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Deborah Grande
The Hilltown Elder Network:
A Study in Service to Elders

ABSTRACT

This study assessed the value and efficacy of in-home services offered by The Hilltown Elder Network (HEN). Pre-existing data first obtained through an annual “Client Satisfaction Survey” issued by HEN administration to HEN clients during FY 2010 was examined. Of the 100 surveys mailed, sixty-nine program participants between the ages of 62 and 95 years, the median age being 84, responded. The agency-designed mixed methods survey functioned to solicit program input, to gauge participant satisfaction and also operated as a tool to gather necessary data for program funding. The objective of the HEN Program was to help seniors to remain living safely and independently in their homes for as long as they wish to and are able. Quantitative and qualitative analysis of the data indicated overall satisfaction among service participants and that the in-home services enhanced participants' overall sense of safety, well-being and independence. The findings suggest that the need and desire for non-medical, client centered in-home services persists and that effective provision of the services is possible.

THE HILLTOWN ELDER NETWORK: A STUDY IN SERVICE TO ELDERS

A project based upon an investigation at the Hilltown Community Development Center, Chesterfield, MA, submitted in partial fulfillment of the requirements for the degree of Master of Social Work.

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2011

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To my teachers

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CHAPTER I

INTRODUCTION

Any form of elder social support, whether facilitated by family, community or the government, will ideally address the specific needs of the older person as well as respect that person's inherent need to maintain dignity and independence. At present, social service programs for older adults face tremendous financial constraints, as do the increasing number of older adults and families in need of the services. Given this situation, it is imperative that existing social services be effective and of good quality, regardless of limited resources. Supports that are client-centered and where satisfaction matters may therefore be most efficacious.

The purpose of this study is to explore the value and efficacy of one social service program from the perspectives of its service recipients. The Hilltown Elder Network, also known as "HEN," is a community program that for the past 16 years has served the need for local homecare service-delivery that supports elder self-sufficiency throughout the rural hill towns of western Massachusetts. The goal of this client-centered program is to assist people in living independently for as long as they want to and are able (Hayes, C. 2010).

The current, anticipated and unprecedented rate of aging and longevity in the United States and throughout the world is well documented (Kinsella & He, 2009). Less evident is a consensus about how to manage the potentially increasing volume of need as a result of current aging and longevity trends. With age, the likelihood of chronic health impairment increases and this may challenge people's ability to remain living independently in their homes (Lehning &

Austin, 2010; Rowan, Faul, Birkenmaier, & Damron-Rodriquez, 2011). Increasingly, homecare that supports an “aging- friendly” home has become an essential aspect of long-term care, especially as the trend toward “aging in place” has become a prioritized value.

This mixed methods descriptive study presents and evaluates data obtained by an annual survey issued by HEN administration to HEN clients during 2010. The focal point of the survey was to gather data on client satisfaction and to gauge whether results aligned with the main goal of the program, which is to support safe and independent living.

Although this study is not a comprehensive program evaluation, client satisfaction has long been an important part of program evaluation and is generally accepted as an important indicator of care or service quality (Hsieh & Essex, 2006, p.1009). The intent of this project is to share one community's established effort to serve their elders. The findings of this study may reveal a proven and effective model of elder homecare service-delivery that other community development centers may find helpful.

CHAPTER II

LITERATURE REVIEW

The purpose of this study is to explore the value and efficacy of homecare services provided by Hilltown Elder Network (HEN). With an aim toward offering quality and helpful services that support elder independence, a client satisfaction survey is issued each fiscal year (FY) to determine if program goals are being met from the perspective of program participants. Additionally, results and information gathered from the survey support applications for state and private funding which are necessary for the programs continued operation. HEN is a local social-service program established by The Hilltown Community Development Center (HCDC) located in the rural hilltowns of western Massachusetts. The HEN program is not connected with more well known elder social-service programs or agencies, such as those federally mandated to operate through “the aging network.”

This chapter will review the literature related to aging and longevity in the context of long-term care. It is widely recognized that older adults want to remain in their own homes as long as possible (Angel & Angel, 1997; Rowan et al., 2011). Angel & Angel (1997) also point out, "The vast majority of such individuals do not need institutionalization, nor do they necessarily need a great deal of help" (p. 136). Gonyea (2005) expands on this idea, relating that "although the presence of chronic illness and disabilities is positively correlated with age, aging does not equal disability" (p. 174). But for families, who provide the majority of long-term care, increased longevity often means, "...extended years of caring for community-residing older relatives with chronic illness or disability" (Hooyman, 2006, p. xxxv). The extent of informal

network responsibilities, such as those provided by friends and family, may be tempered by formal services, such as home and community-based care. However, the growing number of persons over 85, a time when the need for in-home help may increase, puts a demand on formal services that outweighs the supply.

The first section of this chapter will address demographics of the aging population, including the phenomenon of longevity. Next, the concept of age will be discussed and the life course perspective presented, followed by an overview of health and functional status. The third section of the literature review is devoted to home, community and long-term care, including a look at policy and long-term care wherein The Older Americans Act and the evolving world of home and community-based services are discussed. The final section will address aspects of rural living and service delivery followed by a detailed description the Hilltown Elder Network.

The Aging Population

Demographics

Between 2010 and 2050, the total U.S. population is projected to grow from 310 million to 439 million, an increase of 42 percent. As a result,

The nation will also become more racially and ethnically diverse, with the aggregate minority population projected to become the majority in 2042. The population is also expected to become much older, with nearly one in five U.S. residents aged 65 and older in 2030 (Vincent & Velcoff, 2010, p.1).

Between 2010 and 2030 the number of people living in the U.S. aged 65 and over will grow from an estimated 40 million in 2010 to 72.1 million in 2030 (U.S. Department of Health and Human Services (HHS), 2010, page 2). In 2050, the number of Americans aged 65 and older is projected to be 88.5 million, more than double its projected population of 2010. Female

life expectancy continues to exceed male life expectancy and this trend is projected to persist over the next four decades. However, the gap between the number of women and men is expected to narrow due to projection of rapid increase of life expectancy for men (Vincent & Velcoff, 2010, p. 8).

Accounting largely for age structure trends is the "baby boomer" generation, those born between the years 1946-1964. This development, as discussed by Kinsella & He (2009) "...is primarily the result of high fertility levels after World War II and secondarily, but increasingly, the result of reduced death rates at older ages" (p. 13). By 2030, all baby boomers will have celebrated their 65th birthday, constituting an anticipated 20% of the total U.S. population (HHS, 2010). The baby boom generation is also expected to increase the population of rural America through 2020, as previous migration patterns indicate "...an affinity for moving to rural and small-town destinations than older or younger cohorts" (Cromartie & Nelson, 2009).

The fastest growing segment of the aging population is those aged 85 and older (Kinsella & He, 2009; Piercy, 2010; Rogers, 1999). The 85 plus population is projected to increase from 5.7 million in 2010 (a 36% increase from 2000) to 6.6 million in 2020 (a 15% increase for that decade). The 85 plus population now forms 13% of the older population and this is projected to increase by 500% by 2050 (Hooyman, 2008), which translates to an expected 21% of the over 65 population (Vincent & Velkoff, 2010, p.4). Gender differences among the 85 and over population are, as referred to by Gonyea (2005), "striking," given the ratio of approximately 4 men for every 10 women (p. 160).

In 1900, persons aged 100 or more numbered 37, 306. In 2009 persons aged 100 or more numbered 64, 024 (HHS, 2010). By the year 2025, one in 26 Americans can expect to live to be 100 years as compared with the year 2000 life expectancy statistic of 1 in 500 (Hooyman, 2008).

The current 72% increase of Centurions combined with the demographic trend of the baby boomers and the oldest old are indicative of increased life expectancy, "...a social phenomenon without historical precedence" (Kinsella & He, 2009, p. 14).

Life Expectancy

Life expectancy, the average length of time that one can expect to live based on the year born (Hooyman, 2006, xxxii), "...is among the most basic measures of a population's health" (Clarke et al., 2010 p. 1373), and as such correlates with improved medical care and eradication of diseases at early ages (Hooyman, 2006, xxxiii). In addition, public health initiatives and population-based interventions such as improved sanitation and immunization also contribute profoundly to decline of early death rates (Greene, Cohen, Galambos & Kropf, 2007). The phenomenon of longevity involves living longer and healthier lives (Green et al., 2007). However, it is largely recognized that health status later in life is significantly affected by and a reflection of one's particular life course experiences (Angel & Angel, 1997).

Age, Aging and the Life Course

When Buddha was still Prince Siddhartha he often escaped from the splendid palace in which his father kept him shut up and drove about the countryside. The first time he went out he saw a tottering, wrinkled, toothless, white-haired man, bowed, mumbling and trembling as he propped himself along his stick. The sight astonished the prince and the charioteer told him just what it meant to be old (Beauvoir, 1976, p. 7).

At first glance, aging may be regarded solely as a biological phenomenon. Yet to speak of aging is to talk about a multi-faceted experience that we are both subject to and a subject of. Chronological age, for example, is relative in that it varies by culture and social class (Hooyman, 2006). Chronological age, it is discussed, is now hardly useful in the United States other than a

marker for social norms and constructs such as criteria determinants for retirement and receiving age-related benefits such as Social Security and Medicare (Greene, 2000, p. 58, Piercy, 2010, p.3). So what is age and what does it mean to be old?

The cause and effect of all age related processes are not limited to the biological impacts of aging, but are also a result of the psychological as well as social aspects of aging. The field of gerontology has contemplated this idea for at least the past 40 years. In reference to gerontologist J. E. Birren (1969), Greene (2000) writes, "His interest in age-associated changes and their effect on a person's capacity to cope effectively with his or her living conditions led to his description of three kinds of aging: biological, psychological, and social" (p. 58). Greene (2000) describes this as the near beginning of "...how to appraise an individual's level of functioning in a given environment relative to others of the same chronological age" (p. 58). The idea that a person's chronological age is not a sufficient measure relevant to one's personal aging experience is a belief rooted in years of gerontological as well as social science research. Or as Elder (2002), said:

Today we believe that the "lived experiences of people in contexts" are essential for understanding their pattern of aging. But this was not always so (p. 1).

The Life Course Perspective

Introduced by sociologist Leonard Cain in his 1964 paper, *Life-Course and Social Structure*, a life-course perspective was assessed as "...a feature of both individuals and social structure" and thus anticipated elaboration of the life course as a major basis of social organization" (Dannafer & Settersten, 2010, p. 4). This sociologically inspired theory of "age as property" of both social systems and individuals also described as "life course as a social institution" evolved in Europe and the United States and was met with its psychologically

grounded counterpart, life-span development. Both disciplines were further guided by a new methodological paradigm and standard for how to approach research on aging, cohort analysis, which emphasizes variances between biology and timing (Dannafer & Settersten, 2010)

The relationship between the life course, age and ageing processes is conveyed in the work of Neugarten & Hagestad (1976):

The life course is usually viewed as a progression of orderly changes from infancy through old age, with both biological and sociocultural timetables governing the sequences of change. It is often pointed out that a multi-dimensional approach is needed in studying time-related patterns; that social, biological, and psychological age should be separately measured; and that chronological age is a poor index of any of the three (p. 36).

Working with these ideas among many other contributions from fields of sociology, psychology, history and others, Elder (2002), developed a theoretical orientation to the life course based on a set of five principles: 1) development and aging are lifelong processes; 2) people are actors with choices that construct their lives; 3) the timing of events and roles, whether early or late, affects their impact; 4) lives are embedded in relationships with other people and are influenced by them and lastly, 5) changing historical times and places profoundly influence people's experiences (p. 2).

Factors unique to each individual, such as those which influence the life course as well as other aging processes, including the diversity of age itself, all contribute to increasing heterogeneity among older adults. Namely, "...older people are more diverse in their health and socioeconomic status, ethnicity and race, and family situations than other age groups" (Hooyman, 2008, p.2). As discussed further by Richardson and Barusch (2006), "People become

increasingly differentiated as they grow" (p. 13) and therefore heterogeneity is more pronounced.

As a result, during the 1970's researchers, policy-makers and practitioners began to differentiate groups among older adults, resulting in the now commonly employed categories of the *young old* (65-74 years), the *middle old* (75-84 years), and the *oldest old* (85 years and older) (Gonyea, 2005, p. 158). However, Angel & Angel (1997) forewarn that "People do not fit neatly into categories, and whether we are dealing with age, race, or ethnicity the differences between individuals within each category are far greater than the average differences between categories" (p.8).

Health and Functional Status

Health is affected by biological as well as non-biological determinants. These determinants are discussed by Richardson & Barusch (2006) as "theories of aging" and categorized as four aspects: 1) biological aging; 2) psychological aging; 3) social-psychological aging and the 4) sociology of aging (p. 22). Central to the study of *biological aging* (the physical aspects of aging) is the question of why physiological capacities change with age. *Psychological aging* maintains focus on the individual and intrinsic processes that may change with age such as sensory capacities, coping skills, perception and cognitive abilities. Richardson and Barusch describe *social-psychological aging* as that which, "...examines the intersection of the individual with his environment and historically emphasizes social roles, family and social relationships and adjustment to aging." And the *sociology of aging* is defined as that which, "...considers social constructions of aging and economic and systemic influences that affect the organization of an aging society" (p. 22).

Knowledge of classic and contemporary theories of aging informs understanding between normal aging and disordered processes. In this light, professionals that work with older adults

can better differentiate the disordered processes that affect many older adults as opposed to developmental processes that commonly occur in late life. However, it is further emphasized that most theoretical conclusions based on past investigations are not applicable to older adults of diverse ethnic backgrounds: much research from psychology, social-psychology and sociology, "...are based on research that generally used samples of older people from the dominant white male culture" (Richardson & Barusch, 2006, p. 46).

Hooyman (2006) discusses the difference between normal aging and disease-related processes and that this knowledge informs to determine a person's health status. She writes, "Health status encompasses 1) the presence or absence of disease and 2) the degree of disability in level of functioning (p. xxxii). As aging cannot be defined in mere chronological years, the distinction of *functional age* may be more relevant to the combined factors resulting from the complex process of aging.

Functional age reflects the level of cognitive and physical well-being a person has at any given time and is largely determined by a person's ability to perform Activities of Daily Living (ADLs), such as eating, bathing and dressing (Hooyman, 2008; HHS, 2010) or instrumental activities of daily living (IADLs), including preparing meals, shopping, managing money, using the telephone, doing housework and taking medicine (Lehning & Austin, 2010, p. 95). The need for assistance with ADLs and IADLs determines what types of services they will need and possibly whether older adults can remain in their home (Hooyman, 2008, p. 30; Lehning & Austin, 2010, p. 95).

Social models of disability view disability as a situation, not a characteristic (Putnam & Stark, 2006). The authors assert that, "...individuals have a certain set of (in this case) physical capabilities, and their environments have a specific set of demands or requirements," which begs

the question, "Can the person do what she needs to do" (p.80). Two populations of older adults with disabilities are distinguished from one another, those persons who "age into" disability, first experiencing impairment later in life, and those persons who are "aging with disability" constituting people who experienced earlier onset of disability, such as during childhood, youth or middle adulthood (Putnam & Stark, 2006, p. 80).

This change, as discussed by Putnam & Stark (2006) is in part due to an independent living movement led by disability rights activists. The aim of the movement was to shift from a medical model of long-term care to a "de-medicalized" home service delivery that allowed for non-medical personal to perform ADL and IADL tasks, thus expanding the pool of qualified service providers. Personal empowerment is at the crux of this movement wherein, "...consumer-directed care options in home health services seek to shift this balance by affording consumers more choice and control over which services they received, when the services are provided, and by whom" (Putnam & Stark, 2006, p. 81).

In summary, Putnam & Stark (2006) write, "The net effect of functional impairment and disability in old age is generally the same: reduced opportunities to achieve healthy aging objectives and participate fully as community members when appropriate supports, accommodations, and/or accessible environments are not available" (p. 81). This situation is addressed among an ever-evolving literature base on aging and long-term care.

Home, Community and Long-Term Care

Home, for the majority of older persons, is living independently in what has been there longtime residence, such as a single family home or apartment; it is also a place embedded with psychological and emotional attachment, close to familiar people and services (Pynoos, Caraviello & Cicero, 2010, p. 129). Even when people suffer serious declines in their health,

much data confirms that older persons prefer to stay at home (Angel & Angel, 1997, p. 134).

Staying at home is now also referred to as *aging in place*.

However, the context of home life and aging in place must also be considered in the broader environment of community in order to grasp the significance of "...the importance of development and planning patterns that affect vital aspects of a community's livability, such as availability and accessibility of transportation options, shopping venues, social services, medical care, and recreational activities" (Pynoos, Caraviello & Cicero, 2010, p. 129). Such aspects constitute an *aging friendly community* for older adults which is where home and community based long-term care takes place, also understood as an aspect of long-term care. The subject and services that constitute long-term care (LTC) are multi-faceted. Historically, long-term care was discussed in terms of institutional care, such as nursing homes; however, the capacity to live at home with illness or disability has evolved, expanding the meaning of long-term care (Cutler, 1995, p. 229).

Greene et al. (2007) describes long-term care as, "The total delivery system for services to frail older adults who have some limits on biopsychosocial functional capacity that interfere with their autonomous functioning" (p.152). In contrast, Lehning & Austin (2010) describe long-term care as, "...a patchwork of different services and providers of care, rather than a comprehensive system (p.44), with no reference to "frail older adults." Citing an "absence of clarity," Koff and Bursac (1995) suggest that "chronic care" is a more malleable term and discuss, for example, that the phrase "long term care" emphasizes duration of services rather than the services themselves (Introduction). However, as it stands, "long-term care" is the rhetoric in which a variety of supportive services are discussed. The need for long-term care arises from an inability to take care of oneself in a fully safe and independent way, such as when a person has a

chronic illness or disability and needs help with performing ADLs and IADLs, as previously discussed. This can occur at any point in life, thus long-term care is not exclusive to the care of older adults. Long term care is not limited to the needs of older adults. The U.S. Department of Health and Human Services (2010) report,

This year, about 9 million Americans over the age of 65 will need long-term care services. By 2020, that number will increase to 12 million. While most people who need long-term care are age 65 or older, a person can need long-term care services at any age. Forty (40) percent of people currently receiving long-term care are adults 18-64 years old. In all cases, supports that assist with ADLs and IADLs can be facilitated by formal and/ informal services (para. 1).

Greene et al. (2007) writes that two types of services for older adults exist, formal and informal. *Formal* services include those provided by, for example, community-based agencies and *informal* are those provided by family and friends (p. 152). Hooyman, Hooyman & Kethley (1981), as cited by Greene et al. (2007) present a "Continuum of Care" describing a range of older adults' needs, services and interventions. The five continua include

- 1) client need, or how independent or dependent an older adult is
- 2) services, that is, suggested by need
- 3) service settings, or the degree of support for living the client requires
- 4) service providers, whether a person can manage without outside care, can conduct self-care, or requires professional care; and
- 5) professional collaboration, whether the client requires help from more than one discipline (p. 152).

Both informal and formal supports are essential to addressing the continuum of care that makes aging in place possible. However, informal supports are cited as providing 80% of long-term care services (Hooyman, 2008) and this combined with increased life expectancy and the growing expense and complexity of LTC, the imbalance between formal and informal support creates financial and social burdens for many families (Chen, 2006, p. 867). With less demand for institutional care (Romaine-Davis, Boondas & Lenihan, 1995, p. 227) the demand for home and community-based services (HCBS) has grown exponentially. A wide range of policies and programs are designed to meet social services, housing and transportation needs of community-dwelling older residents (Choi, 2006, p. 825). Koff & Bursac (1995) contend that previous research has discussed the historic shift from family to public responsibility that resulted in aging as a "social problem." Fifteen years later, Lehning and Austin (2010) point out that ... "in recent years policy makers have recognized importance of long-term care policy" (p. 44).

Policy and Long-term care

Though not officially called "long-term care," the United States Federal Government has a history of attempting to address the needs of aging Americans. President Roosevelt's The New Deal established The Social Security Act of 1935 and in 1950 President Truman held the first National Conference on Aging. This was followed in 1956 by the establishment of a Federal Council on Aging under President Eisenhower and then the first White House Conference on Aging met in 1961. In 1962 legislation was introduced in Congress to establish "...an independent and permanent Commission on Aging." Then in 1965, under President Johnson and The Great Society initiatives, including Medicare and Medicaid (which were added, respectively, to the existing Social Security Act), the most comprehensive body of legislation aimed at

providing social services and long-term care to persons over 60 was enacted, The Older American Act (OAA) (AoA, 2011, pp. 1-4).

The Older Americans Act and the Aging Network

On July 14, 1965 U.S. President Lyndon B. Johnson remarked at the signing of the OAA, Lengthening the life-span is a major achievement of our time. It is also the source of one of the major challenges to the values and the vision of our great society...The Older Americans Act clearly affirms our Nation's sense of responsibility toward the well-being of all of our older citizens. But even more, the results of this act will help us expand our opportunities for enriching the lives of all of our citizens in this country, now and in the years to come (Johnson, 1965, para. 4, 7).

Enactment of the OAA marked a turning point of U.S. federal and state governments financing and providing social services and long-term care to older people (O'Shaughnessy, 2008). The enactment of the OAA created the Administration on Aging (AoA) within the Department of Health, Education and Welfare which by extension called for the development of State Units on Aging (SUAs). Since 1965 each state has been required to implement the mandates of the OAA and each state has gone about this in a different way.

Within a decade, local implementation of the OAA suffered from planning and administrative issues among the AoA and the SUAs thus a clear need to be "closer to the people" was recognized throughout the nation (Hudson, 2006, p. 494). As a result, a 1973 OAA amendment established Area Agencies on Aging (AAAs). The entire system, ultimately referred to as "The Aging Network," is now comprised of 56 STUs, 655 AAAs, 233 tribal and Native American organizations, and two organizations serving native Hawaiians, as well as nearly 30,000 local service provider organizations. The various agencies host the responsibilities for

planning, development and coordination of social, long-term care and health-support services within each state (O'Shaughnessy, 2008, p.5).

The OAA was created to include funding of local service programs, to establish training and research projects and to stimulate the development of innovative and/or improved services for the elderly. The seven titles that comprise the OAA are named as follows: Title I – Declaration of Objectives; Definitions, Title II – Administration on Aging, Title III – Grants for State and Community Programs on Aging, Title IV – Activities for Health, Independence and Longevity, Title V – Community Service Senior Opportunities Act, Title VI – Grants for Native Americans and Title VII – Vulnerable Elder Rights Protection.

The current purpose of the OAA, as recently described by Principal Policy Analyst of the National Health Policy Forum, Carol V. O'Shaughnessy is "...to help older people maintain maximum independence in their homes and communities, with appropriate supportive services, and to promote a continuum of care for the vulnerable elderly" (2008, p. 4). However, the current aging network was not designed to meet the ongoing and increasingly complex long-term needs of older adults: the broad mission of the OAA has raised concern due to the limited resources available under the act (O'Shaughnessy, 2008).

According to Lehning & Austin (2010), research indicates that what is understood as the current long-term care system (e.g. the aging network) is inadequate to meet the current needs of older adults (p.44). Carbonell and Polivka (2003) also assert that changing the direction of long-term care will be difficult, but the task of creating a more "...consumer-oriented community-based long-term care system will not be as difficult, either politically or fiscally, as trying to maintain the current system for another twenty years (p. 321)."

The historical bias in favor of institutional rather than home-based care in public long-term care systems, as reflected in policy such as Medicaid acute care and nursing home reimbursements, is subject to scrutiny amidst the growing costs of maintaining such a system combined with the preference to stay at home. Polivka & Zayac (2008) discuss the need for an integrated long-term-care system that will support the shift of balance from institutional to home and community based services. They write,

Shifting the focus of public long-term care systems from nursing home care to home-and community-based care is the major long-term-care policy issue confronting state and federal policy makers; continuing dependence on nursing homes will make Medicaid long-term-care costs increasingly less affordable and resources for home and community-based services (HCBS) programs less available” (p. 564).

Home and Community Based Services

Many factors contribute to the progression of home and community-based services (HCBS) as an option of long-term care provision. For one, service providers and the aging network have built a community-based long-term-care system in most states over the past 30 years. Also, the Supreme Court’s *Olmstead* decision, *Olmstead v. L.C.* (1999), “...which guarantees the rights of individuals with disabilities to live in the community or in the most integrated setting feasible” was a significant marker for change (Lightfoot, 2006, p. 58).

According to Lightfoot (2006) the *Olmstead* decision reflected and affirmed the expanding types of formal residential options for people with disabilities as well as the possibility to live at home with appropriate environmental supports. However, “...the formal system of residential living options for older people with disabilities is currently well beyond capacity” (Lightfoot, 2006, p. 58).

It is now recognized that long-term care encompasses institutional care, in-home services, community care and material supports. As institutional costs rose, the preference to age in place recognized, as well as the capacity to provide complex services outside of acute care settings, the options for home and community-based services grew. Additionally, "Because of the continued health care crisis in the United States and the view that institutionalization is neither appropriate for nor preferred by many elderly with disabling conditions, home care is the most rapidly growing segment of the health care industry" (Ozminkowski & Branch, 1995. P. 224). Health care has begun to move from the institutional setting to the home (Castle, p. 44).

Home health care addresses the spectrum of ADL and IADL service delivery. Currently defined by HHS (2011), *home health-care* is the provision of services that assist older adults to remain living independently in their home despite a short or long term compromising medical condition (p.1).

Large scale social, economic and demographic trends which shape the modern world impact families such that even in the best of circumstances and with the best intentions , "...they simply cannot serve as the primary caregiver for the elderly" (Angel & Angel, 1997, p. 113). They add,, "Single mothers who must raise children alone, couples in which both husband and wife work, and children who have moved away from their parent's community or who have no siblings to help share the burden of caring for aging parents are severely limited in what they can do" (Angel & Angel, 1997, p. 113).

The growing need for homecare is such that three groups of homecare providers comprise what has become a homecare industry. These include 1) Medicare-certified home health agencies which provide most skilled nursing and therapy services; 2) private-duty homecare agencies which offer mostly non-medical services such as bathing grooming, transportation and

meal preparation; and 3) hospice agencies which address terminal illness and provide end-of-life care. Homecare physicians and telemedicine are “two innovative aging-friendly practices” the homecare industry is beginning to utilize (Castle, Ferguson and Schulz, 2009, p. 44, 45).

The U.S. Department of Health and Human Services (HHS) (2011) provides the following list of what constitutes home and community-based services,

- Adult Day Care
- Aging and Disability Resource Centers
- Caregiver programs
- Case Management
- Elder Abuse Prevention Programs
- Emergency Response Systems
- Employment Service
- Financial Assistance
- Home Health Services
- Home Repair
- Home Modification
- Information and Referral/Assistance Information Services (I&R/A)
- Legal Assistance
- Nutrition Services
- Personal Care
- Respite Care
- Senior Housing Options
- Senior Center Programs
- Telephone Reassurance
- Transportation
- Volunteer Services

The array of services is so complex that, according to Mitchell (2011), efforts have been made to try and categorize services in a more meaningful way. For example, Mitchell writes that Cox (1993), groups them as *preventive* for those less impaired, *supportive* for the moderately impaired, and *protective* for the severely impaired.

Rural Service-Delivery and the Hilltown Elder Network

While nearly one quarter of our nation’s population lives in the rural and outlying communities in this country, almost all our nation’s health care and social services

continue to be found in the major population centers-sometimes hours away from the people who need them.

Secretary of Health and Human Services,
Tommy G. Thompson,
July 2002 (HRSA, 2002)

The above recognition by the federal government, as cited in Butler & Kay (2004, p. 4), suggests unique circumstances for providing services in rural areas. And by extension, defining what is meant by rural is complex. Bull (2003) states, “The search for a single definition of *rural* has been in progress for so long that many academics and practioners have almost given up hoping that there will ever be a definition usable to all” (p. xii). However, at its most basic level, rural is defined as those areas with 2,500 people or fewer, while urban areas have populations greater then 2,500 (Ginsberg, 1998).

Generalizations also abound in regard to older adults living in rural areas. It is therefore acknowledged that, “...it is important to remember there exists tremendous diversity within and between different regions of the country and among the older adults making up the extremely heterogeneous category of people who are 65 years of age and older” (Butler & Kay, 2004, p. 7). As a result of such diversities, many factors affect independent rural living as well as home and community service-delivery to older adults in rural areas.

According to Cassity-Caywood & Huber (2004) factors that affect independent rural living include, financial resources, knowledge and resource utilization, interpersonal and relationship resources, intrinsic and personal resources and home and dwelling needs. The need for dignity and self-worth completes the previous list and the authors discuss that this need is the

least often discussed in literature but that it is "...vitaly important in considering service provision for rural elders" (p. 236).

Butler & Kaye (2004) describe differences among the challenges rural elders face as compared to rural elders in urban areas. They write that older adults in rural areas tend to be less educated, have lower incomes and less adequate housing (p.8). Butler and Kaye add that "While considerable diversity exists among rural older adults, especially between farm and non-farm elders, there is a greater prevalence of chronic conditions among rural elders than older adults residing in metropolitan areas" (Butler & Kaye, 2004, p. 8). On the whole, as discussed by Saltman, Gumpert, Allen-Kelly, & Zubrzycki, "...the Unites States' rural population has lower incomes, lower employment levels, higher poverty rates and inadequate educational, medical and social services compared with urban and suburban locales of the country" (p. 518).

Discussed in the context of mental health service delivery Bane & Bull (2001) explain that numerous barriers associated with distance and limited resources hinder service delivery to rural elders (p. 230). Over half of nonmetropolitan persons are poor or near poor, and that this is most evident among persons 85 and older. This is of particular concern given that, "...a higher proportion of rural elders are in this oldest-old category than is true for urban areas" (p. 8).

Given the extent of potential restrictions to quality of life for rural elders combined with declines of normal and abnormal aging processes, a program such as The Hilltown Elder Network (HEN) serves what appears to be a potentially great need.

Hilltown Elder Network

"Aging is a normal process, which is not solved, but managed" (Charlie Hayes, personal communication, February 28, 2011).

The Hilltown Elder Network (HEN) originated in 1992, in response to local community need that was first realized by the area Council on Aging (COA). COAs responding to elder needs for help living independently at home approached Hilltown Community Development Center (HCDC) to seek funding for a program which became HEN in 1994. HEN, along with Health Outreach Program for Elders (HOPE), Families Together, and Hilltown Food Pantry, comprise the four current social service programs offered by HCDC. Additional HCDC activities include a Housing Rehabilitation Program, a first Time Homebuyer Program, a Regional Childcare Subsidy Program, and a Senior Housing Planning study. Most services target the seven northern hilltowns of Hampshire County, Massachusetts.

The HEN and HOPE programs are uniquely linked in that they specifically serve elders and, in essence, share a similar objective which is to help rural senior residents remain living safely and independently in their homes for as long as possible. HOPE achieves this as a nursing program and HEN as a service program that provides non-medical elder needs. For 11 years, HEN and HOPE have provided an integrated community approach responsive to the home care needs of the elder population. HEN also works closely with multiple organizations to identify and meet the non-medical needs of the senior population with the aim of delivering coordinated care. As an individually customized service, HEN provides continued weekly assistance (typically 1-4 hours per week), short term assistance (such as helping an elder who recently suffered a broken hip and is recovering at home), or one time assistance for an unusual need, such as the clearing of snow following a heavy storm.

All HCDC programs rely on public as well as private funding sources which are vital to the continued financial capability of HEN; however there is no guaranteed, on-going source of funding for the HEN program through any public source. The largest benefactor is the state of

Massachusetts which offers a competitive Community Development Block Grants (CDBG) each fiscal year (FY). The annual CDBG grant proposal for HEN is written by the social services program manager, Charlie Hayes, as a separate document that becomes a part of the larger HCDC community grant. In the HEN proposal it is required to make statements describing individual, geographic, economic and community need by providing anonymous detailed profiles of the various potential and past participants. Mr. Hayes has explained that documentation is necessary to demonstrate where positive change has occurred, or will be expected to change, and how the change is evidenced (personal communication, February, 14, 2011).

Multiple processes are used to evaluate HEN program impact and to maintain involvement of the community and current/prospective participants in the implementation of the HEN program. These include 1) completion by beneficiaries of an annual survey to solicit program input and to document satisfaction with program; 2) regular feedback from participants' caregivers about participant needs; 3) regular community surveys of seniors; 4) tracking of bi-weekly statistics which are evaluated monthly. These evaluative processes document measures including actual numbers of elders served, hours per week of assistance provided each participant and other data relative to an elder's independence and safety. Additionally, as described by Mr. Hayes, "...the dialogue with other agencies, home-care programs, in-home nursing programs, hospitals, municipalities and long-term-care facilities with who HEN coordinates points of elder services provided an ongoing means of self analysis" (personal communication, February 14, 2011). These methods of self analysis support the goal of coordinated care which is essential to both the health of the program as well as the health of the elders served. Coordinating inter-agency service efforts insures a maximum of unduplicated assistance to seniors.

The HEN program addresses aspects of home and community services that can be organized as direct and indirect outcomes of HEN services. The HEN 2010 grant proposal describes that providing seniors with in-home chore help has many impacts beyond enhancing an elder's ability to remain in their home longer. *Direct impact* include better access to services through provision of escorted transportation, better nutrition through help with shopping and meals, better cleanliness in the home, and reduced loneliness which keeps elders more socially active. *Indirect impact* that results from an elders' ability to stay in their community longer include maintaining what are often life-long associations and friendships. The family, friends and community of elder participants also experience increased well being when an elder relative or friend is safe and well cared for. In some cases, economic viability improves when an able family member can work as needed, maintaining a diversity of ages and historical memory in the community and through increase well being of families (Hayes, 2010). These impacts are observed in a letter written by John Lutz, Executive Director of the local AAA, Highland Valley Elder Services,

As the elder population continues to rise, we face the challenge of meeting this increasing need with resources that do not match the reality of people's lives. We are doing our best to compensate for these shortages, but the provision of services to the rural areas continues to pose difficulties. The HEN program has become an invaluable and necessary part of the service structure for elders living in the Hilltown communities... We support and applaud your efforts to make additional in-home assistance available, through the HEN program. These services increase the capacity of elders, who choose to continue living independently at home, in this very rural area. This has become increasingly critical in our service area as, we have seen three independent rest homes

close in the last year. This eliminates a critical care alternative for many families (October 13, 2010).

The need for HEN services appears to be without question. The need to be addressed is further articulated by Mr. Hayes in that "...many HEN participants reside in locations accessible only through arduous travel, difficult in winter even for younger drivers. That travel to medical facilities requires considerable driving over mountainous, circuitous roadways" (Hayes, 2011). It is also repeatedly emphasized that the rural seniors within the program region need reliable assistance to remain living independently. Reasons for this are documented as, 1) ineligibility for other home care assistance or have no other home care options; 2) they have low incomes and cannot afford to pay privately for services; 3) lack of family/friends to provide regular chore help; and 4) health/mobility issues.

The need for proposed services has reportedly grown steadily over the years, as the number and diversity of needs of seniors in the program region has steadily increased. For example, "With the aging 'boomer' generation, future years may require expansion of the HEN program, which is currently experiencing an influx of younger seniors in their 60s who are disabled or in poorer health than previous participants" (Hayes, 2011, p.6)

However, according to a detailed budget submitted to "Demonstrate Cost Reasonableness" it is evident that even among such challenges during a time of fiscal uncertainty, HEN services are cost effective as compared with State services. It is acknowledged that the cost of comparable services delivered by other in-home assistance programs are challenging to estimate due to variance in needs, site locations and availability of services, however, it is clear that both Medicare and Mass Health are very restrictive in whom they may assist and, according to the grant proposal (2011), their recipients continuously report needing

more help, largely with homemaking, food preparation and transportation. The public cost for the average Medicare home-care case is \$6,000 annually. State Home Care homemaking/chore services cost the Area Agencies on Aging (who act as agent) from \$22-\$35 per hour and these fees are paid to subsidiary for-profit companies. When coupled with an AAAs administrative cost the final, per participant, costs may exceed \$60 per hour (Hayes, 2011). In contrast,

The HEN program serves as an excellent model for cost-effective rural in-home service delivery and is much more efficient in containing costs. HEN participants have differing needs which HEN staff meet via differing methods and amounts of care. The needs, therefore, present the program with varying costs, which range from \$500 to \$3,000 annually per participant and average \$1,000 per HEN participant. By matching seniors with local caregivers, the HEN program can reliably deliver in-home assistance at a per participant hourly cost of \$18.60, including program delivery costs (supervision, payroll) (Hayes, 2011).

The HEN program maintains its necessity in that without it, the affected population which is characterized by advanced age and lack of mobility, would not be able to remain living safely at home. "When seniors can no longer clean the kitchen, remember to take medications, follow medical precautions, wash clothing, or eat balanced meals at regular intervals, a decline in health and well-being follows" (Hayes, 2011). The following is a description of one program participant, intended to illustrate the value and efficacy of HEN services and that even among the oldest old, a little bit of help can go a long way.

Ms "M" celebrated her 103 birthday in June. She lives alone in her ancestral home located outside of a hilltown village. Her daughter lives nearby and helps her mother as much as possible. Health, however, is an issue for the younger woman. Ethel attends the

Town COA senior luncheon regularly and enjoys her independence and her home. She does, however, require some assistance with housekeeping, laundry and vacuuming. Stretching for bed can be a problem as is getting to the laundry room in the basement. Ms. M is able to prepare meals but needs assistance with shopping. Periodically, when a family member is unavailable, HEN is also prevailed upon for escorted transportation to an appointment. Ms. M has been a HEN participant since 1992, when she was only 85 years old! The same HEN caregiver has been attending Ms. M for over 12 years and the two have known one another for the caregiver's lifetime. This welcome and necessary consistency is nearly unheard of in the elder care industry; however, it is a unique beneficial component within HEN and one which we strive to offer (Hayes, 2010).

Despite the current and growing need for services as well as HEN's cost effective structure combined with no guarantee of ongoing funding and the current proposed Federal budget cuts, the probability of HEN's survival is ambiguous. Among multiple reductions affecting social service programs, 74 million may be eliminated from Community Development Block Grants for the State of Massachusetts, HEN's primary funding source. This is on top of current issues that seriously hinder the well being of elders. In late July of 2010, the Mass Budget and policy Center issued a report on budgetary impacts on the Massachusetts public services network, titled "FISCAL FALLOUT: The great Recession, Policy Choices, and State Budget Cuts." Among multiple report excerpt, the following is provided by At Home Newsletter (2010).

Since the beginning of FY 2009, elder home care has been cut by 14 percent, when adjusted for inflation. With this reduced funding, approximately 2,500 fewer frail elders each month are able to receive the community-based long term care services that allow

them to stay in their homes. At one point the hope was that a waiting list for services might be reduced or eliminated. Instead, there are now more than 2,700 elders each month on a waiting list for home care (para. 3).

Summary

Although independence is the essence of American culture, social supports are more often the cornerstone of well-being. Throughout life, one's ability to sustain a sense of sovereignty may be compromised, and this is even more likely as we age. This literature review has located and described many conditions that may affect well being as we "come of age" in the United States, as well as how, as a society, we are addressing the issues. When we talk about aging, we are really talking about health status and all that impacts it. This includes the array of biological, psychological and social aspects of the aging process. Current health status is impacted by what came before, and research indicated that this can always be improved upon. Findings from this literature review suggest the viability that home and community-based services can often replace institutional care, and by extension support the overall health and well being of an individual. The next chapter introduces a method of measuring this possibility.

CHAPTER III

METHODOLOGY

The purpose of this study was to assess the value and efficacy of services offered by The Hilltown Elder Network (HEN). HEN services function as in-home supports which comprise the goal of the program, to assist seniors to continue living safely and independently in their homes for as long as they wish to and are able. The design of this study is primarily descriptive as the results portray a “snapshot in time” regarding the participants’ responses (Anastas, 1999). This study examines and analyzes survey information provided by 69 HEN service recipients who are between the ages of 62 and 95 years, the median age being 84 years old. Data was obtained from a 2010 survey issued by HEN administration to HEN clients who have received services within the past twelve months. The survey solicited feedback regarding aspects of client satisfaction and also operate as a tool to gather necessary data for program funding. This mixed methods study using secondary data included both quantitative and qualitative responses.

HEN Program Details and Participant Eligibility Requirements

The Hilltown Elder Network (HEN) is a localized non-profit social service program which provides modest levels of in-home services to low and moderate income (LMI) seniors aged 60 years and over. HEN operates region-wide within the area consisting of Chesterfield, Cummington, Goshen, Huntington, Peru, Plainfield, Westhampton, Williamsburg and Worthington, collectively known as "The Hilltowns" of Western Massachusetts. Services provided by HEN caregivers can only be those home chores and daily living tasks that applicants

are unable to do themselves due to health conditions and/or mobility limitations. Services offered include:

- 1) home cleaning and laundry assistance
- 2) food shopping and meal preparation
- 3) snow removal and maintenance of safe seasonal home access
- 4) escorted transportation to medical appointments
- 5) assistance with solid heating fuel needs such as firewood and pellets and
- 6) other forms of assistance which help to insure safe and continued independent living conditions for rural elders.

The major objective of HEN is to help seniors to continue living safely and independently in their own homes according to their wish and ability. The program service goal is to provide at least 65 seniors per fiscal year with in-home assistance for an average weekly assistance of 1-4 hours per participant. An eligible participant must be sixty years or older and reside within the specific geographic region. The participant must be income eligible, low-moderate (LMI). Income eligibility is established by State guidelines and although HEN is not a State social service program, the major funding comes from a State Community Development Block Grant (CDBG) and LMI is a funding eligibility factor. In addition, the senior must not be eligible for any other State service of a similar nature. Community outreach and referrals from local hospitals and other area social service providers are the primary vehicle to connecting the service with the participant.

Sample

During the fiscal 2010 year, 100 seniors received services provided by The Hilltown Elder Network (HEN). The population sample for this study originated from the 2010 HEN

survey response rate and all data analysis and findings are based on that result. The survey selection criteria, as determined by HEN administration, include all people who received HEN services within the previous twelve months. Thus, the sample population for this thesis is pre-determined due to the fact that the data was obtained by the agency, not by this researcher. Essentially, the minimum sample number was determined by how many surveys are completed and returned. With that said, a conversation with HEN program director Charlie Hayes (personal communication, February 14, 2011), revealed the following:

The survey has to match the very short attention span of participants, address the varied literacy levels without irritating some and leaving others literally unable to respond, and to balance delicately on the threshold of the personally non-invasive, and obtain sensitive income data and birthdates. We also need to use very large fonts with sufficient blank space for comments: participants often write responses through awkward magnifiers and then there are the cost concerns about paper, copying and postage.

Mr. Hayes added that it is often necessary to personally sit with HEN service-recipients in order to obtain the completed survey. Mr. Hayes reported having been able to pursue this avenue in previous years which resulted in a higher response rate; but in 2010, he was not able to survey elders in person to a great extent. The 2010 survey was issued to 100 participants, of which 69 were returned, equaling a 69% response rate.

Ethics and Safeguards

Permission for this researcher to use HEN survey data results was obtained directly from the program manager of HEN (Appendix A). Procedures to protect the rights and privacy of participants were under the purview of the HEN Administration. The survey introduction, read by each respondent, specified why each person has received the survey, what types of questions

will be asked and why those questions will be asked. It was also written, “Your response is confidential and the results are used for planning purposes. Please feel free to call and talk with me or your local HEN Coordinator if you have questions or need assistance.”

Confidentiality

Since the survey results provided a reference point to determine if actual service provision is in alignment with the program objectives, including client satisfaction and funding qualifications, it was essential to elicit honest feedback: a respondent must feel safe to express, for example, a grievance or concern. If a name is not provided, for example, a concern cannot be addressed. The confidence a participant has in the survey process could have made the difference between a met need and an unmet need.

Survey response was voluntary, though the service recipient may have benefited from participation in multiple ways, including but not limited to, having made a contribution to the data collection necessary for funding, improved program service delivery as well as having taken the opportunity to express oneself.

To ensure maximum confidentiality all completed surveys were kept in their sealed envelopes until they were received by the program manager who then entered all personal data such as name, home address, social security number, birth date and income into encrypted spreadsheets as consistent with State Health Insurance and Portability Act (HIPAA) guidelines. Results were then calculated with all names removed. The program manager was the only person who had access to any name associated with the data. Thus, when working with the data this researcher had no frame of reference regarding identifying information.

Data Collection

The data for this research study was collected through the use of a mixed method survey (Appendix B) created by HEN. The survey, created on Microsoft Word, was distributed in print only and mailed directly to participant's homes on June 25, 2010. Participants were asked to respond by August 1, 2010. The survey consisted of a combination of 12 yes/no, multiple choice, satisfaction scale and open-ended questions, followed by a final section for "other comments." Other than beginning and ending with demographic questions, the organization of the survey questions was fluid, with no indication of categorical sections. This mixed methods descriptive study utilized the pre-existing data obtained through the survey including responses of 69 HEN participants who met the criteria for survey participation.

First issued in 1992 the initial purpose of the "HEN Program Participant Survey" was to determine the level of client satisfaction with the program. A mailed questionnaire format was chosen so participants could take their time completing the instrument in the privacy of their homes. Mailing also allowed for sufficient time, space and assistance if needed. Pre-addressed and stamped return envelopes have been and continue to be provided to participants for convenience and to encourage response rate.

The survey evolved to reflect participants' comments and was modified to respect what Mr. Hayes refers to as "a generational component." For example, Mr. Hayes recalled how, in the past, certain participants were "incensed" at questions that regarded them as potentially "isolated." The survey has also become useful as a tool to secure funding and to document certain program aspects required by the State. As a result, a question about "isolation" remains.

The first section of the survey inquired about participant's demographic information including name, social security number, residence and date of birth. The questions that followed

were both open-ended and closed-ended, arranged interchangeably. Two examples of open-ended questions include “What do you feel is most valuable about the program?” and “What do you feel would happen if you no longer had HEN assistance?” Three examples of close-ended questions include, “Do you feel that your exposure to strain or injury is lessened by having HEN help?”, “Do you feel your overall health has been maintained or improved due to having HEN help?” and “Do you feel that you could live safely and independently in your current home without HEN assistance?”

In addition, certain “yes/no” questions also invited comments, such as “Do you need more help than you are now receiving” followed by, “If yes, what form of additional help do you need [including a list of possible answers to choose from]?” There is also one gradated question, “Would you describe your overall satisfaction with the HEN program as: Excellent, Good, Fair, Poor, or Other? The survey ends with an “other comments” area followed by a “HEN income verification form” requiring answers for two final Demographic questions including specific household size and range of household income.

To qualify for funding HEN must establish evidence of need. HEN must solicit feedback directly from participants in order to accurately determine whether or not program goals were met. Therefore, the instrument was developed to provide responses that would encourage validity and reliability. Commenting on this Mr. Hayes states, “The survey probably does not tell us things we do not already believe, but there is a difference between belief and documented facts” (C. Hayes, personal communication, February 14, 2011).

Mr. Hayes added that as part of the grant application proposal, HEN is required to make statements describing individual, geographic, economic and community need by providing anonymous detailed profiles of the various potential and past participants. He emphasized that

documentation is necessary to demonstrate where positive change has occurred, or will be expected to change, and how the change is evidenced. Survey questions must be constructed so that they can remain comparable to past survey data both for HEN to make their own comparisons but also to reflect the ever changing mood of political issues. For example, within the last ten years there is great emphasis on accountability and measurement and HEN administration is repeatedly challenged to defend demographic data.

The reliability of the study was strengthened by the number of years the survey has been disseminated and that it does function as an instrument that, as explained, was comparable from year to year. Validity was improved upon each year through the responses of HEN participants, and through the attendance of HEN administration to those responses. HEN aimed to provide a valuable and personally satisfying service. Therefore, the creation of the survey, both as an instrument and guide, was integral to the functions of validity and reliability.

Data Analysis

Data collected from the returned, handwritten survey responses provided by program participants were manually entered by HEN administration (Charlie Hayes and an intern assistant) into two separate word documents. One document contained all data, including demographic information as well as results from the open-ended and closed ended questions. The second word document, entitled "Comments" contained lists of all narrative responses organized by question. In some instances, respondents did not answer all questions, but all answers were still included in analysis.

Analysis of the mixed method survey conducted by HEN administration consisted primarily of descriptive statistics for both the quantitative and qualitative portions of the survey. This included demographics of the sample population and summary information for closed-

ended survey responses. The qualitative portion of the survey, inclusive of the open ended questions, was first analyzed using content analysis and then organized quantitatively. On this process Anastas (1999) explained “The analysis of narrative or unstructured data is both similar to and different from the analysis of numerical data...at times, narrative data may be transformed into quantitative data for purposes of counting and classification, and this transformation may be part of the analysis (page 413/414).” All survey results were then exported to Microsoft Excel and using Excel's statistical tools the frequency and percentages of each category were calculated.

Discussion

The HEN survey guide has functioned as a forum to solicit client driven concerns and input, to measure satisfaction with services and also as an information gathering device to obtain State required information needed to secure CDBG as well as private funding that HEN needs to operate.

As previously noted in this chapter, personal communication with Mr. Hayes revealed, “The survey probably does not tell us things we do not already believe, but there is a difference between belief and documented facts” (C. Hayes, personal communication, February 14, 2011). It is therefore expected to find that almost all program participants would rate a high level of satisfaction with services, especially since the primary aim of the survey is to document participant satisfaction. It is also expected to find that most participants would report improved sense of safety as a result of HEN services given the nature of the services as well as the reasons they are provided. An unexpected finding might include reports of overall dissatisfaction of program service-delivery.

A discussion of the limitations can be found in the final discussion chapter. These limitations will shape recommendations for future research.

CHAPTER IV

FINDINGS

This study assessed the value and efficacy of in-home services offered by The Hilltown Elder Network (HEN) by analyzing pre-existing data first obtained through an annual survey issued by HEN administration to HEN clients during 2010 (Appendix B). The survey was designed to solicit program input and to document participant satisfaction with the program. The objective of the HEN Program is to help seniors to remain living safely and independently in their homes for as long as they wish to and are able. Almost all participants described overall satisfaction with the HEN program as “excellent” or “good,” and over half felt that without HEN services they could not continue to live safely and independently in their current home. Other significant findings included a good majority feeling less isolated as well as experiencing improved health as a result of HEN services.

The findings that follow begin with participant demographics, including age, household size, economic status, town of residence and services received at time of survey. Next, results from yes/no questions are presented, categorized by four categories, direct service, caregivers, safety and quality of life. Following this, results for participant satisfaction are presented. The chapter concludes with findings from three open-ended questions.

Participant Demographics

The data from sixty nine (out of 100) participants were used for this study. The sample of participants was somewhat diverse among the older adult age groups, though a large representation existed near or above the oldest old with 49 % being 80-89 years old and 16 %

being 90 years old and above. The remaining 35% were divided among three age ranges including 6 % being 60-64 years old, 3% being 65-69 years old and 26% being 70-79 years old. The household size of respondents showed the majority of respondents lived alone, totaling 72 % followed by 26% living with one other person and 1% living with two other people.

The economic status of participants was mostly divided among two out of the four categories. Each category offered a range of gross annual household income described respectively as “extremely low” income, “very low,” “low,” followed by “over”, meaning the participant would not qualify for services. The categories are based on regional “median household income” established by the state of Massachusetts. The results included 46% reporting extremely low income (below 30% of median household income), 41% with very low income (between 30-50% of median household income), 12% with low income (between 50-80% of median household income) and the remaining 1% reported over which equaled above 80% of median household income.

To receive HEN services a person must reside within the designated service area, which at the time of the 2010 survey included seven towns. Residential distribution (based on 100% of the 69 respondents) included the towns of Goshen and Plainfield reporting the fewest participants with 9% respectively, followed by Westhampton at 12%, Chesterfield and Worthington each at 14%, Cummington with 16%, and the largest participant base of 26% was located in Williamsburg.

The participants utilized the array of services offered by HEN. The majority of participants reported use of general cleaning which equaled 78%. The breakdown of additional services received from highest percent to lowest included: driving/errands 23%, snow removal

22%, shopping and other 19% respectively, heavy chore 17%, laundry 16%, firewood, etc. 6% and meal preparation 4%. Demographic characteristics are illustrated in the Table 1.

Table 1

Demographic Characteristics of the Participants

n=69

Age	60-64	6% (4)
	65-69	3% (2)
	70-79	26% (18)
	80-89	49% (34)
	90 and above	16% (11)
Household size	1 person	72% (50)
	2 people	26% (18)
	3 people	1% (1)
Annual Household Income (median based)	Below 30%	46% (32)
	Between 30-50%	41% (28)
	Between 50-80%	12% (8)
	Above 80%	1% (1)
Town	Chesterfield	14% (10)
	Cummington	16% (11)
	Goshen	9% (6)
	Plainfield	9% (6)
	Westhampton	12% (8)
	Williamsburg	26% (18)
	Worthington	14% (10)
Services Currently Receiving	General Cleaning	78% (54)
	Heavy Chore	17% (12)
	Laundry	16% (11)
	Shopping	19% (13)
	Meal Preparation	4% (3)
	Driving/Errands	23% (16)
	Snow Removal	22% (15)
	Firewood, etc.	6% (5)
Other	19% (13)	

The first section of the survey, as presented in Table 1, inquired about participant's demographic information. The questions that followed were both open-ended and closed-ended, arranged interchangeably throughout the survey. For purposes of data description and presentation, the following quantitative and qualitative portions will, for the most part, be separated in the remainder of the findings chapter, even among two-part questions that involved both closed and open-ended portions. Two exceptions include a section on caregivers and a section on client satisfaction: in these sections the open-ended responses associated with the closed-ended question will be presented together. Quantitative client satisfaction data are also presented separately in Table 9, while the remaining quantitative data are presented in Tables 2-8.

Seven questions constituted a "yes" or "no" answer and although not categorized by theme in the actual 2010 HEN survey or results, the quantitative (yes/no) questions are organized below by categories including direct service, caregivers, safety, and quality of life. One question addressed direct services, two focused on the caregiver, as did two questions for safety and well-being respectively.

Direct Services

The main question here was, "Do you need more help than you are now receiving, yes or no?" The large majority of participants indicated that they did not need more help than they were receiving at the time of the survey. Of the 65 participants that answered this question 68% (n=47) responded "no", 26% (n=18) responded "yes" and the remaining 6% (n=4) were reflected in the "Blank, N/A or?" option. This question was followed by ancillary questions including, "If yes, what form of additional help do you need?" as well as a place to estimate how many

additional hours might be needed. Answers to the follow-up questions were not accessible for this study. See Table 2 below.

Table 2: Do you need more help than you are now receiving?

Yes	No	Blank, N/A
18	47	4
26%	68%	6%

Caregivers

The two questions in regard to HEN caregivers were 1) have your HEN caregivers been reliable and helpful? And, 2) in addition to the services HEN provides, is having a friendly connection to your caregiver important to you? The first question yielded 69 responses, and almost all participants 90% (n=62) showed that HEN caregivers have been reliable and helpful. Only 1 participant expressed “no” and the remaining 9% (n=6) responded “blank, N/A or other.” The second question that inquired about the importance of a friendly connection with a caregiver also had 69 responses and a vast majority of “yes” replies, equaling 91% (n=63), followed by 4% (n=3) “no” and an equal 4% leaving the answer “blank, N/A or other.” See Tables 3 and 4 below.

Table 3: Have your HEN caregivers been reliable and helpful?

Yes	No	Blank, N/A
62	1	6
90%	1%	9%

Table 4: In addition to the services HEN provides, is having a friendly connection to your caregiver important to you?

Yes	No	Blank, N/A
63	3	3
91%	4%	4%

Safety

The first question that related to safety was, “Do you feel that your exposure to strain or injury is lessened by having HEN help?” Most participants, 87% (n=60), answered “yes” and 4% (n=3) answered “no.” Six people, or 9% of 69, did not respond to this question. The second question in this category, “Do you feel that you could continue to live safely and independently in your current home without HEN assistance?” received an over half “no” response of 55% (n=38) and a “yes” response of 35% (n=24), with 10% (n=7) no response. See Tables 5 and 6 below.

Table 5: Do you feel that your exposure to strain or injury is lessened by having HEN help?

Yes	No	Blank, N/A
60	3	6
87%	4%	9%

Table 6: Do you feel that you could continue to live safely and independently in your current home without HEN assistance?

Yes	No	Blank, N/A
24	38	7
35%	55%	10%

Quality of life

This last set of questions asked, “Do you feel less isolated as a result of having help from HEN?” and “Do you feel your overall health has been maintained or improved due to having HEN help?” In regard to isolation about two thirds, 75% (n=52) of elders answered “yes”, a few, 13% (n=9) answered no and the remaining 12% (n=8) did not respond. The second question in regard to overall health yielded a good majority, 80% (n=55), of elders replying “yes”, with a few, 9% (n=6), saying “no” and 12% (n=8) neither yes nor no. Results are displayed in Tables 3 and 4. See Tables 7 and 8 below.

Table 7: Do you feel less isolated as a result of having help from HEN?

Yes	No	Blank, N/A
52	9	8
75%	13%	12%

Table 8: Do you feel your overall health has been maintained or improved due to having HEN help?

Yes	No	Blank, N/A
55	6	8
80%	9%	12%

Participant Satisfaction

Survey respondents were asked to rate their level of satisfaction with services offered by HEN (Table 3). Of those, a good majority, 71% (n=49) thought the services were excellent, 23% (n=16) indicated services were good, 1% (n=1) fair and 4% (n=3) opted for other or blank.

Table 9 Participant Satisfaction



Following this question respondents were asked to openly comment on areas of improvement. The survey reads, “If you believe that HEN needs improvement we would appreciate your comments on which areas *most* need attention.” Only a few participants responded, 16% (n=11), and made suggestions for improvement. Five additional people (7%) indicated they saw no need for improvement and the remaining 53 elders (77%) left the answer blank. Despite the low response rate, a range of suggestions that addressed issues such as communication, reliability and services were mentioned. One person wrote, “We need more dependable caregivers,” while another indicated, “Snow removal could be improved. General cleaning is excellent.” One person suggested, “Coordinators could do a follow up inquiry on service delivery & satisfaction with HEN worker assigned to each client” and another emphasized, “Focus on the requirements of the client.”

This final section of findings details participants' responses to the two remaining open-ended questions followed by a section inviting "Other comments." This section offered flexible, open-ended opportunities for the participant to communicate perceived strengths of the program as well as general comments to the participants' discretion. Responses may inform HEN administration about what is going well and as a result offers a window into whether the programs service delivery goals are being met, or not. The following data are organized by the two questions: What do you feel is most valuable about the program? And, what do you feel would happen if you no longer had HEN assistance? Other comments will be presented at the end of this section.

Open-ended Question 1: What do you feel is most valuable about the program?

A total of 56 elders (81%) commented on this question and responses were arranged by HEN administration into 11 categories reflecting a range of themes, though some responses fell into more than one category.

Two groupings, "reliability/dependability/knowing it's available" and "able to stay at home/independence" each reflected the largest overall response rate of 17% (n=12). Responses that reflect the former theme were very straight forward such, "Dependability," "Reliability," or "It's good to know help is available if needed." The latter theme offered a bit more context such as, "Makes me feel more independent. I don't have to always ask or beg someone to take me to Drs, shopping, etc," and "It helps me stay out of a nursing home."

The next most cited theme was described as "helped/being helped" reflecting a 16% (n=11) response. Examples included, "Helps me keep my sanity," and "Having a chore, which I cannot do, taken care of." Remaining themes included specific services such as "cleaning and transportation," which received 13% (n=9) followed by "other/general," 14% (n=10). The theme

"caring" 9% (n=6) came next, and then "they do what I can't," 6% (n=4). Three categories "Quality of care," "companionship/communication," and "prompt/on time" were each noted a 3% (n=2), response and the last theme "Saving money/free of charge" was observed in 4% (n=3) of responses.

Additional examples included, "I can live alone OFF a bus line in my own home without a car." "It helps me do what I am not able to do in the winter & summer." "Allows me to continue to feel I have quality to my life, even though there are some things I cannot do." "Makes me feel more independent; I don't always have to ask or beg someone to take me to the Drs, shopping etc," as well as "receiving services with no charge, services otherwise unaffordable allowing seniors to stay in their homes. The program is a God-send."

Open-ended Question 2: What do you feel would happen if you no longer had HEN assistance?

Almost all participants 93% (n=64) offered a response to this question and, as in the last question, some answers fit into more than one category, which was also reflected in the breakdown within as well as between categories. The sections with the largest response rate, 25% (n=17) were described as, "house unclean/chores undone/couldn't get to doctor" and "unsafe/hardship/pain/lower quality of life." Responses such as, "That which my caregiver does for me just wouldn't get done," "I would have no way to get my groceries or get to medical appointments," and "I wouldn't be able to get the medical help I need because I'm disabled" reflect the first part. "Daily living would be much harder. Would be unable to keep up quality of living," "Health and quality of life would deteriorate," and "Daily living would be much harder" reflect the latter category.

"Other/blank" response was reported at 17% (n=12), while "nursing home/couldn't live independently," 16% (n=11) and "hire someone/rely on family member/find other source of help," 14% (n=10) were the next more common themes. "Higher expenses/unsure how to pay" and "don't know/inconceivable" were documented at 10% (n=7) and 6% (n=4), respectively.

Responses such as, "I'd die sooner," "It would be very depressing" and "I would be discouraged" reflect an emphasis on the theme of well-being which can be drawn from each of the categories. "I don't know, I'd have to come up with an answer" and "It would be very hard for me to stay in my home," are continued reflections on the perceived impact of life without HEN services.

Other Comments

For this section, results of the HEN survey noted an apparent continued response about whether participants could continue to live at home without HEN. This researcher's review of responses concurs with that of HEN administration though also observes a cross section of comments. Examples include, "Please continue this program," "HEN helps tremendously-peace of mind knowing the big cleaning will be done, allows me to still have pride in my home and helps keep the value up," and "Am old and unsteady-believe it is important to have my caregiver here and also to be assured that she would be available if I needed her in an emergency," all purport a perceived value of the program. In the end one person wrote "too many questions and a waste of paper and postage" while another commented, "I would force myself, until I had a heart attack and died. I will keep my own home."

CHAPTER V

DISCUSSION

The objective of this study was to assess the value and efficacy of in-home services provided by the Hilltown Elder Network (HEN). Data was obtained from a 2010 survey issued by HEN administration to HEN clients who had received services within the past twelve months. The findings presented support the overall assertion that HEN in-home services contribute to an elder's ability to remain safely and independently in their home, and by extension enhance overall well-being and quality of life, as measured by results of quantitative and qualitative responses. Findings align with previous research that documents formal home and community-based services as viable options that support the possibility of aging in place despite disability, chronic illness or impairments resulting from normal aging processes.

This chapter discusses the findings in the following order, 1) Key findings, describing the relationship between the study results and previous literature; 2) implications for social work practice, discussing how social workers can incorporate the findings from this study and why this is important to the field of social work; and 3) recommendations for future research in the area of home and community-based services. This chapter will also emphasize the limitations and biases of this study.

Key Findings

The value and efficacy of services provided by HEN were explored through the responses of an annual participant satisfaction survey. This section, exploring results through a secondary data analysis in comparison to the previous literature located in chapter II, is divided into the

following sub-sections, demographics, quantitative findings and qualitative findings. The quantitative findings are organized by four sub-sections including, direct services, caregivers, safety and quality of life. The qualitative findings are organized by question and will be followed by the client satisfaction scale.

Demographics

The majority of participants are among, or very near, the “oldest old” age category. The implication of this demographic is significant in that “...those in the oldest ages often require additional care giving and support” (Vincent & Velkoff, 2010, p.4). It is also evident throughout statistics on aging that the fastest growing segment of the aging population is those aged 85 and older, and this is expected to increase exponentially over the next few decades (Kinsella & He, 2009; Piercy, 2010; Rogers, 1999). Bane & Bull (2001) noted that, “...a higher proportion of rural elders are in the oldest-old category than is true for urban areas” (p. 8), which is likely to impact demand for services. The baby boom generation, as discussed by Vincent and Velkoff, (2010), may add to this demand in rural areas as a result of projected migration patterns. Almost all program participants reported annual household income among the range of “low” to “extremely low.” Bane and Bull (2001) caution about limited access to affordable services given that over half of rural elders are poor. This assertion indicated a need for the free services provided by HEN. Additionally, almost all participants reported living alone which adds to increased vulnerability.

Quantitative Findings

Direct Services

Just over one fourth of HEN participants reported the need for additional HEN services which may positively reflect HEN’s ability to accommodate the basic home and community

needs of program participants. Angel & Angel (1997) wrote that “The vast majority of such individuals do not need institutionalization, nor do they necessarily need a great deal of help” (p.136). The summary of “Ms. M” written by Hayes (2011) indicated that despite enjoying much independence at 103 years old, “She does, however, require some assistance with housekeeping, laundry and vacuuming. Stretching for bed can be a problem as is getting to the laundry room in the basement. Ms. M is able to prepare meals but needs assistance with shopping.” It appears that even with basic supports, depending on the individual, it is possible to remain living independently at home.

Caregivers

Formal supports offer a range of services, and in the realm of home and community-based services, formal supports are more common as options to age in place evolve. The facilitators of formal supports, the caregivers, must be skilled in ways that serve the needs of the client as well as respect the client’s inherent need for dignity and independence. When asked about the reliability and helpfulness of caregivers, HEN participants almost unanimously responded that, yes, they experienced their caregiver as reliable and helpful, which is important in all aspects of service delivery in general. In addition, almost all added that a friendly connection with their caregiver was important. Connections to others reduce a sense of isolation and loneliness that one may feel when old, and living alone with minimal or no access to transportation. In this spirit, Pynoos, Caraviello & Cicero (2010), write “Connections to in-home service provisions as well as informal neighborhood networks provide a defense against isolation among single elderly occupants” (p.143).

Safety

Safety is a major concern for elders living alone and an aging friendly home is synonymous with a safe home, as well as a fundamental aspect of long-term care. The need for long-term care arises from an inability to take care of oneself in a fully safe and independent way. As discussed, formal services increasingly assist in making a home or community aging friendly. When asked if exposure to strain or injury is lessened by having HEN help most participants answered yes, reflecting HEN's capacity to have influence in that sphere. When asked whether or not they felt they could continue to live safely and independently in their current home without HEN assistance, just over half responded "no," indicating a measurable impact of services. Viewing this from the perspective of "functional impairment" as discussed and Putnam & Stark (2006), the participant has a greater opportunity to live safely and independently due to a more accessible living environment thus increasing their overall sense of safety and independence, the main objective of HEN services.

Quality of Life

Quality of life refers to a state of general well being, and this can be a result of all services combined. The need of direct services fulfilled; an environment conducive to safety and independent living; a fulfilling relationship with caregivers, all contribute to quality of life. Questions in this section specifically asked about perceptions of reduced isolation and maintained or improved overall sense of health as a result of HEN services. In both respects, the majority of participants replied affirmatively. Most seniors prefer to stay at home even when suffering a serious decline in their health (Angel & Angel, 1997). This could impact their quality of life, depending on the severity of their situation and access to services, however, the alternative, such as institutional living, is largely perceived as undesirable. As discussed by

Pynoos, Caraviello & Cicero, 2010, home is a place embedded with psychological and emotional attachment. HEN also emphasizes the connection the importance of maintaining the connection to what is familiar including people as well as environments of the home and community.

Qualitative Findings

Two open-ended questions were asked, as well as a comments section, which concluded the survey; responses to the comments contained themes conducive to the open-ended questions and are considered in this part of the discussion. The results of the first question, *what do you feel is most valuable about the program*, indicated a broad range of experiences. Some spoke of reliability and dependability, several emphasized that they were able to stay home and in turn felt more independent. Others likened the assistance to the value of companionship and others were simply happy to have a clean house. The varied responses indicate the array of services offered and the perceived value of service, perhaps based on level of need fulfillment. For example, a range of services are offered and each participant is entrusted to know what they need, which is at the essence of this client-centered program. Having a say in provision of services can be a source of personal empowerment which is at the heart of the movement to “de-medicalize” home service delivery, as discussed by Putnam & Stark (2006).

The results of the second question, *what do you feel would happen if you no longer had HEN assistance*, also received a variety of responses from almost all participants. Some reported that things just wouldn't get done or that they would feel unsafe or experience hardship. Many said they wouldn't be able to get to the doctor or that daily life would be much harder. Others suggested giving up or depression might occur and many reported they might have to move. Again, it can be derived that overall quality of life is improved as a result of HEN services. And

by extension, improved health and functional status: Through positively impacting biological and non-biological determinants, as discussed by Richardson & Barusch (2006)

Participant Satisfaction Scale

Almost all participants reported satisfaction with HEN services and very few offered suggestions for improvement. The participants of HEN are, by definition, as heterogeneous a group of older adults as any other cohort of older adults. This includes differences in expectation and perception resulting from internal and external influences across the life span. As noted by Richardson and Barusch (2006), “People become increasingly differentiated as they grow” (p. 13). It may be inferred that despite these differences we all benefit from improved quality of life and results of the satisfaction scale indicate that having our basic needs met is essential for well being.

Implications for Social Work Practice

Research on aging and social work informs that implications for social work practice are exceptionally vast. Hooyman (2006) writes,

The opportunity and challenge for the social work profession is to address both increased longevity for the majority of older adults along with life span inequities for historically disadvantaged populations. Social Work, with its person-in-environment perspective and strengths-based values, is pivotally placed to foster innovative, multicultural, and cross-generational partnerships to enhance the well-being of adults and their families as they age (p. xxxvii).

The rapid growth of the older population means that social workers will increasingly encounter older adults in a variety of treatment settings (Hooyman, 2006, p. xxxi), which in turn

expands the context of social work practice (Greene, 2007, p.2). However, few social workers have yet to become “aging savvy” (Wilson, 2006, p. 1041).

As discussed, the point of HEN services is to assist elders in their ability to remain living safely and independently in their home for as long as they wish to and are able. Home, therefore, is central to the value of living independently, and this is known by the evident need and desire for home and community-based services, such as those provided by HEN. The reality, however, of formal service access and availability is limited due to political and financial constraints. It is therefore imperative, as Greene et al. (2007) writes that "As a part of their knowledge base, social workers require an operating knowledge of federal, state, and local policies affecting older adults" (p. 296).

For example, the efficacy of the aging network has come into question and the topic is poised for discussion as The Older Americans Act comes up for re-authorization this year, 2011. Eligibility and planning are central components of concern. For example, program eligibility requirements have progressively eliminated those elders who are *without considerable need of* support services. As is described by Hooyman (2006),

Having lessened emphasis on service provision to relatively well elders in the community, many states now extended coverage of the vulnerable from the frail old to the younger adults with disabilities. In this way the "eligibility axis" began to swing from elders in various circumstances to frail and disabled adults of all ages (p. xxxvi)

Essentially, the policies are what dictate the availability of public resources, and through this knowledge the social worker will be able to provide a more comprehensive treatment plan that will consider the multiple components of continuum of care. A HEN client, for example, either doesn't qualify for such public resources or are able to access some, but not all needs are

fulfilled. Options like HEN may be far and few between, but just because a person does not qualify for state care does not mean that services do not exist. In such cases, assessment, intervention, advocacy and coordination of care, all central tenants to professional social work practice, are essential in meeting the needs of older adults. Advocacy may be a particularly critical component in regard to an elder who has mental impairment more so than physical impairment, as the bias of services toward physical impairment is prevalent (Romaine-Davis, Boondas & Lenihan, 1995, p. 227).

Recommendations for Future Research

This section discusses the potential limitations and biases of the study and areas of further interest and future investigations are explored. This section is divided into the following subsections, 1) limitations and biases, and 2) future studies.

Limitations and Biases

Limitations of this study may be located in characteristics of the design or methodology, that, as defined by Cline (n.d.),

...set parameters on the application or interpretation of the results of the study; that is, the constraints on generalizability and utility of findings that are the result of the devices of design or method that establish internal and external validity. The most obvious limitation would relate to the ability to draw descriptive or inferential conclusions from sample data about a larger group (para. 4).

Reference to the above description would suggest a limitation in that results from the survey are useful for purposes of HEN program development and documentation of results; however the instrument itself is very specific to the overall objective and environment of the HEN program. It would not be possible, for example, to draw descriptive or inferential

conclusions about rural elders in another part of the country, especially given the relatively small sample size, but perhaps more so because of the great differences among rural areas and homogeneity of older adults, as discussed in the literature review. Another limitation involves the participant's ability and willingness to fill out, and return, the survey. Variance among attention span, literacy, eye site, manual dexterity and perceived invasiveness of questions about income and birthdates, as discussed by program manager Charlie Hayes, may all contribute to a sampling limitation. Given the multiple factors discussed, generalizability of the study cannot be assumed.

Study biases can be located in data collection, errors of perception or measurement, within the researcher, in the research question or design, and/or the sample selection (Anastas, 1999, p. 590). Conducting a study costs time and money. To increase response rate, HEN administration must often follow up with participants and this can be a time consuming process as well as a labor of love. For the 2010 survey, HEN administration was unable to follow up in a comprehensive way, unlike previous years. Whereas this may have resulted in reduced sample size, limited contact between, "...the researcher and the researched," as discussed by Anastas (1999, p. 314), may reduce the influence of participant subjective reactions, thus reducing a bias in data collection.

The reason that bias is pervasive is because we want to confirm our beliefs, and this is problematic because scientific research is organized about proving itself right, not wrong. Anastas (1999) writes, "The researcher is often immersed in the observational context, and the researcher and the methods of study themselves are part of what is studied and observed" (p.73). Although this study utilized a secondary data analysis based primarily on description of what

was already know, personal beliefs and values still influenced the literature review process, interpretation of findings, and perhaps most important, a bias in choice of the research topic.

Future Studies

Time was a limiting factor, and it is hoped that future research of elder home and community dwellers can be accomplished among those who are currently receiving home and community-based services as well as among those who may be in need of such services. Great emphasis was placed on the value of in home supports including a reduced feeling of isolation, an increased feeling of safety and independence as well as an overall improvement in quality of life. Perhaps there is much we do not know that could inform practice and service-delivery such as what influences perception of satisfaction of care. As noted in the introduction, client satisfaction is a measurement of quality of services, which in turn can only improve a human's overall sense of well being. The value of these improvements may be immeasurable, but perhaps not un-documentable.

Future research might be done to explore specificities about heterogeneity among rural older adults as well as cohort analysis. People among the oldest old, especially, have lived through tremendous cultural changes and now is the time to inquire about their stories. To this end, a life course perspective may be useful in that, "A central tenant to the life course include interactions between the individual and the environment, between the personal and the political, and between the micro (or clinical) and the macro (or policy) levels (Hooyman p. xxxii)." This kind of thinking helps conceptualize how we think about age and aging. This informs empathy and also may temper either implicit or explicit ageism. It is a framework that places people in the context of their lives and can offer an explanation of how our lives end up the way they do and how we might best respect one another's needs.

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Appendix A



October 5, 2010

Smith College
School for Social Work
Lilly Hall
Northampton, Ma 01060

To Whom It May Concern,

Hilltown Community Development Corporation and the Hilltown Elder Network (HEN) give permission to Deborah Grande to locate her research in this agency.

Ms. Grande will be analyzing data gathered from a 2010 HEN survey, and other regional survey data, distributed to and completed by our HEN Program clients and area residents.

Hilltown CDC and the HEN Program will abide by the standards related to the protection of all participants.

Sincerely,

Charlie Hayes
Social Services Program Manager
Hilltown CDC



A United Way Member Agency

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Appendix B

6/21/10

Greetings from The Hilltown Elder Network

We are writing to you because you are a HEN Program participant and have received HEN services during the past 12 months. In order to support the HEN Program activities Hilltown CDC applies to several funding sources. The major source of funding for HEN has been the Massachusetts Community Development Block Grant program. Our current proposal for 2010 is being evaluated in Boston at this time. Funding also comes from private sources and from individual donors and from HEN co-payments. To remain eligible for Massachusetts Block Grant funds we must gather information annually about HEN program participants' needs, levels of satisfaction, details concerning the forms of assistance provided and forms of additional services desired.

We are required to obtain only basic information, such as your age, town of residence and your most basic unmet needs. We also need to determine your level of satisfaction with HEN and list the services you would wish to see provided in the future. It is also required to have each participant complete a form which designates household income levels. We also must determine which program changes might be needed, based on input from you as program participants, and we want to offer each participant a means to convey your concerns to us.

The forms for you to provide this necessary information on are included with this letter. A stamped and addressed return envelope is also included for your convenience.

Your response is confidential and the results are used for planning purposes.

*We need to receive your completed survey by **August 1, 2010**.* Please feel free to call and talk with me or your local HEN Coordinator if you have questions or need assistance.

Thank you for being part of this great program!

HILLTOWN ELDER NETWORK
HEN PROGRAM PARTICIPANT SURVEY

June 2010

Your name: _____ **Social Security # :** _____

Your address: _____ **Town:** _____

Mailing address (if different): _____

Your date of birth: _____

Please circle the types of HEN services that you are currently receiving?

General cleaning

Heavy chore

Laundry

Shopping

Meal preparation

Driving/errands

Snow removal

Firewood/stove pellets etc.

Other services (please list here): _____

Do you need more help than you are now receiving? Yes____ **No**____

If yes, what form of additional help do you need (for example, escorted medical transport)? _____

If you feel that you *do* require additional assistance please estimate the *amount of extra time needed each week*. It might be helpful to contact your HEN Coordinator to estimate the additional time needed.

_____ **hours per week**

Would you describe your overall satisfaction with the HEN program as:

Excellent ?___ Good ?___ Fair ?___ Poor ?___ Other ?___

If you believe that HEN needs improvement we would appreciate your comments on which areas *most* need attention:

What do you feel is most valuable about the program? _____

Have your HEN Caregivers been reliable & helpful? Yes___ No___

Comments regarding your caregivers?

Do you feel that your exposure to strain or injury is lessened by having HEN help? Yes___ No___

In addition to the services HEN provides, is having a friendly connection with your HEN caregiver important to you? Yes___ No___

Do you feel less isolated as a result of having help from HEN?
Yes___ No___

Do you feel that your overall health has been maintained or improved due to having HEN help? Yes___ No___

Two last questions:

What do you feel would happen if you no longer had HEN assistance (for example, if there were no longer a HEN program)?

Do you feel that you could continue to live safely and independently in your current home without HEN assistance?

Yes _____ No _____

Other comments: _____

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The next page is the HEN income verification form. It is very important. Kindly check off the box that reflects your household's annual income and mail it to us, along with the completed survey, by August 1, 2010.

Once again, thank you very much!

HILLTOWN ELDER NETWORK

Gross Annual Household Income:

Effective 5/10

Name: _____

Town: _____

Household size (everyone who lives in your household): _____

Find your household size, then check one box on that same line showing into which range your income falls:

Household Size:	Income Below:	Income Between:	Income Between:	Income Above:
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1 person	\$17,350	\$17,351 - \$28,900	<input type="checkbox"/> \$28,901 - \$45,100	<input type="checkbox"/> \$45,100
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2 people	\$19,800	<input type="checkbox"/> \$19,801 - \$33,050	<input type="checkbox"/> \$33,051 - \$51,500	<input type="checkbox"/> \$51,500
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3 people	\$22,300	<input type="checkbox"/> \$22,301 - \$37,150	<input type="checkbox"/> \$37,151 - \$57,950	<input type="checkbox"/> \$57,950
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4 people	\$24,800	<input type="checkbox"/> \$24,801 - \$41,300	<input type="checkbox"/> \$41,301 - \$64,400	<input type="checkbox"/> \$64,400
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Signature: _____ Date: _____

Thank you very much!