4

Source: State List of Organizations

Table 3. Bivariate Relationships in State Level Organization List (AAA)

Relationships	χ^2
County and	
Employment	128.8***
Home delivered meals	106.9***
Information referral	106.9***
Medical care	82.6*
Volunteer services	106.9***
Non-profit organizations and	
Advocacy assistance	545.4***
Educational programs	261.1***
Food stamp assistance	17.9***
Health insurance counseling	17.***
Home delivered meals	545.4***
Information referral	545.4***
Legal services	19.6***
Prescription expense assistance	17.9***
Volunteer services	545.4***
Mental health services	135.4***
For-profit organizations and	
Case management	969.5***
Comprehensive services	959.5***
Elder abuse and neglect	607.4***
Geriatric assessment	737.2***
Homemaker services	969.5***
Housing options services	579.1***
Medical care	605.9***
Sitter companion services	989.3***
Wellness programs	276***

* p<.10
** p<.05
*** p<.01

NOTE: Because of the large number of variables, only significant relationships are reported. All non-reported pairings do not have a statistically significant relationship.

Table 4. Bivariate Relationships for Lives and Needs

Relationships	χ^2
Race and	
Education	4.929*
Attend church groups	2.725*
Need help paying for medication	2.891*
Age cohort and	
Sleep problems	4.597*
Not performing housework	6.052**
Stating need for help with housework	5.937*
Stating need for help with nutrition	5.553*
Stating need for legal help	6.295**
Stating need for help with healthcare	5.486*
Attending church services	7.191**
Education cohort and	
Stating need for help w/ transportation	6.519**
Stating need for help with healthcare	5.489*
Stating need for help with housing	9.334***
Income cohort and	
Stating need for help w/ prescriptions	6.188**
Stating need for help with repairs	7.824**
Listening to music	4.862**
Live alone and	
Run errands	4.629*
Talk on the phone	7.400**
Social contact and	
Watching television	16.446**
Listening to music	25.412***
Reading	14.477*

* $p<.10$
** $p<.05$
*** $p<.01$

NOTE: Because of the large number of variables, only significant relationships are reported. All non-reported pairings do not have a statistically significant relationship.

Table 5. Facility Summaries

Facility	Description
A	Located in an old elementary school in a poorer and minority section of town. The facility is multi-purpose, with a daycare, afterschool program, community activities, senior day center, and adult day care. Equipment was old and in some cases rusted, furnishing was old, hand-me downs. Quaint, homey feel, reasonably clean. Few windows located high on the walls.
B	Located in an old elementary school in a poor and largely minority residential community on the outskirts of town. White cement block building with 3 primary rooms (office, kitchen/dining, sitting). Sparsely furnished and decorated. TV in sitting room, with people playing cards and dominos. Formica tables in dining area. Clean, stark, white, windows only on one side. No visible technology in the office.
C	Located in the old town post office, centrally located and visible across from police, fire and government bildings. Kitchen and dining/activity area with large, open space. Piano, television and games present. Windows all around. Offices for other agencies in building.
D	Located adjacent to a residential, middle-class neighborhood, but not in a high traffic area. Center is part of a municipal complex and is surrounded by sports fields. It is a free standing building with congregate dining, general purpose area (including exercise classes), kitchen, library, office. Clean, new, bright, windows, sparsely furnished with an institutional feel.
E	Located in an old school complex, specifically the free-standing cafeteria. Large room with stage, bright/light with windows on 2 sides (separate kitchen), small office. Walking track outside with flowering bushes and trees intentionally put there to encourage people to get out to exercise. Away from town in largely rural area. Quilting rack (everyone involved in this activity).
F	This center is part of government complex, right off the center of town and near the municipal offices on one side and residential neighborhood on the other. Two large rooms (not easily joined), activities the day we were there were in one large room with tables and chairs, adjacent to an administrative office, and kitchen.
G	Set in residential, lower-middle class neighborhood, adjacent to a day care center. This is a residential facility. Front porch with rocking chairs, living room with television, sitting/reading room, two contiguous dining rooms, kitchen, staff offices and approximately 20 private bedrooms. Many staff present (approx. 7). Outdoors was just lawn with no external amenities. All female residents.

Facility	Description
H	Set in mixed use neighborhood, residential in parts, business and churches in other. Also mix of high end ante-bellum homes and lower income homes. Part of a church complex. Facility for seniors was a large room with a kitchen off the back, pantry and office. High windows, tall ceiling, but bright. TV in front of room.
I	Middle/ upper middle class mixed use and newly developing area. Facility is a stand-alone center with large parking lot. Large foyer with 2 staff at welcome desk, 2 sitting areas, 3 multi-purpose rooms, 1 very large for dance, exercise, etc. along with a cafeteria and seating; 1 multi-purpose room for art program; billiards room; exercise room; small exercise pool; showers and lockers; several offices. Open to the public 55+. Open 7 days/week all day except Sunday (1/2 day on Sunday).
J	The center is located in a low-income residential neighborhood in advanced state of decay and disrepair 3 blocks off of downtown. Building was newer than construction around it, and primarily housed a multi-county transportation program with the nutrition center added to it. Main room with tables/chairs, kitchen, several offices (front, 2 private rooms, large work area, 1 other private office). Cramped and old furniture, but atmosphere of clients was cheerful, loud (in a positive way), light-hearted. Several staff with active environment.
K	This program is located in a large church social hall (connected to the church) in a largely African American neighborhood adjoining a former factory and the back of a strip mall. Activities in the hall include meal preparation in the kitchen, a large open area with tables, a television, games, and a piano. The facility is older, but also clean with bright, waxed linoleum floors. Other rooms included a computer room, "clothes closet," and bathrooms.
L	This stand-alone facility is located adjacent to other city facilities (community center, ball fields, park, swimming pool). The building contains a front sitting area with television, wide hallway, large staff office also used for quilting, kitchen, smaller meeting rooms, a large communal area with piano, porches, and walking trails with pond, flowers and shade trees. The building was bright, clean, newer and had no odor.
M	Located in a stand-alone building, this large senior center has an array of hallways and rooms for different activities, from line dancing to ceramics to chair caning to language lessons, and so on. See facility map at end of fig. 7 for greater detail. The facility is in excellent condition, bright with windows, and well manicured grounds. The facility also includes an adult day care program, meals on wheels, a lunch room, and a snack bar, as well as a gift shop where items made at the center are on sale as a fundraiser.

Facility	Description
N	This center is a residential facility and includes a complex of buildings designed for multiple levels of functioning. The main building houses the single-room occupancy residents, many of whom receive daily living assistance. This building also holds a central sitting room, staff offices, dining room, library and kitchen. The facility is open, bright and clean.
O	This senior center is located in the upstairs area of a larger community center, and includes a medium sized room, kitchenette, staff office and bathrooms. The facility is temporary housing for the program as their stand-alone facility was damaged during the spring tornados. While it was clean and bright, it simultaneously has no windows. Although the community center is home to a wide range of programs for all ages, the senior center is not connected to these programs even on a temporary basis. The entrance to the senior center rooms is on a separate side of the building. The temporary location is significantly farther away from where most of the clients live than the regular location, and as such attendance has been lower since they were forced to move.

Table 6. Overview of Facilities

Center	Type	Location	Hours	Race-Consumers	% Race-City/Area[5]	Transport	Odor
A	AD SC CDC	Low-income neighborhood	All day	Mostly black	W: 78.1 B: 16.8	Self, van, bus	Strong
B	AD SC	Low-income neighborhood	Half day	Mostly black	W: 69.9 B: 26.6	Center van	Strong
C	NC	Downtown	Half day	Mostly white	W: 69.9 B: 26.9	Public, car, van	Moderate
D	SC	Middle-class neighborhood	Half day	Mixed	W: 71.3 B: 22.7	Center van, car	None
E	SC	Middle-class neighborhood	Half day	Mostly white	W: 65.3 B: 31.7	Personal	None
F	SC	Government complex	Half day	Mixed	W: 85.7 B: 9.4	Personal, van	Strong
G	RF	Lower middle-class neighborhood	24 hrs	White	W: 85.7 B: 9.4	None	Strong/ institutional
H	SC	Mixed use/ class neighborhood	Half day	Mostly black	W: 50.4 B: 46.3	Center van, city bus, personal	Low
I	SC	Middle class neighborhood	All day	Mostly white	W: 50.4 B: 46.3	Largely personal car, van	None
J	NC	Lower-class	Half day	Mix	W: 46.4	Van, personal	None

[5] Source: U.S. Census Bureau QuickFacts http://quickfacts.census.gov/qfd/states/01000.html; figures based on cities where available and counties otherwise.

Center	Type	Location	Hours	Race-Consumers	% Race-City/Area[5]	Transport	Odor
		neighborhood			B: 51.7	car	
K	SC	Lower-income neighborhood	Half day	All black	W: 47.7 B: 49.6	Van, personal car	None
L	SC	Complex of municipal facilities	Half day	Mostly white	W: 83.1 B: 14.4	Van, personal	None
M	SC NC AD	Business area	Full day	Mostly white	W: 64.5 B: 30.2	Van, personal	None
N	RF	Off of business area	24 hrs	Mostly white	W: 80.1 B: 13.0	None	Low
O	SC	Complex of municipal facilities	Half day	Mostly white	W: 24.1 B: 73.5	Van, personal	None

KEY:
AD= Adult Daycare
SC= Senior Center
NC= Nutrition Center
RF= Residential Facility
CDC= Site of children's daycare center
Oth= Other

Table 7. Facility Administrators

Center	Race	Gender	Age
A	B	F	50s
B	B	F	50s
C	W	F	40s
D	*	*	*
E	W	F	60s
F	B	F	60s
G	W	F	30s
H	B	F	50s
I	W	F	40s
J	B	F	30s
K	B	F	50s
L	W	F	40s
M	W	F	50s
N	B	F	30s
O	B	F	50s

Table 8. Distribution of Annual Budget Range

Annual Budget Range	% Respondents	Cumulative %
Less than $100,000	26.7	26.7
$100,000 to $250,000	16.3	43.0
$250,000 to $500,000	11.6	54.7
$500,000 to $1 million	14.0	68.6
$1 million to $5 million	18.6	87.2
$5 million to $10 million	3.5	90.7
$10 million +	9.3	100.0

N=86 respondents

Table 9. Distribution of Full Time Employees or Equivalents

Number of Employees	% Respondents	Cumulative %
0	4.0	4.0
1-20	58.7	62.7
21-40	4.0	66.7
41-60	4.0	70.7
61-80	5.3	76.0
81-100	2.7	78.7
101+	21.3	100.0

N=75

Table 10. Distribution of Volunteer Support

Number of Volunteers	% of Respondents	Cumulative %
0	24.7	24.7
1-20	46.8	71.7
21-40	11.7	83.1
41-60	5.2	88.3
61-80	0.0	88.3
81-100	0.0	88.3
101+	11.7	100.0

N=77

Table 11. Distribution of Volunteer Service Activities

Category of Service	% Respondents	Cumulative %
Leisure/recreational	24.3	24.3
Clerical	10.3	34.6
Nutrition services/meals	9.6	44.2
Education	9.6	53.7
Home delivered meals	8.1	61.8
Errands/Doctor visits	8.1	69.9
Transportation	5.9	75.8
Information/referral	5.1	80.9
Friendly visiting	4.4	85.3
Fundraising/donations	4.4	89.7
Spiritual/pastoral care	4.4	94.2
Sitter/companionship	2.9	97.1
Lawn care/home repair	2.9	100.0

N=136 responses; multiple selections possible

Table 12. Partnership Relationships by Program Area and Partner

Program Area	Program Funding	Program Design	Program Delivery	Program Evaluation	Model Program/ Best Practices
Partner					
Federal Government Agency	50.8	16.9	14.4	16.9	14.4
Alabama State Government	41.5	17.8	16.1	17.8	11.9
Alabama Local Government	25.4	6.8	15.3	5.9	3.4
National Professional Association	4.2	10.2	6.8	14.4	17.8
Other National Nonprofit Organization	10.2	6.8	7.6	5.9	12.7
Alabama Professional Association	9.3	8.5	10.2	10.2	13.6
Other Alabama Nonprofit Organization	11.0	7.6	6.8	7.6	6.8
State Government in Other State	1.7	1.7	0.8	2.5	3.4
Local Government in Other State	1.7	2.5	1.7	1.7	3.4
Other	5.9	1.7	5.1	3.4	2.5

N=118 respondents; multiple selections possible

Table 13. Information Relationships by Program Area and Information Source

Program Area	Program Funding	Program Design	Program Delivery	Program Evaluation	Model Program/ Best Practices
Information Source					
Federal Government Agency	54.2	17.8	22.9	16.1	16.1
Alabama State Government	41.5	20.3	22.0	16.9	14.4
Alabama Local Government	30.5	2.5	13.6	5.9	3.4
National Professional Association	6.8	11.9	8.5	11.9	25.4
Other National Nonprofit Organization	8.5	5.9	6.8	7.6	14.4
Alabama Professional Association	11.0	11.9	9.3	8.5	24.6
Other Alabama Nonprofit Organization	14.4	6.8	12.7	5.9	14.4
State Government in Other State	2.5	1.7	0.8	1.7	5.9
Local Government in Other State	2.5	1.7	0.8	2.5	7.6
Other	5.9	0.8	4.2	4.2	0.0

N=118 respondents; multiple selections possible

Table 14. Most Important Source of Information by Program Area and Information Source

Program Area	Program Funding	Program Design	Program Delivery	Program Evaluation	Model Program/ Best Practices
Information Source					
Federal Government Agency	34.0	23.0	19.0	21.4	15.6
Alabama State Government	25.2	24.6	21.5	19.6	18.8
Alabama Local Government	15.1	8.2	15.2	5.4	3.1
National Professional Association	3.1	14.8	13.9	14.3	21.9
Other National Nonprofit Organization	5.7	1.6	2.5	16.1	10.4
Alabama Professional Association	3.1	11.5	7.6	7.1	14.6
Other Alabama Nonprofit Organization	6.3	6.6	7.6	7.1	6.3
State Government in Other State	1.9	3.3	2.5	1.8	3.1
Local Government in Other State	1.9	1.6	3.8	1.8	3.1
Other	3.8	4.9	6.3	5.4	3.1

N=118; multiple selections possible

Table 15. Distribution of Most Beneficial Service

Category of Service	% Respondents	Cumulative %
Medical care	12.5	12.5
Nutrition	9.4	21.9
Other	7.5	29.4
Educational programs	5.6	35.0
Housing options/services	5.6	40.6
Prescription expense assistance	5.6	46.3
Transportation assistance	5.6	51.9
Comprehensive services	4.4	56.3
Emergency financial assistance	4.4	60.6
Home delivered meals	3.8	64.4
Leisure/recreational	3.8	68.1
Homemaker services	3.1	71.3
Volunteer services	3.1	74.4
Home repairs	2.5	76.9
Information/referral	2.5	79.4
Sitter/companion service	2.5	81.9
Wellness program	2.5	84.4
Advocacy assistance	1.9	86.3
Alzheimer support	1.9	88.1
Geriatric assessment	1.9	90.0
Case management	1.3	91.3
Elder abuse/neglect prevention	1.3	92.5
Employment services	1.3	93.8
Financial counseling	1.3	95.0
Food stamps	1.3	96.3
Health insurance counseling	1.3	97.5
Clothing	0.6	98.1
Friendly visiting	0.6	98.8
Grocery shopping/delivery	0.6	99.4
Income security	0.6	100.0
Lawn care	0.0	100.0
Legal services	0.0	100.0
Medicaid waiver	0.0	100.0

N=160; multiple selections possible

Table 16. Distribution of Greatest Future Service Challenge

Greatest Future Service Challenge	% Respondents	Cumulative %
Funding	46.7	46.7
Lack of staff	10.7	57.4
Aging population	9.8	67.2
Rising health care costs/health reform	8.2	75.4
Economy/economic outlook	5.7	81.1
Lack of affordable in-home services	4.9	86.1
Lack of housing	4.1	90.2
Lack of information/education	3.3	93.4
Income security	2.5	95.9
Lack of transportation	1.6	97.5
Lack of services in area	1.6	99.2
Prescription drug cost/management	0.8	100.0
Physical limitations	0.0	100.0

N=122; multiple selections possible

Table 17. Distribution of Reason for Greatest Future Service Needs

Reason for Greatest Future Service Need	% Respondents	Cumulative %
Rising health care costs/health reform	21.6	21.6
Income security needs of clients	13.5	35.1
Funding	10.8	45.9
Lack of affordable home services	9.0	55.0
Aging population	8.1	63.1
Lack of housing	7.2	70.3
Lack of transportation	6.3	76.6
Lack of education/information	5.4	82.0
Economy/economic outlook	4.5	86.5
Prescription cost/management	3.6	90.1
Physical limitations	3.6	93.7
Lack of services in area	2.7	96.4
Lack of staff	2.7	99.1
Government regulation	0.9	100.0

N= 111; multiple selections possible

Fig. 1

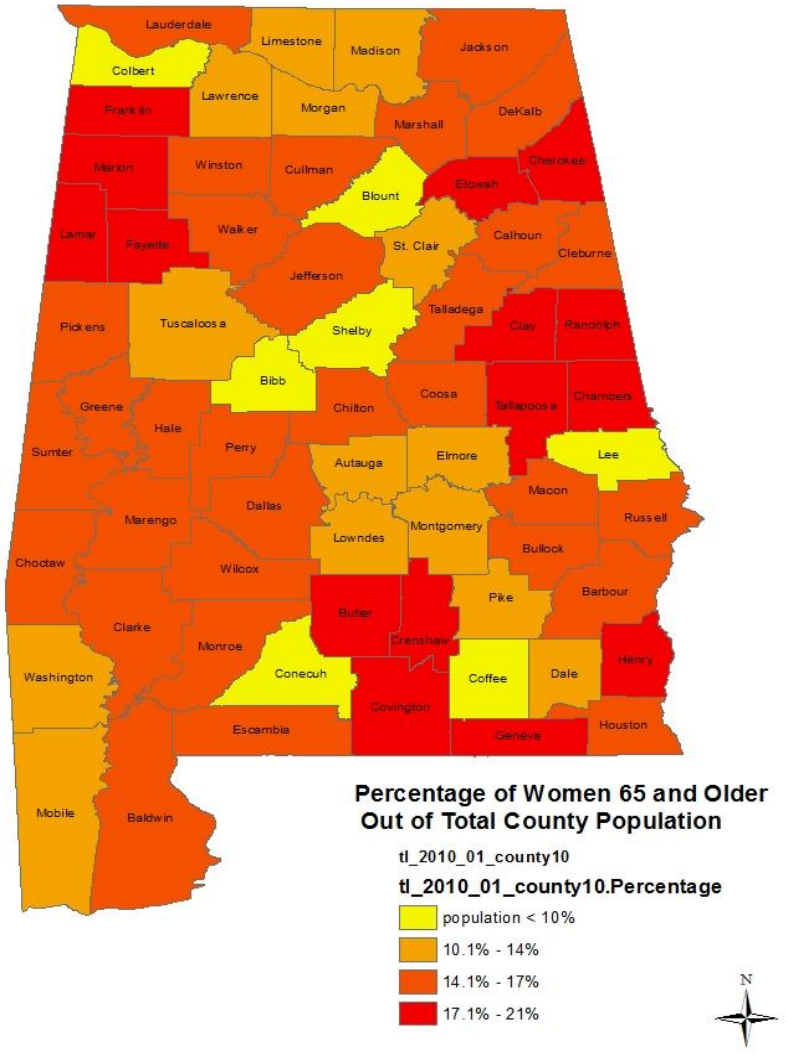

Lauderdale
Limestone
Madison
Jackson
Colbert
Lawrence
Morgan
Marshall
DeKalb
Franklin
Marion
Winston
Cullman
Blount
Etowah
Cherokee
Lamar
Fayette
Walker
St. Clair
Calhoun
Cleburne
Jefferson
Pickens
Tuscaloosa
Shelby
Talladega
Clay
Randolph
Bibb
Coosa
Tallapoosa
Chambers
Greene
Hale
Chilton
Sumter
Perry
Autauga
Elmore
Lee
Macon
Dallas
Russell
Marengo
Montgomery
Lowndes
Bullock
Choctaw
Wilcox
Barbour
Pike
Butler
Clarke
Crenshaw
Monroe
Henry
Washington
Conecuh
Coffee
Dale
Covington
Escambia
Geneva
Houston
Mobile
Baldwin
Percentage of Women 65 and Older
Out of Total County Population
tl_2010_01_county10
tl_2010_01_county10.Percentage
population < 10%
10.1% - 14%
14.1% - 17%
17.1% - 21%
N

Fig. 2

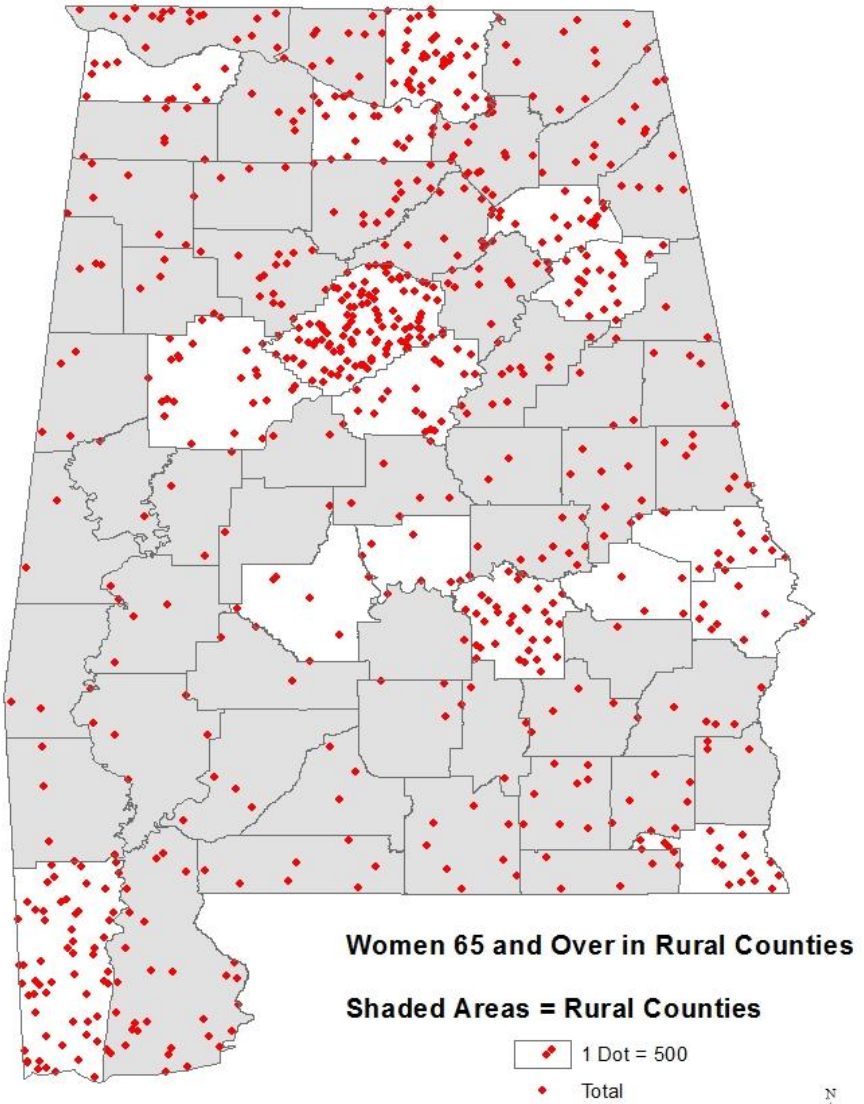

Women 65 and Over in Rural Counties
Shaded Areas = Rural Counties
1 Dot = 500
Total
N

Fig. 3

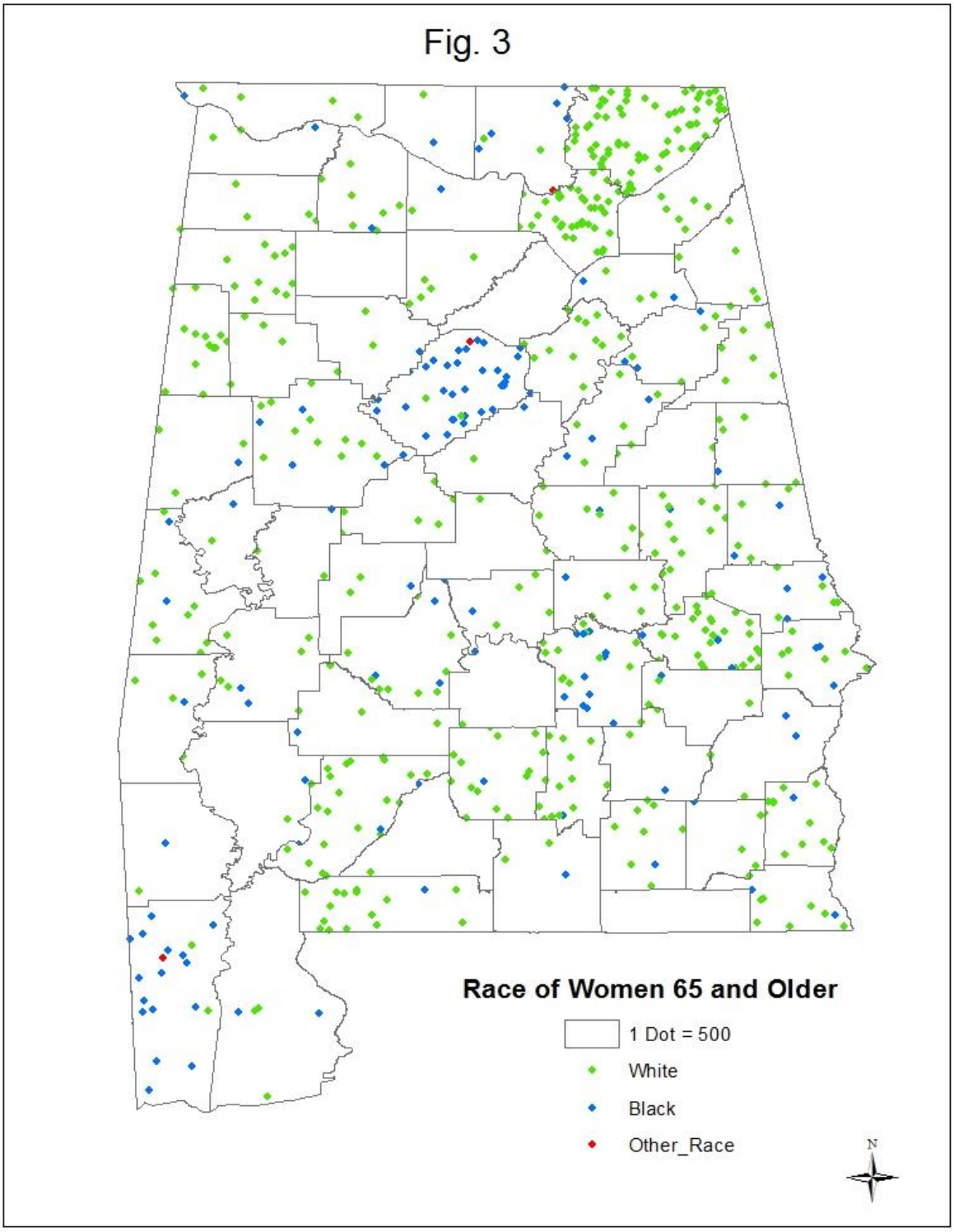


Fig. 4

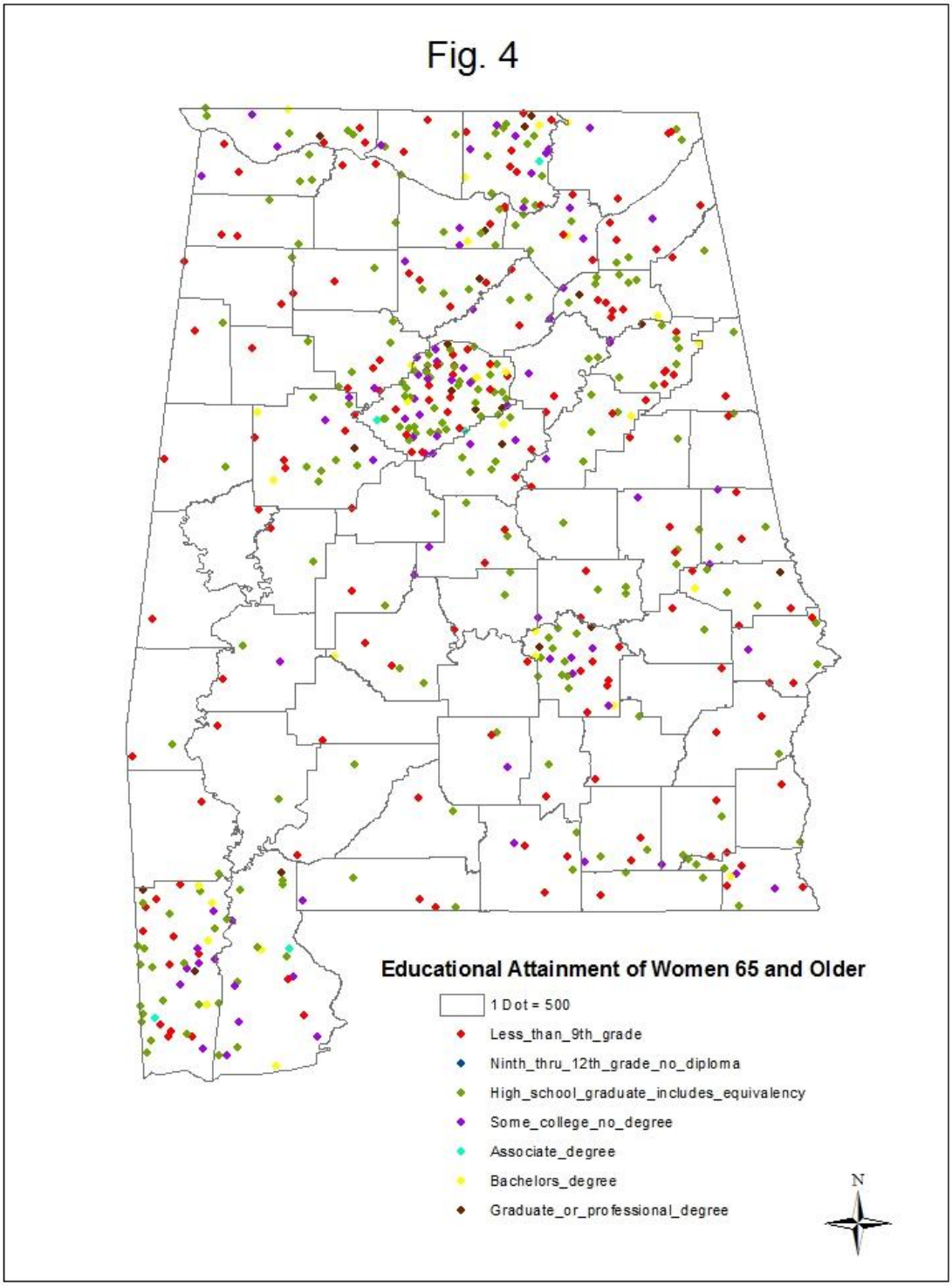

Educational Attainment of Women 65 and Older
1 Dot = 500
Less_than_9th_grade
Ninth_thru_12th_grade_no_diploma
High_school_graduate_includes_equivalency
Some_college_no_degree
Associate_degree
Bachelors_degree
Graduate_or_professional_degree
N

Fig. 5

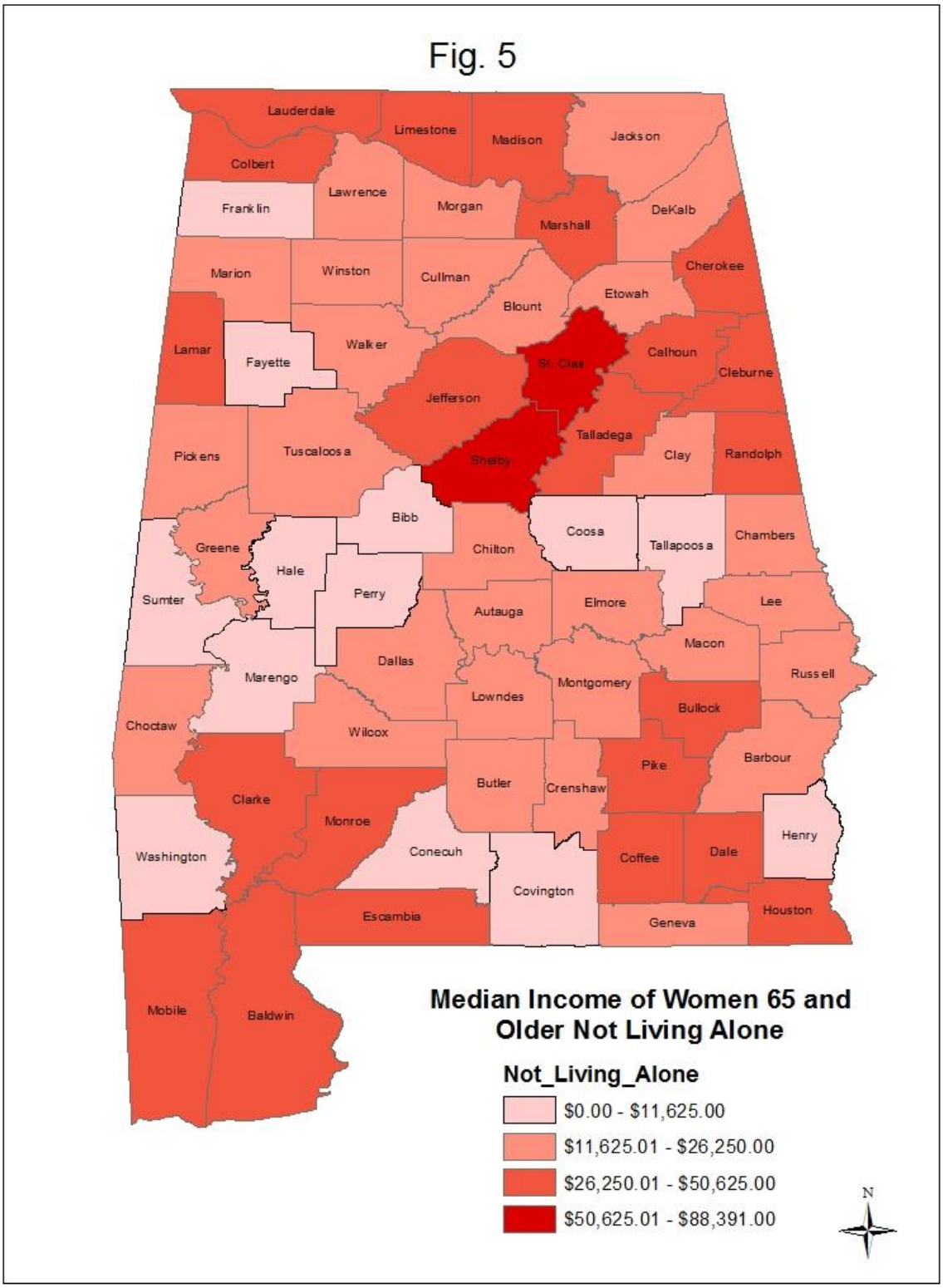

Lauderdale
Limestone
Madison
Jackson
Colbert
Franklin
Lawrence
Morgan
Marshall
DeKalb
Marion
Winston
Cullman
Blount
Etowah
Cherokee
Lamar
Fayette
Walker
St. Clair
Calhoun
Cleburne
Jefferson
Talladega
Pickens
Tuscaloosa
Shelby
Clay
Randolph
Bibb
Coosa
Tallapoosa
Chambers
Greene
Hale
Chilton
Sumter
Perry
Autauga
Elmore
Lee
Macon
Dallas
Russell
Marengo
Montgomery
Lowndes
Bullock
Choctaw
Wilcox
Barbour
Pike
Butler
Crenshaw
Clarke
Monroe
Henry
Washington
Conecuh
Coffee
Dale
Covington
Escambia
Geneva
Houston
Mobile
Baldwin
Median Income of Women 65 and Older Not Living Alone
Not_Living_Alone
$0.00 - $11,625.00
$11,625.01 - $26,250.00
$26,250.01 - $50,625.00
$50,625.01 - $88,391.00
N

Fig. 6

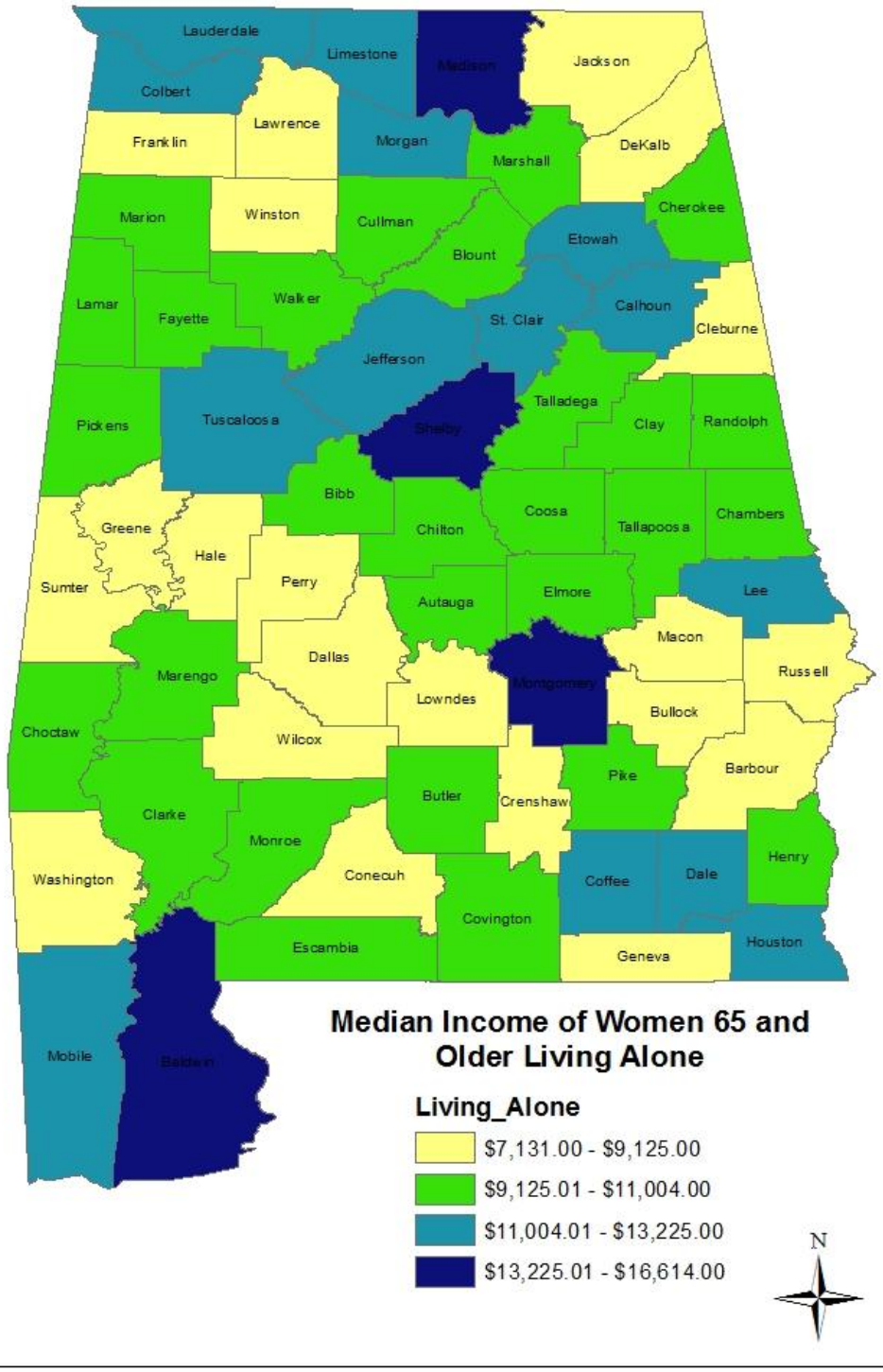

Lauderdale
Limestone
Madison
Jackson
Colbert
Lawrence
Franklin
Morgan
Marshall
DeKalb
Marion
Winston
Cullman
Cherokee
Etowah
Blount
Lamar
Fayette
Walker
St. Clair
Calhoun
Cleburne
Jefferson
Pickens
Tuscaloosa
Shelby
Talladega
Clay
Randolph
Bibb
Greene
Chilton
Coosa
Tallapoosa
Chambers
Hale
Sumter
Perry
Autauga
Elmore
Lee
Macon
Dallas
Marengo
Montgomery
Russell
Lowndes
Choctaw
Bullock
Wilcox
Barbour
Butler
Crenshaw
Pike
Clarke
Monroe
Henry
Washington
Conecuh
Coffee
Dale
Covington
Escambia
Houston
Geneva
Mobile
Baldwin
Median Income of Women 65 and Older Living Alone
Living_Alone
$7,131.00 - $9,125.00
$9,125.01 - $11,004.00
$11,004.01 - $13,225.00
$13,225.01 - $16,614.00
N

Figure 7. Facility Pictures

2200 Drake Ave. SW, Huntsville, AL 35805

Huntsville Art Room

Huntsville Workout Room

The Madison Village ALF

6016 Wall Triana Hwy, Madison, AL 35757

Dumas Wesley SAIL Center

126 Mobile Street, Mobile, AL 36695

Mobile Regional Senior Community

3201 Hillcrest Road, Mobile, AL 36695

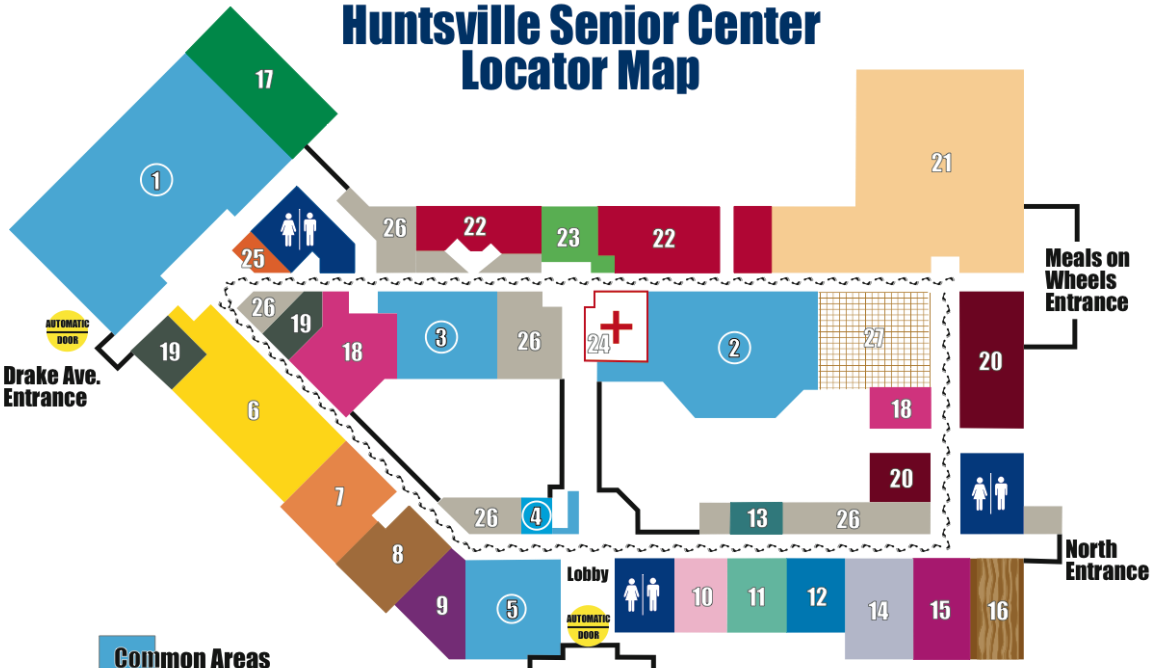
Normandale/St. Paul Senior Center

706 E. Patton Avenue, Montgomery, AL 36111

Gillespie Senior Center

332 Doster Road, Prattville, AL 36067

Huntsville Senior Center Locator Map



Common Areas

1. Twickenham Ballroom / Auditorium
2. Cortyard Cafe / Cafeteria
3. Merrimack Class Room
4. Front Desk / Library
5. Gift Shop

6. Studio 60
7. Ceramics
8. Pottery
9. China Painting
10. Weaving
11. Sewing/Quilting
12. Chair Caning
13. Stained Glass
14. Painting
15. Lapidary
16. Wood Working
17. Billiards
18. Card&Game Rooms
19. Computer Labs

Walking Path
8 times around=1 Mile

20. Meals on Wheels / M.O.W Office
21. Adult Day Health
22. Administrative Offices
23. Conference Room
24. Health Room / Nurses
25. Snack Shop
26. Offices/Storage
27. Kitchen

Huntsville-Madison County Senior Center, Inc. . 2200 Drake Avenue . Huntsville, Al 35805 . www.seniorview.com

Figure 8. Staff Positions with Licensure and/or Certification

Assisted Living Administrator
Certified Home Care Aide
Certified Companion Aide
Certified Credit Counselor
Certified Dietary Manager
Certified Food and Sanitation Program
Certified Nursing Assistant
Certified Thanatologist
Licensed Healthcare Administrator
Licensed Marriage and Family Therapist
Licensed Nurse Practitioner
Licensed Practical Nurse
Licensed Professional Counselor
Licensed Respiratory Therapist
Licensed Social Worker (LBSW, LGSW, LCSW)
Medical Laboratory Technologist
Medical Social Worker
Nurse certification in hospice and palliative care
Nursing Home Administrator
Occupational Therapist
Physical Therapist
Physician (MD, DO)
Registered Dietician
Registered Imaging/Radiology Technologist
Speech Language Pathologist
Teacher certification

N=52; multiple selections possible

Figure 9. Accreditation Relationships

Alabama Association on Aging
Alabama Department of Mental Health
Alabama Department of Public Health
Alabama Department of Senior Services
Alabama Department of Transportation
American Diabetes Association
Area Agency on Aging
Center for Medicaid and Medicare Services (US DHHS)
Housing and Urban Development (US DHUD)
Local government
Corporation for National and Community Service
Council on Accreditation for Family and Children
Council on Quality and Leadership
Joint Commission
Regional Councils on Aging
South Alabama Planning and Development Commission
United Way

N=39; multiple selections possible

Figure 10. Program Evaluation Methods

Number of clients served
Number of dollars spent per person
Client feedback through case notes and client surveys
Demographic information about clients served
Periodic reports and newsletters to governing bodies such as board of directors
Feedback from advisory boards
Caregiver evaluations
Accreditation programs
Internal quality assurance programs including monthly quality audits
Benchmarking in connection with national professional organization
Thank you notes and other feedback from clients and client families
Recommendations from clients to others about services and programs

N=64

Figure 11. Umbrella Organization Relationships

Alabama Association of Nonprofits
Alabama Department of Postsecondary Education/Adult Education
Alabama Department of Senior Services
Alabama Department of Veterans Affairs
Alabama Nursing Home Association
Alabama Regional Councils on Aging
Assisted Living Association
Catholic Charities USA
Children's Hospital of Alabama
Corporate offices of private business
Corporation for National and Community Service
Councils of Local Government
County-level Health Care Authorities
County Commissions
Food Nutrition Center
Hands On Network
HUD Neighborhood Network
Lifelines Counseling Services
Salvation Army Divisional and Territorial Offices
SEAN Tracker (resource for charitable organizations)
Senior Corp
Quality of Life Health Services
United Way
United Methodist Center for Senior Citizens

N=27; multiple selections per possible

Appendix A: Federal and State Programs in Alabama

Programs	
Federal	
	Alabama Cares
	Engaging Aging: Senior Community Service Employment Program
	Legal Assistance
	Long-term Care Ombudsman
	Nutrition: Congregate and Home-Delivered Meals
	Senior Medicare Patrol
	State Health Insurance Assistance Program
	Medicaid Elderly and Disabled Waiver and Personal Choices
State	Constituent Services
	Disaster Assistance
	Elder Abuse Awareness Day Rally
	Hall of Fame
	Masters Games of Alabama
	Ms. Senior Alabama
	SenioRx Prescription Assistance Program
	United We Ride
	Wellness Program

Source: Alabama Department of Senior Services 2009.

Bibliography

Aday, Ronald, Gayle Kehoe, and Lori Farney. 2006. "Impact of Senior Center Friendships on Aging Women Who Live Alone." *Journal of Women and Aging.* 18: 57-65.

Administration on Aging. 2001. *National Center on Elder Abuse*. http://www.ncea.aoa.gov/NCEAroot/Main_Site/FAQ/Nursing_Home_Abuse/Reports_Studies.aspx (accessed January 23, 2011).

Agranoff, Robert. 2007. *Managing Within Networks: Adding Value to Public Organizations*. Washington, DC: Georgetown University Press.

Agranoff, Robert. and Michael McGuire. 2003. *Collaborative Public Management: New Strategies for Local Governments.* Washington DC: Georgetown University Press.

Alabama Department of Human Resources. 2010. *Elder Abuse FAQs.* 2010. http://www.dhr.alabama.gov/page.asp?pageid=286 (accessed January 23, 2011).

Alabama Department of Public Health. 2011. *Alabama's Health, 2011 Annual Report*. Montgomery, AL: State of Alabama Department of Public Health.

Alabama Department of Senior Services. 2009. *Aging in Alabama: Living Today for a Better Tomorrow*. *Fiscal Year 2009 Annual Report*. Montgomery, AL: State of Alabama Department of Senior Services.

Albright, Ada, Bonnie Brandl, Julie Rozwadowski, and Mary K. Wall. 2004. *Building a Coalition to Address Domestic Abuse in Later Life.* Washington, DC: National Clearinghouse on Abuse in Later Life and AARP Foundation National Legal Training Project.

All, Anita. "The Mistreatment of Elderly People. 1998."*Journal of Women and Aging* 10: 97.

American Bar Association. 2009. *BIFOCAL*. July 2009. Chicago, IL: American Bar Association.

Anthony, Elizabeth K., Amanda J. Lehning, Michael J. Austin, and Michael D. Peck. 2009. "Assessing Elder Mistreatment: Instrument Development and Implications for Adult Protective Services." *Journal of Gerontological Social Work.* 52 (8): 815-836.

Baker, David. 2006. "The Meaning and the Measure of Health Literacy." *Journal of General Internal Medicine.* 55:878-883.

Baldi, Renee. 1997. "Training Older Adults to Use the Computer: Issues Related to the Workplace, Attitudes, and Training." *Educational Gerontology.* 23:453-465.

Barker, David, Michael Wolfe, Joseph Feinglass, Jason Thompson, Julie Gazmararian, and Jenny Huang. 2007. "Health Literacy and Mortality Among Elderly Persons." *Archives of Internal Medicine.* 16:1502-1509.

Brown, Mitchell. 2008. "Improving Organizational Capacity among Faith- and Community-based Domestic Violence Service Providers." *In Innovation in Effective Compassion*. Washington, DC: DHHS.

Butrica, Barbara, Richard Johnson, and Sheila Zedlewski. 2007. "Volunteer Transitions among Older Americans." *The Retirement Project.* Washington, DC: The Urban Institute.

Cardenas, David, Karla Henderson, and Beth Wilson. 2009. "Experiences of Participation in Senior Games Among Older Adults." *Journal of Liesure Research.* 41 : 41-56.

Carstensen, Laura, and William Fremouw. 1988. "The Influence of Anxiety and Mental Status on Social Isolation Among the Elderly Nursing Homes." *Behavioral Residential Treatment.* 3:197-208.

Chambre, Susan Maizel. 1984. "Is Volunteering A Substitute for Role Loss in Old Age? An Empirical Test of Activity Theory." *The Gerontologist.* 24:18-39.

Chaskin, Robert J., Prudence Brown, Sudhir Venkatesh, and Avis Vidal. 2001. *Building Community Capacity.* Aldine de Gruyter: New York.

Cho, Young, Shoou-Yih Lee, Ahsan Arozullah, and Kathaleen Crittenden. 2008. "Effects of Health Literacy on Health Status and Health Service Utilization Amongst the Elderly." *Social Science and Medicine.* 66 : 1809-1816.

Dabelko-Schoeny, Holly, and Shawn King. 2010. "In Their Own Words: Participants' Perceptions of the Impact of Adult Day Services." *Journal of Gerontological Social Work.* 53:176-192.

Duggleby, Wendy, Badia Abdullah, and Joan Bateman. 2004. "Persevering: The Experience of Well Elderly Women Overcoming the Barriers to the U.S. Health Care System." *Journal of Women & Aging.* 56:119-132

Federal Interagency Forum on Aging Related Statistics. 2006. *Older American Update.* http://agingstats.gov.

Foundation for Health and Aging. 2005. *Health Assessment.* http://www.healthinaging.org/aginginthеknow/chapters_ch_trial.asp?ch=8 (accessed Janary 21, 2011).

Foote, Janet, Anna Giuliano, and Robin Harris. 2000. "Older Adults Need Guidance to Meet Nutritional Recommendations." *Journal of the American College of Nutrition.* 55: 628–640.

Gatto, Susan, and Sunghee Tak. 2008. "Computer, Internet, and E-Mail Use Among Older Adults: Benefits and Barriers." *Educational Gerontology* 34:800–811.

Glass, J. Conrad, and Beverly Kilpatrick. 1998. "Gender Comparison of Baby Boomers and Financial Preparation for Retirement." *Educational Gerontology.* 45: 719–745.

Golant, Stephen. 2006. "Supportive Housing for Frail, Low-Income Older Adults: Identifying Need and Allocating Resources." *Supportive Housing for an Aging Society*. 34: 37-43.

Hale, Kathleen. 2011. *How Information Matters: Networks and Public Policy Innovation.* Washington, DC: Georgetown University Press.

Hale, Kathleen and McNeal, Ramona. 2011. "E-Government Dreams Deferred? Online Experiences, Citizen Engagement, and Trust in Government." Paper Presented at the Annual Meeting of the Southern Political Science Association, New Orleans, LA, January 6-9, 2011.

He, Wan, Manisha Sangupta, Victoria Velkoff, and Kimberly DeBarros. 2005. *65+ in the United States:2005.* Washington, DC: National Institute on Aging and U.S. Bureau of the Census.

Into, Frances. 2003. "Older Women and Financial Management: Strategies for Maintaining Independence." *Educational Gerontology.* 29 : 825–839.

Iosifesco, Alice, Ethan Halm, Thomas McGinn, Albert Siu, and Alex Federman. 2008. "Beliefs About Geriatric Drugs Among Elderly Adults in Hospital-based Primary Care Pratices." *Patient Education and Counseling.* 73 : 377-383.

Ivery, Jan, Deborah Akstein-Kahan, and Kathleen Murphy. 2010. NORC Supportive Services Model Implementation and Community Capacity. *Journal of Gerontological Social Work.* 53 (1): 21-42.

Jacobs-Lawson, Joy, Mitzi Schumacher, and Alicia Webb. 2007. "'Gender Differences in Predictors of Late-Life Health Insurance Knowledge." *Journal of Women & Aging*. 21:121 - 136.

Kaiser Family Foundation. 2001. "Women and Medicare." *The Medicare Program*. Menlo Park, CA: Henry J. Kaiser Family Foundation.

Kayser-Jones, Jeanie. 2000. "Advocacy for The Mentally Impaired Elderly: A Case Study Analysis." *American Journal of Law & Medicine.* 16 (4): 354-376.

Lagana, Luciana. 2008. "Enhancing the Attitudes and Self-Efficacy of Older Adults Toward Computers and the Internet: Results of a Pilot Study." *Educational Gerontology.* 34: 831–843.

Libson, Nancy. 2006. "The Sad State of Affordable Housing for Older People." *Supportive Housing for an Aging Society*. Winter : 45-58.

McNeal, Ramona., Kathleen Hale, and Lisa Dotterweich. 2008. "Citizen-Government Interaction and the Internet: Expectations and Accomplishments in Contact, Quality, and Trust." *Journal of Information Technology & Politics.* 5 (2): 213-229.

Mossberger, Karen, Caroline J. Tolbert, and Mary Stansbury. 2003.*Virtual Inequality: Beyond the Digital Divide.* Washington, DC: Georgetown University Press.

Mulroy, Elizabeth A. 2003. Community as a Factor in Implementing Interorganizational Partnerships: Issues, Constraints, and Adaptations. *Nonprofit Management and Leadership.* 14 (1): 47-67.

O'Shaughnessy, Carol. 2002. *Older Americans Act Nutrition Program.* Report, CRS Report for Congress, D.C.: The Library of Congress. .

Phelps, Neal. 1997. "Our Seniors." *Journal of Educational Sociology.* 31: 117-123.

Provan, Keith, and Brinton Milward. 2001. "Do Networks Really Work? A Framework for Evaluating Public Sector Organizational Networks." *Public Administration Review.* 61: 414-423.

Rosenthal, Rita. 2008. "Older Computer-Literate Women: Their Motivations, Obstacles, and Paths to Success." *Educational Gerontology.* 34:610–626.

Saunders, Edward. 2004. "Maximizing Computer Use Among Elderly in Rural Senior Centers." *Educational Gerontology*. 30:573-585.

Sharkey, Joseph. 2003. "Risk and Presence of Food Insufficiency Are Associated with Low Nutrient Intakes and Multimorbidity among Homebound Older Women Who Receive Home-Delivered Meals." *The Journal of Nutrition*. 68:3485-3492.

Smith, Stanley, Stefan Rayer, and Eleanor Smith. 2008. "Aging and Disability:Implications for the Housing Industry and Housing Policy in the United States." *Journal of the American Planning Association*. 88:289-306.

Sobell, Linda Carter, and Mark B. Sobell. 1992. "Timeline Follow-back: A Technique for Assessing Self-reported Alcohol Consumption." In Raye Z. Litten and John P. Allen (eds.), *Measuring Alcohol Consumption*: *Psychosocial and Biological Methods.* New Jersey: Humana Press.

Sorkin, Dara, and Karin Rook. 2002. "Loneliness, Lack of Emotional Support, and the Likelihood of Having a Heart Condition." *Annals of Behovorial Medicine*. 290-298.

Tiamiyu, Mojisola F., and Lisa Bailey. 2001. "Human Services for the Elderly and the Role of the University-Community Collaboration: Perceptions of Human Service Agency Workers." *Educational Gerontology.* 27:479-492.

U.S. Census Bureau. 2009. *Statistical Abstract of the United States 2009*. Washington, DC: Government Printing Office.

United States Department of Labor. 2010. *Alabama at A Glance.* http://www.bls.gov/ (accessed January 20, 2010).

Volunteering in Alabama. 2009. http://www.volunteeringinamerica.gov/AL (accessed January 23, 2011).

Ward, Gillian, Carol Jagger, and William Harper. 1998. "A Review of Instrumental ADL Assessments for Use with Elderly People." *Reviews in Clinical Gerontology*. 66: 65-71.

Yaffe, Kristine. 2001. "A Prospective Study of Physical Activity and Cognition Decline in Elderly Women." *Archive of Interal Medicine.* 161: 1703-1708.

Author Biography & Contact Information

Mitchell Brown, PhD
Associate Professor
Department of Political Science
Auburn University
7080 Haley Center
Auburn, AL 36849
334-844-6170
brown11@auburn.edu

Mitchell Brown, Ph.D., is an Associate Professor in the Department of Political Science at Auburn University and Research Director for the Institute for Community Peace in Washington, DC. Her broader research agenda focuses on the empowerment efforts of marginalized communities, particularly those efforts enacted through organizations. From 2006-2009 she served as co-Principal Investigator of the evaluation of the Rural Domestic Violence and Child Victimization Enforcement Grant Program Special Initiative: Faith-based and Community Organization Pilot Program, a program of the Office of Violence Against Women (OVW) at the Department of Justice (DOJ) through her role as Research Director at the Institute for Community Peace (ICP).

Kathleen Hale, PhD, JD
Associate Professor
Department of Political Science
Auburn University
7080 Haley Center
Auburn, AL 36849
334-844-6145
halekat@auburn.edu

Dr. Kathleen Hale is an Associate Professor in the Department of Political Science at Auburn University where she teaches in graduate and undergraduate programs. Kathleen studies relationships between government and nonprofit organizations around the concepts of public policy innovation, governance, and capacity building. In addition to this project, her work includes studies of contemporary innovations in election administration, e-government, electronic information policy, and criminal justice reform. Her work has been published in *Public Administration Review, Policy Studies Journal, Journal of Information Technology & Politics,* and *Government Information Quarterly.* Her recent book is titled *How Information Matters: Networks and Public Policy Innovation* (Georgetown Press 2011).