Life Issues of Florida Women: Mid-Life and Beyond

2006 Annual Report

Florida Commission on the Status of Women

Florida Commission on the Status of Women

Office of the Attorney General
The Capitol, PL-01
Tallahassee, FL 32399-1050
Phone: (850) 414-3300
Fax: (850) 921-4131
Web: www.fcsw.net

Dear Floridian

On behalf of the Florida Commission on the Status of Women, we are honored to present our Fifteenth Annual Report, ***Life Issues of Florida Women: Midlife and Beyond***. This report was created to highlight a myriad of issues faced by Florida women age 55 and older, examining both the challenges and opportunities women confront throughout the last third of their lives.

The Florida Legislature, through Section 14.24, Florida Statutes, mandates the Commission to study the changing and developing roles of women in American society, including the socioeconomic factors that influence the status of women, the development of individual potential, and the encouragement of women to utilize their capabilities and assume leadership roles. The Commission's mission is to empower women from all walks of life in achieving their fullest potential. It is in fulfilling our mandate and mission that the Commission has chosen ***Life Issues of Florida: Women Midlife and Beyond*** as the focus of this 2006 Annual Report.

This report contains articles authored by experts in the health, transportation, housing, finance and sociology, among others, each focusing on significant issues of older women. It is our hope that this information impacts numerous audiences, including policymakers and government agencies. Most importantly, we hope that our message helps improve the lives of all Florida Women.

Sincerely,

Kathleen Passidomo
2006—2007 FCSW Chair

Laura McLeod

Laura McLeod
Annual Report Committee Chair

Acknowledgments

The Florida Commission on the Status of Women (FCSW) is grateful to the many individuals whose knowledge and dedication to Florida's women made this report possible.

This document is a compilation of research and essays by scholars, educators, advocates and professionals in numerous fields that affect women. The following individuals provided invaluable assistance in the creation of this report: Connie Siskowski, R.N., Ph.D., President and Founder of Boca Respite Volunteers; Stephen M. Golant, Ph.D., Professor, Department of Geography, University of Florida; Lisa Bacot, Executive Director, Florida Commission of the Transportation Disadvantaged; Marianne Issa, R.Nn, B.S.N., Florida Department of Health; Elizabeth Goldsmith, College of Human Sciences, Florida State University; Heather J. Gibson, Ph.D., Associate Professor, Department of Recreation, Parks and Tourism, University of Florida; Anastasia Garcia, Esq., Family Law Attorney; and Sara J. Czaja, Ph.D., Department of Psychiatry and Behavioral Sciences, University of Miami School of Medicine. Without their expertise, knowledge and experience, this project would not have been possible.

A special note of appreciation goes to the FCSW Annual Report Committee for their input and guidance of this project: Kathleen Passidomo, Esq., Commission Chair; Laura McLeod, Annual Report Committee Chair, Claudia Kirk Barto, Carrie Estevez Lee, Janet Mabry, Anita Mitchell, and Norma S. White, L.H.D. Also, former FCSW Commissioner Jeanne O'Kon, Ph.D., for her editing expertise in the publication of this report.

For their contributions throughout the creation of this report, FCSW employees, Lindsey Interlandi, Ebony Harris, Angella Jones, Michele S. Manning, CPM, and Kelly S. Sciba, APR, are thanked. FCSW would also like to extend our gratitude to Governor Charlie Crist, The Florida Legislature and the Office of the Attorney General for your continued support of the Commission and making this publication possible.

This report is dedicated to all Florida Women age 55 and older who are living full lives longer than most ever dreamed.

Forward

Dear Floridian:

The Florida Commission on the Status of Women publishes an annual report covering topics of specific interest to Florida's women. This year is no exception, as you will see from this an extraordinary report focusing particularly on the issues important to senior women. This publication is intended to be a tremendous asset to women throughout the state by providing insight on subjects related to aging, senior concerns and other meaningful matters.

Florida has always been a wonderful place to live and to retire. Our seniors are a rich asset to our state and deserve respect and recognition as such. I am confident that the Attorney General's Office and the Florida Commission on the Status of Women will continue to champion the rights and interests of Florida's women, including our senior citizens, through works such as this report. This report will be a unique and informative resource.

Sincerely,

Bill McCollum
Florida Attorney General

Table of Contents

Part I: Life Issues of Florida Women: Mid-life and Beyond

Forward
by Attorney General Bill McCollum, 3

About the Florida Commission on the Status of Women 6

Caregiving in Later Life—If Only There Was an Easy Recipe!
By Connie Siskowski, R.N., Ph.D. 8

Housing and Long-Term Care Needs of Florida's Older Women: Acknowledging the Gender Gap
By Stephen M. Golant, Ph.D. 19

Florida: A National "Headlight" for Elder Transportation Services
By Lisa Bacot 36

Introduction to Preparedness Planning for Women Over 55
By Marianne Issa R.N., B.S.N. 44

Financial Issues: Mid-Life and Beyond
By Elizabeth Goldsmith, Ph.D 51

Leisure in the Lives of Mid and Later Life Floridian Women
By Heather J. Gibson, Ph.D. 54

The Basics of Osteoporosis
By The Healthy Bones Project of the NACW 64

Older Women and HIV/AIDS
By Jane P. Fowler 66

Special Concerns for Elderly Immigrants
By Aude Sicard; Prolgue by Marie Flore Lindor-Latortue 70

Visitation and Custody Rights of Grandparents
By Anastasia Garcia, Esq. 74

A Summary of Recent Findings Regarding Older Women and the Use of Technology
By Sara J. Czaja, Ph.D. 76

Facts: Participation in the Labor Force
By The U.S. Department of Labor 79

Additional Resources 80

Part II: 2006 Annual Report: Florida Commission on the Status of Women

Commission History Highlights 84

FCSW Commissioners 86

Former Commissioners 95

The Florida Commission on the Status of Women

The Florida Commission on the Status of Women is dedicated to empowering women in achieving their fullest potential, to eliminating barriers to that achievement, and to recognizing women's accomplishments.

About the Commission

The Florida Commission on the Status of Women (FCSW) is established in the Office of the Florida Attorney General, and consists of 22 members. The Governor, the Speaker of the House of Representatives, the President of the Senate, and the Attorney General appoint four members, and the Chief Financial Officer and Commissioner of Agriculture each appoint three members. Each member serves for a term of four years. No member may serve more than eight consecutive years.

Commission Priorities

The Commission studies and makes recommendations on various issues including domestic violence, employment and education, family, welfare reform, gender equity, health care, and the judicial system.

Commission Mandate

As required by Section 14.24, Florida Statutes, the Commission is mandated to study and make recommendations to the Governor, Cabinet and Legislature on issues affecting women. These recommendations are presented in the form of an annual report, which is distributed during the first quarter of each year. Topics may include, but are not limited to:

socioeconomic factors influencing the status of women;

the development of individual potential;

the encouragement of women to utilize their capabilities and assume leadership roles;

the coordination of efforts of numerous organizations interested in the welfare of women;

the identification and recognition of contributions made by women to the community, state and nation;

and the implementation of recommendations to improve working conditions, financial security, and legal status of both sexes.

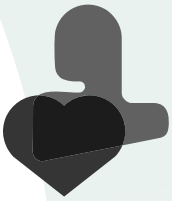
Commission Publications

Each year, the Commission produces an Annual Report on issues affecting women. In addition, the Commission has produced a number of educational brochures, calendars and special reports. Please contact the Commission office for copies of the following FCSW Publications:

- **1992 Annual Report "*Women in the Workplace*"**
- **1993 Annual Report "*Women's Health Care*"**
- **1994 Annual Report "*Justice and Human Rights; How They Apply to Women*"**
- **1995 Annual Report "*Welfare Reform in Florida*"**
- **1996 Annual Report Benchmark Study**
- **1996 Publication "*Women and Health, A Status Report*"**
- **1997 Annual Report "*Women and Economic Development*"**
- **1998 Annual Report "*A Definitive Study on Young Women Ages 12-18 in Florida*"**
- **1999 Annual Report "*Reflections and Projections: Women in Florida*"**
- **2000 Annual Report "*A Study of Women's History Education in Florida's Public Schools*"**
- **2001 Annual Report "*Prevention by Intervention: Girls in Florida's Juvenile Justice System*"**
- **2002 Publication "*Creating Change Challenging Tradition: Florida Women Public Officials*"**
- **2002 Annual Report "*A Passion to Play! 30 Years of Women's Athletics in Florida*"**
- **2003 Annual Report "Women and Money: Practical Money Skills for Women"**
- **2004 Annual Report "Legally Yours: A Guide for Florida Women"**
- **2005 Annual Report "Florida Women Mean Business"**
- **2005 and 2006 "Summary of Florida Laws Affecting Women"**
- **1999, 2000, 2004 FCSW Calendar**
- **2001, 2002 and 2003 Women's History Calendar**
- **Women's Hall of Fame Brochure**

The FCSW is administratively housed in the Office of Attorney General Bill McCollum.

For more information on the Commission visit our website at www.fcsw.net.



Caregiving in Later Life – *If Only There Was an Easy Recipe!*

By Connie Siskowski, R.N., Ph.D.

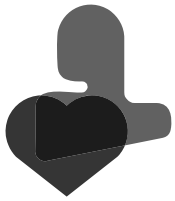
Connie Siskowski, R.N., Ph.D., is founder and president of Boca Respite Volunteers and the Caregiving Youth Project in Boca Raton, FL.

Caregiving – It is An Art

As one ages, some aspects of life are simpler and others much more complex. One thing is for sure, living is never static – it is dynamic with the ever presence of decisions and trade-offs. The chances of making the "right" decision are greater with informed decisions. We often deny, procrastinate and then feel that it is impossible to make some decisions until one is in the moment…in the experience…and sometimes it is then too late.

Caregiving is one of those experiences. The relationships, issues, and challenges of each family, each individual, and each health condition are unique to that caregiving family. There is no recipe book. There is also no guarantee that because an individual is a woman, successful caregiving will emerge from that female body, particularly the older body which may be undergoing its own health challenges.

Women caregivers who are 55 years of age and older may be required for a variety of situations. It is most difficult when a woman feels that she has no other option. She may care for a spouse or significant other, a parent, an extended family member, the sequel of a life-long experience of raising a child with a disability who is now an adult with the challenges of his or her future now looming in the horizon, or it may even be the daunting responsibility of caring for grandchildren. During the "55 alive" and beyond years the responsibilities of caregiving with adequate resources and support can give renewed purpose and meaning to life. However, the majority of caregiving women lack both.



(Continued from page 10)

Employed Older Caregivers

Although in recent years more men have taken on caregiving responsibilities, it is typically the woman—whether she is mother, wife, or daughter — who is the primary caregiver. Today it is common for a woman who is 55 years of age or older to be working. Employed caregiving women are likely to change their working schedules to meet the needs of their caregiving role often without regard for lower pay and associated benefits along with fewer opportunities for advancement.[1]

The Florida Department of Elder Affairs administers three volunteer-based programs, RELIEF, Senior Companion Program and AmeriCorps.

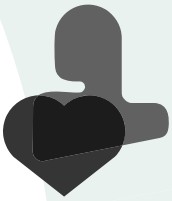
Additionally, retirement benefits, including those from Social Security, may also diminish. A female caregiver in her 50's or 60's who cares for a parent is 2.5 times more likely than her non-caregiving counterpart to live in poverty.[2] The calculated economic value of the adult caregiving role is $306 billion annually,[3] however not only to the family but also to society, caregiving is neither adequately recognized nor supported.

A Toll on Health

The chronic stresses of caregiving also take a toll on the health of the caregiver. Unsupported older spousal caregivers have a 63% higher mortality rate than those who receive support.[4] Throughout history, people and their families who have plentiful financial resources seem to fare well, including managing their health care at home. However, while wealth purchases services, it does not relieve the burden of stress upon the family caregiver who may now need to handle two lives instead of one. Seeing a loved one with ill health compounded by an inability to alleviate the suffering, along with feeling personally overwhelmed and fatigued, creates the perfect scenario for the family caregiver to become a patient.[5] When this happens, who is there to care for both persons?

Furthermore, when the care receiver has dementia, the multiple negative consequences of caregiving include immuno-suppression, coronary heart disease, hypertension, anxiety, depression, exacerbation of chronic illnesses, and even premature death. This results from hyper-production of IL-6. IL-6 is a pro-inflammatory cytokine that is typically associated with

(Continued on page 12)



(Continued from page 11)

age-related conditions and its production was found to be four times greater among stressed caregivers.[6] *The results of this study may also hold implications for caregivers of persons with other diagnoses.*

Caregiving by "older" women, those who are in their seventh and eighth decades of life or more is of particular concern because often these women feel there is no choice. Additionally, they are typically poor requestors of assistance, poor self-advocates, and inadequate navigators of the long-term care system. When caregivers do not speak English and cultural norms dictate that the best place for care is at home, there is greater potential for compounding these issues.

As people age, close friends and family die, leaving fewer people in the support network of older persons to call upon for assistance. Isolation besieges caregivers by default. Volunteer respite services offer some relief but they are not universally available, nor are health professionals universally aware of caregiver needs and/or available community services.

Economic Priorities

Economic constraints weigh heavily on caregiving decision-making. There are several factors that contribute to economic hardship: a) people outlive their savings; b) fixed income of previous years is now inadequate; c) increased out-of-pocket medical expenses use up minimal disposable income; d) blended families have protected financial assets; and, e) children protect their future assets and may not encourage sound decision-making or the use of income assisting techniques.

Moreover, households that are dependent upon the income from one who is disabled may be less likely to seek facility placement, even when there are indications for more intense or nursing home care. They are less likely to have in-home help through long-term care insurances and waiting lists are typically long for in-home public support.

Expanded Home Care Capabilities

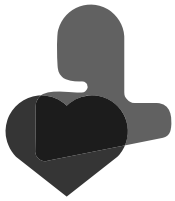
Technological advances allow persons to be cared for at home

(Continued on page 13)

Who Are Caregivers?

A recent Department of Elder Affairs survey of caregivers found that about half of caregivers provide care for a spouse while the other half are children or other relatives caring for a parent or loved one.

Florida Department of Elder Affairs http://elderaffairs.state.fl.us/english/caring.html



(Continued from page 12)

who in yesteryear would be cared for in a nursing home. There are staffing and qualification requirements of facilities in order to provide safe care. Yet, few providers focus on an assessment of the caregiver capabilities or other family as staff who are available to provide care. Thus, it is the caregiver, and particularly the older caregiver, who bears the burden and incurs consequences of noble acts.

Even when someone is in a facility surrounded by competent and qualified staff to help with personal care and life's basics, the family caregiving continues with different caregiving activities and still the emotional strain. Caregiving families require education, guidance, and integrated systems to support them in caregiving roles. Many people, including healthcare professionals, are not aware of community resources that help with care, nor do they know how to find and access them.

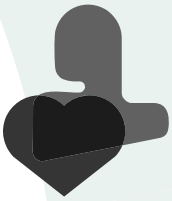
Legislative Support

The National Family Caregiver Support Program, enacted in 2000, has provided millions of family caregivers with information, assistance in accessing services, training, respite, and other supplemental services.[7] This program, administered by the Department of Health and Human Services of the Administration on Aging, benefits caregivers who are age 60 years or older as well as those caring for someone over the age of 60 years. In Florida, as in other states, monies for these benefits are distributed through the Area Agencies on Aging, and while they each follow established guidelines, there are differences in benefits from region to region. New legislation, signed by President Bush in December 2006, is for lifespan respite. Once implemented, it will hopefully begin to somewhat relieve caregivers of all ages.

Florida Can Do Things Differently!

The State of Florida has incredible resources in its family caregivers that need to be recognized and integrated into a systems approach. Families have changed more quickly than systems can respond and family-centered care rather than age-associated care makes sense for the future. A central resource for caregivers of all ages, cultures and caregiving situations in Florida would be meaningful.

(Continued on page 14)



(Continued from page 13)

Florida has examples of caregiver support that include women who are 55 years of age and older. There are disease specific associations that offer support, as well as the Florida Respite Coalition, the Polk County Caregivers Association in Lakeland, and the Sunflower House in Brevard County. Ultimately, real change can occur when the healthcare system identifies a caregiving family at the point of diagnosis and begins a system of planning and support from day one. Caregiving is an art as well as a special honor and relationship like no other.

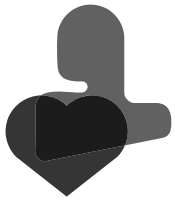
Caregiving women who are approaching their sixth decade and beyond have the opportunity of using the wisdom of their years to inform themselves and protect and preserve their own well being. Healthy habits must continue as a priority for caregiver well-being and sustainability. Caregiving women must make sure their legal status and financial well-being are sound. They must become knowledgeable about the health condition(s) with which they are participating in managing and work towards developing meaningful relationships with health providers to assure the best outcome and treatments. They must be open to developing a Plan B, to documenting care, to utilizing regular respite, and to being willing to explore advances in therapeutic modalities.

The role of the Internet in caregiver support is gaining momentum. There is information, education, skills building, and a sense of community to reduce isolation. Obtaining information from trusted and reliable resources is crucial in decision- making. These resources include:

- Children of Aging Parents (CAPS) – the oldest US caregiving organization offering information and referrals, support groups, educational outreach, speaker's bureau and publications as it seeks to heighten public awareness that the health of the family caregivers is essential to ensure quality care of the nation's growing elderly population. 1-800-227-7294 www.caps4caregivers.org.

- Family Caregiver Alliance – a public voice that supports and sustains caregivers throughout the country with information, education, services, research and advocacy. 1-800-445-8106

.(Continued on page 15)



www.caregiver.org.

- National Alliance for Caregiving - an organization created in support of family caregivers and the professionals who assist them; and to increase public awareness of issues facing caregiving families. 1-301-718-8444 www.caregiving.org.

- National Family Caregivers Association (NFCA) – offers free membership for all family caregivers and benefits including formation, education, publications and advocacy. 1-800-896-3650 www.thefamilycaregiver.org.

- Well Spouse Foundation – "When one is sick...two need help" is the slogan of the international support organization for wives, husbands and partners of the chronically ill and/or disabled. 1-800-838-0879 www.wellspouse.org.

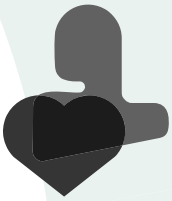
- **Internet Support:**
    a. www.caregiver.com
    b. www.caregivershome.com
    c. www.care-giving.com
    d. www.caregiving.com
    e. www.strengthforcaring.com

In conclusion and for future consideration three primary concerns for caregiving families in Florida:

- The need to develop special support services to protect the health of older spousal caregivers and to provide them with caring assistance upon the death of their spouse.

- The promotion of the assessment of caregiver capabilities followed by the encouragement of alternate solutions when the caregiver is unable to provide the care needed.

- The issues that are rapidly growing as our the population in Florida becomes more diverse including the needs of minority caregiving families, particularly among older women who have no expectation of reaching out for help that is so needed.



Endnotes

[1]U.S. Bureau of Labor Statistics: *Highlights of Women's Earnings in 2003.* Report 978. September 2004.

[2]Donato, Katharine and Wakabayashi, Chizuko: *Women Caregivers are More Likely to Face Poverty.* Sallyport, Magazine of Rice University Vol., 61 No.3. Spring 2005.

[3]Arno, P.S. (2006). *Economic Value of Informal Caregiving: 2004.* Update presented at the Care Coordination & the Caregiver Forum, Department of Veterans Affairs, January 25-27, 2006.

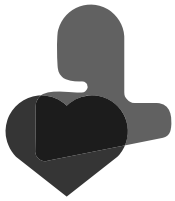
[4]Schultz, R., & Beach, S. (1999). Caregiving as a risk factor for mortality. *Journal of the American Medical Association*, 282, 2215-2219.

[5]National Alliance for Caregiving (NAC) & Evercare. (2006). *Caregivers in Decline.* Bethesda, MD: Author.

[6]Kiecold Kiecolt-Glaser, J.K., Preacher, K.J., MacCallum, R.C., Atkinson, C., Malarkey, W.B. & Glaser, R. (2003). Chronic stress and age-related increases in the proinflammatory cytokine IL-6. *Proceedings of the National Academy of Sciences of the United States of America*. *100*(15), 9090-9095.

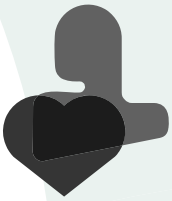
[7]U.S. Dept Health and Human Services. National Family Caregiver Support Program. Administration on Aging. Available at: www.aoa.gov/prof/aoaprog/caregiver/caregiver.asp.

Family Caregiver Support



Facts in Brief	Florida	United States
Older Population		
Population age 60+	3,545,100	45,797,200
Population age 65+	2,807,600	34,991,800
Population age 85+	331,300	4,239,600
Proportion age 65+ (National rank)	1st	N/A
Proportion age 85+ (National rank)	4th	N/A
Adults with Disabilities		
Percent of population age 21 to 64 with a disability	21.9%	19.2%
Percent of population age 65+ with a disability	39.5%	41.9%
Children Raised by Grandparents		
Number of grandparents raising grandchildren	147,893	2.4 million
Number of children being raised by grandparents	258,982 (7.1% of children under age 18)	4.5 million (6.3% of children under age 18)
Informal Caregiving		
Number of informal caregivers in the state	1.6 million	27.2 million
Caregiving hours per year	1.7 billion	29 billion
Market value of informal care	$15 billion	$257 billion

Developed by the National Association of State Units on Aging and the National Conference of State Legislatures with support from the U.S. Administration on Aging, http://www.ncsl.org/programs/health/forum/fcsflorida.htm.



Florida Area Agencies on Aging

Visit http://www.f4a.org/services.html or http://elderaffairs.state.fl.us/english/aaa.html

Area Agencies on Aging are federally-mandated organizations charged with the responsibilities of planning, coordinating, monitoring, and funding programs benefiting the needs of persons 60 years of age and older, as well as advocating on behalf of elder concerns.

Older Americans Act

Passage of the Older Americans Act by Congress in 1965 initiated the Administration on Aging (AOA) and the building of a national network of Area Agencies throughout the United States. The Act also provided for the establishment of a designated unit on aging in each of the nation's states.

Department of Elder Affairs

In Florida, the state unit is the Department of Elder Affairs (DOEA). The Department has the responsibility for overseeing both federal and state monies appropriated for aging programs.

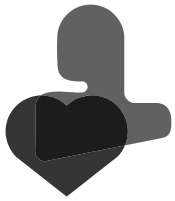
Florida's Aging Network

DOEA works closely with the eleven Area Agencies on Aging in Florida. The Area Agencies administer funds locally and contract with a variety of provider agencies to offer a wide array of services designed to address the needs of their senior constituencies.

Some of the services funded through Area Agencies on Aging include:

- Congregate and Home Delivered Meals
- Senior Center Activities and Adult Day Care
- Case Management
- Transportation
- Homemaker and Personal Care
- Legal Assistance
- Minor Home Repair
- Alzheimer's Respite
- Information and Referral

Contact Information



Northwest Florida Area Agency on Aging
5090 Commerce Park Circle
Pensacola, Fl 32505
850-494-7100
(Escambia, Okaloosa, Santa Rosa and Walton Counties)

Area Agency on Aging of North Florida, Inc.
2414 Mahan Dr.
Tallahassee, Fl 32308
1-866-467-4624 or 850-488-0055
(Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla and Washington Counties)

Mid-Florida Area Agency on Aging
5700 S.W. 34th St., Suite 222
Gainesville, Fl 32608
352-378-6649 or 1-800-262-2243
(Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy Marion, Putnam, Sumter, Suwannee and Union Counties)

ElderSource, Area Agency on Aging for Northeast Florida
4160 Woodcock Drive, 2nd Floor
Jacksonville, Fl 32207
904-391-6600 or 1-888-242-4464
(Baker, Clay, Duval, Flagler, Nassau, St. Johns and Volusia Counties)

Area Agency on Aging of Pasco-Pinellas
9887 4th Street North, Suite 100
St. Petersburg, Fl 33702
727-570-9696
727-570-5098 (Fax)
(Pasco and Pinellas Counties)

West Central Florida Area Agency on Aging, Inc.
5905 Breckenridge Pkwy., Suite F
Tampa, FL 33610-4239
813-740-3888
(Hardee, Hillsborough, Highland, Manatee and Polk Counties)

Senior Resource Alliance
988 Woodcock Rd., Suite 200
Orlando, Fl 32803
407-228-1800
(Brevard, Orange, Osceola and Seminole Counties)

Area Agency on Aging of Southwest Florida
2285 First Street
Fort Myers, Fl 33901
239-332-4233
Email: info@aaaswfl.org
(Charlotte, Collier, DeSoto, Glades, Hendry, Lee and Sarasota Counties)

Area Agency on Aging of Palm Beach/Treasure Coast, Inc.
1764 N. Congress Ave., Suite 201
West Palm Beach, Fl 33409
561-684-5885
(Indian River, Martin, Okeechobee, Palm Beach and St. Lucie Counties)

Aging and Disability Resource Center of Broward County
5345 N.W. 35th Ave.
Ft. Lauderdale, Fl 33309
954-714-3456
(Broward County)

Alliance for Aging
9500 S. Dadeland Blvd., Suite 400
Miami, Fl 33156
305-670-6500
(Miami-Dade and Monroe Counties)

There's No Place Like Home

By Department of Health and Human Services, Administration on Aging, http://www.aoa.gov/eldfam/housing/housing.asp

There really is no place like home. When asked about their preference for housing, most seniors answer, "What I would really like to do is to stay right here." The person's own home represents security and independence to most Americans.

Most housing, however, is designed for young. Active and mobile people. To live at home, a person must, at the very least, have access to transportation, go shopping, cook. And do household chores. Many of us will lose one or more of these abilities as we grow older.

One option is to purchase in-home services, to cope with declining abilities. For a fee, an army of workers will appear to cut your grass, wash your windows, cook your meals, do the shopping, and even provide personal care and/or skilled nursing care. This may be the option for you, depending on the amount of help you need. However, this can be expensive and will require a lot of management and coordination.

For people willing to relocate, there are plenty of options, although there may be some confusion about what all the terms mean. You may hear about "board and care homes," "personal care homes," "life care" and "continuing care retirement facilities." All refer 'to some type of "assisted living" or service-oriented housing.

"In almost every city in Florida, there are long waiting lists of low-income seniors who are in need of affordable housing. As these seniors wait for housing that they can afford, they become more frail and go longer without the supportive services they need to remain healthy and independent. In many cases, by the time their name comes up on the waiting list, they have already been placed in a nursing home."

- Jane Johnson, Director of Housing, Florida Association of Homes for the Aging
Presentation to The Commission on Affordable Housing and Health Facility
January 14th, 2002
Miami, FL
http://govinfo.library.unt.edu/seniorscommission/pages/hearings/020114/johnson.html

Housing and Long-term Care Needs of Florida's Older Women: Acknowledging the Gender Gap

By Stephen M. Golant, Ph.D.

STEPHEN M. GOLANT, Ph.D., a gerontologist and geographer, is currently a Professor in the Department of Geography at the University of Florida (1980 - present). Dr. Golant has been conducting research on the housing, care, mobility, and transportation needs of the elderly population for most of his academic career.

The author expresses his appreciation to Dr. Joan Hyde and Ms. Dora Kerner for their helpful comments on an earlier draft of this paper.

Women in Florida and in other states are expected to live an additional 28 years following their 55th birthday—to age 83—almost 4 years longer than men.[2] As they move through their middle and older years, they are more likely than men to experience three scenarios in their lives requiring that they cope with physical and mental frailties afflicting themselves and their family members. Their decisions will profoundly influence the suitability of their housing and care arrangements and the quality of their lives.

Scenario One

Beginning in their 40s and through their 60s, women will deal with an older mother or father who becomes frail and needs assistance. If other extended family members side are unavailable, women often assist her husband's parents. They must decide whether to invite their mothers or fathers into their own homes, offer or arrange sufficient assistance to allow them to stay put or age in place in their familiar homes, or encourage them to occupy an independent (congregate) living apartment, assisted living arrangement, or a nursing home. Typically, they spend a considerable amount of time caring for the older parent who is reluctant to move despite having difficulties living independently. At the same time, they may still have younger children, and sometimes even grandchildren, living in their household.[3] Thus, they become members of the so-called "sandwich generation" of women who are simultaneously saddled with the care responsibilities for both a dependent child and an older parent.[4] As marriage and childbearing have occurred at ever higher ages and people are living longer, this has become a more likely scenario.

(Continued on page 22)

(Continued from page 21)

Scenario Two

When women are in their 70s and 80s, their typically older husbands experience the frailties of old age. Wives are the most counted on for caregiving assistance and again will be faced with wrenching housing and care decisions. Their own health will influence their options. When they become caregivers for their husbands, they have an average age of just over 73. Thus, they may be asked to assist at the very time their own abilities are restricted by the debilitating physical and mental health problems of old age.[5] Even if their husbands opt to occupy a special purpose residential care arrangement, such as an assisted living facility or a nursing home, their caregiver responsibilities will continue. Women often feel compelled to function as proactive "watchdogs" or "adult babysitters" of their husband's care.

Scenario Three

When women reach their 70s and 80s, they must decide how to cope with their own physical and mental vulnerabilities. Those who cannot rely on a caring spouse are deprived of the often most dependable source of assistance. Marital decisions made earlier in life will be critical—remaining single, getting divorced, or having not remarried. Married women, however, are not guaranteed that they will be spared from dealing with the vulnerabilities of old age alone. Their typically older husbands may offer limited help because they also will be frail. These vulnerabilities along with their being unaccustomed to helping with household tasks may contribute to a living environment in disarray. Because they have shorter life spans than their often chronologically younger wives, they are also usually the first to die. Thus, the married older woman is also left without a spouse to assist with her demanding shelter and care needs. In the best of worlds, the rhythms of the life cycle will come full circle. A child—most likely, a daughter, but perhaps also a son or sibling will step up to assume the caregiving responsibilities. This may be less likely in Florida, however, where large geographic distances separate older persons and their grown children.

Florida is a showcase for these scenarios if only because of its

(Continued on page 23)

(Continued from page 22)

large current and projected population of older women. In 2007, over 2.9 million women were aged 55 and older, with almost a million aged 75 and older. Over the next 25 years these numbers will increase dramatically and by 2030, it is projected that 5.4 million women will be over the age of 55, with almost 2 million over the age of 75.[6] This 55 and older population will be a highly visible group representing almost 31% of Florida's female population in 2007, rising to 40% in 2030.

The Caregiving Scenarios and their Unintended Consequences

The above scenarios illustrate the pre-eminent role played by older women—mostly spouses, daughters, and daughters-in-law—as caregivers to this country's older population. Spouses spend an average of 153 hours a month assisting their husbands; daughters or daughters-in-laws spend an average of just under 100 caregiving hours.[7] The extent and quality of their efforts often determine if a frail parent or a spouse can remain in his or her own dwelling or move to some planned residential care arrangement.

For many wives and daughters, the caregiving role is an emotionally satisfying and a "giving back" gratifying experience. It can be construed as on-the-job training preparing them to cope with the frailties of their own old age. Whatever its rewards, caring for a family member often becomes very stressful. A cumulating body of research finds that older women who care for a family member may pay a heavy price.[8] Compared with their noncaregiving counterparts, they have higher rates of physical injuries, depression, anxiety, suicides and alcohol abuse, and they are sometimes abused by those they help.[9] When two or more siblings are both trying to assist, personal conflicts may erupt when they disagree on difficult care decisions. Daughters who did not have the best of past relationships with their mothers may be reluctant and even abusive caregivers. Working caregivers experience another layer of downsides. They are more likely to miss or to be late for work, require temporary leaves of absence, and have lower work productivity, altogether reducing their desirability as employees and their opportunities for promotion.[10]

(Continued on page 24)

(Continued from page 23)

Sadly, even as these caregivers make considerable personal sacrifices and have the best of intentions, their considerable efforts do not assure good quality care. Most caregivers have no training or experience to prepare them for their demanding responsibilities and they do not take full advantage of the resources available in their communities. Inadequate and irresponsible care always looms as unpleasant possibilities.[11] There is rarely careful government oversight of the informal care delivered in ordinary households.

Coping with the Scenario of their Own Frailty: Women Who Need Long-Term Care

Older women at all ages are at greater risk than older men of experiencing chronic physical or mental health problems that threaten their ability to live independently. Among the most important are arthritis, back/neck problems, heart problems and hypertension. Their impact may be magnified because older women are more likely to experience multiple chronic health problems, that is, comorbidities.[12] These ailments limit their physiological abilities, resulting in difficulties stooping or kneeling, reaching over one's head, writing, walking 2-3 blocks, and being able to lift 10 pounds.[13] The result is that women are more likely than men to need personal assistance performing what are commonly referred to as "activities of daily living" (or ADLs) or "instrumental activities of daily living" (or IADLs). ADLs refer to getting in and out of bed or a chair, taking a bath or shower, dressing, getting around inside the dwelling, eating, and using or getting to a toilet. IADLs refer to preparing meals, doing light housework, taking the right amount of medicine, keeping track of money or bills, and going outside the home.[14] Women may also have more difficulties coping with these activity limitations than men because of their higher rates of depression, anxiety, and other emotional problems.[15]

These gender demographics result in older women having a higher risk of ever needing long-term care.[16] Specifically, almost 8 out of 10 women who today turn age 65 in 2005 as compared with less than 6 out of 10 men, will eventually need assistance. Furthermore, women face the prospects of needing care longer—

(Continued on page 25)

(Continued from page 24)

just under 4 years as compared with just over 2 years for men. Additionally, 28% of women versus 11% of men will receive care for more than five years.[17] Most older women will receive needed assistance in the comfort of their familiar dwellings and long-occupied communities. Even the most vulnerable seniors express a strong preference to age in place.[18] A smaller percentage of frail older persons will rely on in-home care services by paid workers, or the personal care offered in assisted living or nursing home arrangements.

Coping with the Scenarios of Old Age: Two Challenges Especially Confronted By Older Women

The Demographic Challenge.—Coping successfully with these scenarios would be difficult under any circumstances, but older women are also disadvantaged because they have lower incomes than men. Being unmarried because of divorce or separation is unquestionably one of the most important predictors of poverty among older women. The widowed older woman also confronts some especially harsh economic realities. The death of a husband typically results in a reduction in her Social Security benefits and any private pension benefits she received in conjunction with her husband's past employment are typically reduced or stopped.

At least since the 1970s, widowed, divorced and never married age 65 and over women are typically more than three times as likely as married women to have incomes below the poverty level; separated older women are over seven times as likely. At higher chronological ages the poverty risk is even greater.[20] These poverty rates are especially high among African-American and Hispanic older women who are also more likely to be divorced or separated than white women, a trend that is projected to worsen.[21]

Even as today's women are more likely to have longer work histories, better jobs, and stronger earning histories than previous generations, their future Social Security benefits are scheduled to be lower relative to their earnings, and a later retirement age will mean smaller monthly benefits for those who take early benefits. Medicare premiums are also likely to take a bigger chunk out of the average Social Security check, and real personal tax rates are expected to be higher.[22]

(Continued on page 26)

(Continued from page 25)

The Mobility Challenge.—Driving one's own vehicle is unquestionably the mode of choice of older persons seeking to access multiple destinations within their communities. As the older American population has increasingly opted to locate in low-density suburbs or has been attracted to small town and rural living, the private vehicle has become even more essential.[23]

Today's older women, however, are less likely than older men to hold a driver's license. This gender gap initially becomes apparent when men and women are in their 50s and becomes magnified at the highest chronological ages. Older women in their 70s and higher, especially with lower incomes, have the lowest licensure rates of any age group. Lack of flexible transportation hampers older women who have assumed responsibility for a parent's or husband's caregiving needs or who are themselves trying to hold on to their independence.

Three factors are crucial: a large share of these women never learned to operate a vehicle earlier in their lives; second, at the higher chronological ages, they confront chronic health problems that make driving unsafe or impossible; and third, a high share of female immigrants to the United States are not licensed to drive. Hispanic and Asian women who are in their 50s and older are less likely than most groups to hold driver licenses.[24]

The good news is that over time this gender gap will close as the first factor (the cohort effect) dissipates in its influence. The gap—albeit smaller—will persist, however, because of the latter two factors.

Aging in Place and the Older Woman: It Ain't Nirvana

When frail older women remain in their own households, receiving inferior care from a well-intentioned family member may not be their only danger. They are also at risk of experiencing two other types of housing problems that cause us to question our ideal notions about aging in place.

(Continued on page 27)

(Continued from page 26)

First, a large share of low-income women—both homeowners and renters—now occupy dwellings in which they have high monthly expense burdens—that is, they spend more than 30% or even more than 50% of their incomes on their housing costs. Women who own their homes confront a unique set of financial stresses. Although most will have paid off their mortgages, their heating and cooling expenditures, property and hazard insurance, and property taxes can take a large chunk of their small fixed monthly incomes and make it difficult for them to pay for their other essential health care and living expenses.[25] Paradoxically, these recurrent expenditures may be unnecessarily high because they are utilizing only a fraction of their dwelling's space—once originally intended for a larger household. When they seek to draw on the equity of their dwellings to help pay for their expenses, low-income older women often turn to home refinancing strategies with unfavorable lending terms, namely high upfront closing and insurance costs and higher interest rates, especially if they apply for subprime or reverse mortgage loans. Florida's older women confront some distinctive financial problems when they occupy condominiums in the process of being upgraded or equipped for special physical needs. They must deal not only with increasing monthly condominium fees, but also large and sometimes frequent "one-time" condominium assessment charges to pay for the major physical renovations of their buildings. Financial realities often make an involuntary move their only option.

Second, women who are longtime homeowners must deal with all the maintenance and upgrade needs of an older dwelling. Dwellings with poor insulation, leaks, hard-to-open windows, and dated lighting, electrical, air and heating systems may jeopardize both their comfort and their safety. Even well-maintained dwellings, however, have features that increase their risk of accidents. Among the most common are slippery walking surfaces, the absence of grab-bars in bathrooms, torn and worn carpeting and unsecured throw rugs, unobtrusive balcony door thresholds, inaccessible cupboards, hard-to-reach appliance controls, unsafe space heaters, clutter, difficult to negotiate (transferring to and from) sofas, chairs, and beds, and poorly located electrical and plumbing fixtures.[26] Their limited finances

(Continued on page 28)

(Continued from page 27)

and inability to rely on their own sweat labor make it difficult for them to remedy these deficiencies. They may also be unable to count on the help of their children, who may lack the time, energy, interest, or money to help.[27] Getting assistance from these family members may be especially problematic in Florida when they live out of state. When the older occupants look for paid help, horror stories abound about their unsuccessful efforts to find affordable, but honest and competent workers.[28] Small problems often turn into larger and more costly ones.

Third, staying put in the familiar dwelling may be a one-way path to loneliness for the substantial share of older women who are unmarried or those who cannot depend on their spouses or children for emotional supports. Older women are more likely than older men to report being lonely and this risk is greater when they have lower incomes, higher levels of frailty, and are at the higher chronological ages.[29] Studies have also linked loneliness to the increased risk of symptoms of depression[30] and even Alzheimer's Disease.[31] These experiences contrast with the social relationships or recreational programs available to older women in purposively-planned residential care arrangements, such as congregate living or assisted living facilities.

In Florida, older women living alone may be especially disadvantaged. They must cope alone with the sudden and devastating onset of extreme natural disasters (e.g., hurricanes, tornadoes). Absent telephone service and electricity—and sometimes elevator service in their high-rise buildings—they feel isolated and helpless. They are especially vulnerable when they need medical or personal assistance during these times of crisis.

The Specific Needs of Older Women in Government-Assisted Rental Housing

Coping with the frailties of old age may be especially difficult for occupants of this state's federal housing rent-assistance programs, which provide affordable rental apartments to those with low incomes—for example, Public Housing, HUD-subsidized privately owned multifamily rental properties (especially Section 202), and Rural Section 515 properties. Along with their lower

(Continued on page 29)

(Continued from page 28)

incomes that severely restrict their care options, government assisted rental housing is often filled with older women over the age of 75, who live alone, are less educated, and are African Americans. Many are also unable to rely on family assistance. As one indicator, only 37% of an interviewed sample of these tenants in Florida felt that if they were sick or disabled, they could rely on someone to help them for a sustained period of time.[32]

The demographics of these older women put them at considerable risk of needing at least some long-term care, such as housekeeping, congregate meals, transportation, personal care, and medication management. There is, however, an inadequate supply of affordable rental complexes in Florida and elsewhere[33] that offer such supportive services to their tenants. Older women who might otherwise cope with their vulnerabilities in their apartments may have little choice but to move to more institutional-like residential settings.[34] On a more positive note, we have witnessed an increase in the availability of affordable rental complexes combined with supportive services targeting the frail—indeed the first affordable Public Housing project offering licensed assisted living (Helen Sawyer Plaza) was developed in Miami, Florida. A variety of political, administrative, and fiscal barriers, however, still restrict their availability.[35]

Choices: Slim Pickings

In light of the caregiving and dwelling problems often faced by older women, it is not easy to avoid the uncomfortable feeling that they or their family members opt to age in place in their current dwellings because the other choices are simply untenable. There is a danger that we over-rely on this one-size-fits-all solution even as we offer older women relatively few other viable options. Finding a smaller, easier to maintain, and more affordable home close to where one currently lives is difficult in Florida because of the shortage of moderately priced housing in its urban areas. Older persons are also discouraged from owning elsewhere because they confront the prospects of having a much larger property tax burden in a new dwelling—even if it is smaller. Relocating homeowners in Florida lose the benefits of the state's Save Our Homes cap on dwelling tax appraisal

(Continued on page 30)

(Continued from page 29)

valuations. Seniors may also be discouraged from moving to rental accommodations not only because of a narrow selection of affordable properties and their lack of supportive services, but because the equity they realize from selling their dwellings will make them ineligible for home- and community-based services potentially available to them under the Medicaid program.

There is, of course, no shortage of planned residential care arrangements in Florida that combine shelter and care in attractive hotel-like settings. Here older occupants can maintain their dignity, privacy and autonomy, even when they are afflicted with the most severe chronic health problems and disabilities. Assisted living and continuing care retirement communities now cater to older persons as impaired as those occupying nursing homes. Typically, over 70% of their occupants are women.[36] These options are restricted, however, to higher income older persons or those with children able and willing to absorb their high monthly costs and sometimes their large entrance fees.[37] Those searching for comparable affordable shelter and care options find that they are in very short supply.[38] When they are confronted by such limited choices, the poorest and most frail seniors may find they have little option but to remain in their current homes and apartments—whatever their problems—or to occupy a nursing home bed funded under the Medicaid program.[39]

Conclusion

This brief overview reveals a fundamental truism—that the housing and long-term care challenges of old age disproportionately impact the lives of older women. A wide array of legislative solutions—often in partnership with the private sector—will be necessary to address the inadequacy of their current shelter and care choices—particularly those available to the unmarried and the poor. Even as the aging in place mantra dominates, there is a danger that we romanticize the ordinary

(Continued on page 31)

(Continued from page 30)

apartment or house as a place to deliver and receive long-term care. In so doing, we may be failing to provide more appropriate and affordable housing and residential care arrangements to the most vulnerable groups of older women, and we may be presumptuously assuming that women should bear the brunt of elder caregiving responsibilities. Stakeholders in the state must also be wary of avoiding debate about governmental solutions that seem outside their legislative privy. As a prime example, any federal legislation that reduces Social Security benefits will disproportionately increase the ranks of poor older women in Florida—and the difficult task of satisfying their increased demands for affordable shelter and care will fall on this state's fiscal shoulders.

Stephen M. Golant, Ph.D.
Department of Geography, P.O. Box 117315
3117 Turlington Hall, University of Florida
Gainesville, Florida 32611
Office: 352-392-0494 Ext. 218
email: golant@geog.ufl.edu or golantsm@earthlink.net

Endnotes

[1]The author expresses his appreciation to Dr. Joan Hyde and Ms. Dora Kerner for their helpful comments on an earlier draft of this paper.
[2]Donna L. Hoyert et al., *Deaths: Final Data for 2003, National Vital Statistics Reports, Vol. 54, No. 13* (Washington, DC: National Center for Health Statistics, 2006).
[3]E. Fuller-Thomson and M. Minkler, "American Grandparents Providing Extensive Child Care to Their Grandchildren: Prevalence and Profile," The *Gerontologist* 41, no. 2 (2001).
[4]Charles R. Pierret, "The 'Sandwich Generation': Women Caring for Parents and Children," *Monthly Labor Review* September (2006).
[5]Richard W. Johnson and Joshua M. Wiener, *A Profile of Frail Older Americans and Their Caregivers* (Washington, DC: Urban Institute, 2006).
[6]Florida Economic & Demographic Research, "Florida Total Population by Age, Race and Gender: April 1 1970-2030," (The Florida Legislature, Florida, Economic & Demographic Research, 2007).
[7]Johnson and Wiener, *A Profile of Frail Older Americans and Their Caregivers*.
[8]Genworth Financial, *The Impact of Long Term Care on Women* (New York: Genworth Financial, 2006).
[9]S. R. Beach et al., "Risk Factors for Potentially Harmful Informal Caregiver Behavior," *Journal of American Geriatrics Society* 53, no. 2 (2005), Lynn F. Feinberg, K. Wolkwitz, and C. Goldstein, *Ahead of the Curve: Emerging Trends and Practices in Family Caregiver Support* (Washington, DC: AARP, 2006).
[10]Alice Ho, Karen Davis Collins, and Michelle M. Doty, *A Look at Working-Age Caregivers' Roles, Health Concerns, and Need for Support* (New York: The Commonwealth Fund, 2005), OWL, *Women and Long-Term Care: Where Will I Live, and Who Will Take Care of Me* (Arlington, VA: OWL, 2006).
[11]Marcia Clemmitt, "Caring for the Elderly," *Congressional Quarterly Researcher* 16, no. 36 (2006), International Longevity Center-USA, *Caregiving in America* (Washington, DC: International Longevity Center-USA, 2006).
[12]L. Jans and S. Stoddard, *Chartbook on Women and Disability in the United States* (Washington, DC: National Institute on Disability and Rehabilitation Research, 1999).
[13]Federal Interagency Forum on Aging Related Statistics, *Older Americans 2006: Key Indicators of Well-Being* (Washington, DC: National Center for Health Statistics, 2006).
[14]Jans and Stoddard, *Chartbook on Women and Disability in the United States*.
[15]U.S. Department of Health and Human Services, Health Resources and Services Administration, *Women's Health USA 2004* (Rockville, MD: U.S. Department of Health and Human Services, 2004).

(Continued on page 33)

(Continued from page 32)

[16]P. Kemper, H. L. Komisar, and L. Alecxih, "Long-Term Care over an Uncertain Future: What Can Current Retirees Expect?" *Inquiry* 42, no. 4 (2005).
[17]Ibid.
[18]AARP, *Fixing to Stay: A National Survey on Housing and Home Modification Issues* (Washington, DC: AARP, 2000).
[19]Alicia H. Munnell, *Why Are So Many Older Women Poor?* (Boston: Center for Retirement Research at Boston College, 2004).
[20]Ibid.
[21]Kilolo Kijakazi and Wendell Primus, *Options for Reducing Poverty among Elderly Women by Improving Supplemental Security Income* (Washington, DC: Center on Budget and Policy Priorities, 2000), Kathryn H. Porter, Kathy Larin, and Wendell Primus, *Social Security and Poverty among the Elderly* (Washington, DC: Center on Budget and Policy Priorities, 1999).
[22]Alicia H. Munnell, "Boomer Women: Retirement's Brave New World," *Aging Today* 28, no. 1 (2007).
[23]Stephen M. Golant, "Deciding Where to Live: The Emerging Residential Settlement Patterns of Retired Americans," *Generations* 26, no. 11 (2002), Stephen M. Golant, "Supportive Housing for Frail, Low-Income Older Adults: Identifying Need and Allocating Resources," *Generations* 29, no. 4 (2006).
[24]Alan E. Pisarski, *Commuting in America III* (Washington, DC: Transportation Research Board, 2006).
[25]Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century, *A Quiet Crisis in America: A Report to Congress* (Washington, DC: American Association of Homes and Services for the Aging, 2002), Stephen M. Golant, "Government-Assisted Rental Accommodations: Should They Accommodate Homeowners with Unmet Needs?" *Maine Policy Review* 12, no. 2 (2003).
[26]John I. Gilderbloom and John P. Markham, "Housing Modification Needs of the Disabled Elderly: What Really Matters," *Environment and Behavior* 28, no. 4 (1996), Laura N. Gitlin, "Adjusting "Person-Environment Systems": Helping Older People Live The "Good Life" At Home," in *The Many Dimensions of Aging*, ed. Robert L. Rubinstein, Miriam Moss, and Morton H. Kleban (New York: Springer Publishing Co., 2000), Susan Lanspery and Joan Hyde, eds., *Staying Put: Adapting the Places Instead of the People* (Amityville, NY: Baywood Publishing Co., 1997).
[27]Joint Center for Housing Studies of Harvard University, *Remodeling Homes for Changing Households* (Cambridge, MA: Joint Center for Housing Studies of Harvard University, 2001).

(Continued on page 34)

(Continued from page 33)

[28]Neighborhood Reinvestment Corporation, *Aging in Place: Solutions to a Crisis in Housing and Care* (Washington, DC: Neighborhood Reinvestment Corporation, 2002).
[29]Martin Pinquart and Silvia Sorensen, "Influences on Loneliness in Older Adults: A Meta-Analysis," *Basic & Applied Social Psychology* 23, no. 4 (2001).
[30]J. T. Cacioppo et al., "Loneliness as a Specific Risk Factor for Depressive Symptoms: Cross-Sectional and Longitudinal Analyses," *Psychology and Aging* 21, no. 1 (2006).
[31]Robert S. Wilson et al., "Loneliness and Risk of Alzheimer Disease," *Archives of General Psychiatry* 64, no. 2 (2007).
[32]Stephen M. Golant, *The CASERA Project* (Tallahassee, Florida: Stephen M. Golant and Margaret Lynn Duggar & Associates, Inc., 1999), Stephen M. Golant, "Housing the Poor and Vulnerable Elderly," *Shelterforce* 22, no. 1 (2000).
[33]Douglas Rice and Barbara Sard, *The Effects of the Federal Budget Squeeze on Low-Income Housing Assistance* (Washington, DC: Center on Budget and Policy Priorities, 2007).
[34]Jon Pynoos, Penny Hollander Feldman, and Joann Ahrens, eds., *Linking Housing and Services for Older Adults: Obstacles, Options, and Opportunities* (New York: Haworth Press, 2004).
[35]Stephen M. Golant, "Political and Organizational Barriers to Satisfying Low-Income U.S. Seniors Need for Affordable Rental Housing with Supportive Services," *Journal of Aging and Social Policy* 12, no. 2 (2003).
[36]American Association of Homes and Services for the Aging, *Continuing Care Retirement Communities* (Washington, DC: American Association of Homes and Services for the Aging, 2005), American Seniors Housing Association, *The Benefits of Independent Living Communities* (Washington, DC: American Seniors Housing Association, 2003).
[37]Genworth Financial, *Genworth Financial 2006 Cost of Care Survey* (New York: Genworth Financial, 2006).
38S. M. Golant and J. R. Salmon, "The Unequal Availability of Affordable Assisted Living Units in Florida's Counties," *The Journal of Applied Gerontology* 23, no. 4 (2004).
[39]Lisa Alecxih, *Nursing Home Use By "Oldest Old" Sharply Declines* (Washington, DC: The Lewin Group, 2006).

Common Housing Terms and Organizations

By The Florida Department of Elder Affairs,
http://elderaffairs.state.fl.us/english/housing.html

Assisted Living Facilities

Assisted living facilities (ALFs) provide housing, meals, personal care services and supportive services to older persons and disabled adults who are unable to live independently.

Adult Family Care Homes

Adult Family Care Homes (AFCHs) are private residences that provide housing, meals and personal care services to older persons and disabled adults who are unable to live independently.

Adult Day Care Centers

Adult Day Care Centers (ADCCs) provide services on a daily basis to frail elders and disabled adults who cannot stay alone during the day, but who do not need 24-hour inpatient care. ADCC services may include nursing care, social services, restorative services, medical and health care monitoring, exercise, recreational activities, physical, occupational and speech therapy, medication administration and well-balanced meals, as well as transportation to and from the facility. ADCCs can also provide the respite family members require to sustain healthy relationships while caring for their elderly loved one at home.

U.S. Department of Housing and Urban Development (HUD)

The U.S. Department of Housing and Urban Development (HUD) is the federal agency that oversees the public housing and Section 8 rental housing programs. In addition, HUD provides information regarding buying, selling and/or renting a home, as well as other housing-related information for consumers.

Florida Department of Community Affairs - Housing Resources

The Florida Department of Community Affairs (DCA) maintains Web-based inventories of affordable rental properties and multifamily properties for the elderly and disabled. DCA also provides other useful tools and resources for persons seeking housing in Florida .

Older Drivers in Florida

By The Florida Department of Transportation
http://www.dot.state.fl.us/trafficoperations/Operations/ElderRdUser.htm

Florida leads the nation with 18 percent of its population 65 and older. By the year 2020, one in four Florida residents will be 65 and older. Of these, almost one half will be 75 or older. For seniors, driving is the preferred method of travel as over 80 percent of trips made by those 65 and older are made in cars.

While older drivers are involved in fewer total crashes, the are in more crashes per miles driven. This also applies to injuries, where the number of injuries is less, but the severity is dramatically higher. Older drivers are less likely to survive a serious crash than younger drivers. Drivers 70 and older are more than twice as likely to be involved in a fatal crash than middle aged drivers.

Several trends in the health, economic and social status of older women will make these planning efforts complex. Tomorrow's older women will likely have somewhat improved longevity and possibly somewhat less disability for a given age than today's. They will more likely have had a long labor force experience, be more educated and affluent as a group and be responsible for a household. In addition, families will be smaller, creating more pressure for individual older women to be self-sufficient for mobility and transportation needs. All of this will raise the demand for safe mobility and transportation access, and at least in the near future, lead to more use of automobiles.

Seniors who no longer drive are faced with a lack of alternative transportation. Taxis are costly for people on a fixed income, and elderly people turn to friends, family or public transportation.

Making Roads Safer for Older Drivers

As we age, we experience a steady decline in certain skills that are very important for safe driving. Although not everyone ages at the same rate, beginning around age 55, we begin a gradual

decrease in our ability to process information, remember and make judgments in traffic situations. A good example is determining the distance and approach time of oncoming traffic.

However, visual losses are the most significant. We need more light to distinguish features along the roadway and must be closer to read signs and follow other traffic cues. Older eyes also need more time to recover from the glare of bright headlights at night. And these visual losses begin very early in life - around age 20. Medical studies have shown that the average 60-year old requires eight times more light than the average 20-year old, which explains why older drivers have particular difficulty driving at night.

Sometimes the driving abilities of older drivers are impacted by the medication they are required to take, and reaction times for older drivers may be up to 30 percent greater than younger drivers.

Florida: A National "Headlight" for Elderly Transportation Service

By Lisa Bacot

Lisa Bacot is Executive Director of the Florida Commission for the Transportation Disadvantaged, Tallahassee.

It's a bright, sunny morning in southwest Florida. An elderly woman is watching the clock, as she needs to arrive to her doctor's office by 9:30 a.m. sharp. A van pulls up her driveway and she's on her way to her medical appointment. The woman's name is Ms. Berlin and she is a long-time rider of the Good Wheels, Inc. transportation system in Lee County. She also has sat on the Board of Directors for Good Wheels since the organization began in 1990. Although she has had multiple sclerosis for more than 50 years, and has utilized a wheelchair for the past 20 years, she remains a very active member of the community. Ms. Berlin attends numerous meetings for the National Multiple Sclerosis Society and other disability and transportation related events to ensure her voice is heard.

In many states, this very productive, active woman would have risked losing her independence when her ability to drive stopped many years ago. It's a good thing she lives here in Florida, as she is still able to maintain her mobility and quality of life everyday, thanks to the transportation program administered by the Florida Commission for the Transportation Disadvantaged.

The State of Florida is known not only for its sunny weather and beautiful beaches, but it's also known as one of the leaders in the arena of coordination of human service transportation and other innovative transportation programs. Florida began the Transportation Disadvantaged (TD) Program back in 1979, with a legislative mandate to coordinate all social service transportation through one local, county-wide entity. It seemed like an impossible task, but the Coordinating Council on the Transportation Disadvantaged, the predecessor of the Florida Commission for the Transportation Disadvantaged, took on this challenge and rose to the occasion.

During the early stages of transportation coordination, the Coordinating Council began contacting transportation providers,

(Continued on page 39)

(Continued from page 38)

local planners, agency administrators, advocacy groups and client users in each county to assess the level of interest and capability in coordinating human service transportation. Some early conclusions of the input that the Coordinating Council received some 26 years ago still ring true today in many parts of the nation[1]:

- Reliable and moderately priced transportation is a major concern to elderly, disabled, and low income citizens.
- Rural citizens have few to no options, yet they cannot afford to live in areas where adequate transportation services are available.
- Social service agencies are providing commendable but often cost inefficient transportation for agency clients.
- Elderly, disabled and low income citizens who are not agency clients are striving to be self-sufficient, but have severe transportations problems, including excessive costs and scarcity of transportation services.
- There appear to be no Federal barriers hindering a more efficient use of social service transportation resources. Most impediments were embodied in state agency administrative bureaucracy and reluctance of local affiliates to share “hard-earned” transportation resources.
- The amount of Federal and State funds expended for disadvantaged client transportation is largely unknown.

These universal problems were systematically addressed in Florida, with the primary objectives being to reduce actual expenditures, increase the amount of services, improve the use of resources and improve the provision of services. The Coordinating Council began developing rules to implement strategies to address these challenges. After the language was drafted, the Coordinating Council conducted further public hearings and held workshops around the state to take input. Many consumer groups, including those that represent elderly individuals, attended these meetings and provided valuable testimony. Some of the facilities that serve the elderly constituency had serious reservations about the ability of the coordinated transportation system to deliver quality services at reasonable costs. There was also a reluctance to share the vehicles with other types of transportation disadvantaged

(Continued on page 40)

(Continued from page 39)

citizens[1].

Even with these hesitations, the coordinated effort in Florida flourished and the TD program now provides nearly 53 million trips per year to Florida's most vulnerable citizens. Each county in Florida has a "community transportation coordinator", or CTC, whose charge it is to ensure transportation services are provided in a safe, effective and efficient manner. This CTC is to be aware of all transportation services occurring in their respective service area to persons who are "transportation disadvantaged", as defined in 427.011(1), Florida Statutes:

> *"Transportation disadvantaged means those persons who because of physical or mental disability, income status, or age are unable to transport themselves or to purchase transportation and are, therefore, dependent upon others to obtain access to health care, employment, education, shopping, social activities, or other life-sustaining activities, or children who are handicapped or high-risk or at-risk ..."*

The elderly population remains one of largest users of the transportation disadvantaged system. A full 40% of all riders are considered elderly. This is not surprising due to the fact that the State of Florida leads the nation with 18 percent of its population 65 and older. By the year 2020, one in four Florida residents will be 65 and older. Of these, almost one half will be 75 or older.[2]

The State of Florida has attempted to improve not only the services that the non-driving elder receives, but the driving elder as well. For seniors, driving is the preferred method of travel, as 89 percent of trips made by those 65 and older are made in cars, either as a passenger or a driver.[3] While older drivers are involved in fewer total crashes than other age groups, proportionately, elders are involved in a more significant number of crashes as compared to the total miles driven. This also applies to injuries, where the individual number of injuries may be less, but the severity is dramatically higher than younger drivers. Older drivers are less likely to survive a serious crash than younger drivers. Drivers 70 and older are more than twice

(Continued on page 41)

(Continued from page 40)

as likely to be involved in a fatal crash than middle aged drivers[3].

That Florida Department of Transportation (FDOT) began their Elder Road User Program in 1991 to help seniors maintain their mobility and provide a safer system in which they can travel. The primary emphasis was to make roadway improvements, based on the FHWA's Highway Design Handbook for Older Drivers and Pedestrians that compensate for the natural effects of aging that apply to driving - especially visual impairment and a decrease in decision making. These improvements or countermeasures provided better guidance along roadways, more legible signs and increased advance warning of upcoming traffic and roadway conditions[4].

The FDOT began implementing these improvements immediately through routine maintenance activities and the work was completed within two years of implementation. With the implementation of the Elder Road User Program, they are working to improve the safety, access, and mobility of Florida's aging population. While these improvements are tailored to meet the needs of elder drivers, an added benefit is that it will help provide a safer roadway system for drivers of any age. For additional information on the Elder Road Use program, contact Gail Holley at gail.holley@dot.state.fl.us or (850) 410-5414.

Both transportation professionals and advocates for elderly persons have successfully joined together in Florida to form a partnership to ensure all citizens have access to safe, reliable and quality transportation services. By improving the mobility of elderly passengers and drivers, the lives of all Floridians are improved.

For more information, please contact:
Lisa Bacot, Executive Director
Florida Commission for the Transportation Disadvantaged
605 Suwannee Street, MS 49
Tallahassee, Florida 32399-0450
(850) 410-5711
Lisa.bacot@dot.state.fl.us

Endnotes

[1]Coordinating Council on the Transportation Disadvantaged (1980), "Transportation and You", Annual Report. Tallahassee, Florida.

[2]Elder Road Use Program Web Page, January 2007, http://www.dot.state.fl.us/trafficoperations/Operations/ElderRdUser.htm

[3]AARP Public Policy Institute (August 2005), Fact Sheet: Community Mobility Options: The Older Person's Interest.

[4]Elder Road Use Program Web Page, January 2007, http://www.dot.state.fl.us/trafficoperations/Operations/ElderRdUser.htm

The mission of the Florida Commission for the Transportation Disadvantaged is to ensure the availability of efficient, cost-effective, and quality transportation services for transportation disadvantaged persons.

Visit http://www.dot.state.fl.us/ctd/.

Community Transportation Contact Information by County

Visit http://www.dot.state.fl.us/ctd/contacts/ctcsbycounty.htm for more information.

Alachua
MV Transit
Phone: (352) 375-2784 x 1000

Baker
Baker County Council on Aging
Phone: (904) 259-2223 / (904) 259-9315

Bay, Holmes, Walton, Washington
Tri-County Community Council, Inc.
Phone: (850) 547-3689

Bradford, Dixie, Gilchrist, Lafayette
Suwannee River Economic Council
Phone: (386) 362-4115 x 242
Reservations: Bradford - (904) 964-6696
Dixie, Gilchrist - (352) 498-7366
Lafayette - (904) 294-2202

Brevard
Space Coast Area Transit
Phone: (321) 635-7815 ext. 236

Broward
Broward County Board of County Commissioners
Phone: (954) 357-8494
Fax: (954) 357-8345

Calhoun
Calhoun County Senior Citizens Association
Phone: (850) 674-4163

Charlotte
Charlotte County Transit Department
Phone: (941) 833-6244

Citrus
Citrus County Transit
Phone: (352) 527-5420

Clay
Clay County Council on Aging, Inc./Clay Transit
Phone: (904) 284-5977

Collier
Collier County Board of County Commissioners
Phone: (239) 213-5889
Reservations (Intelitran) : (941) 649-0228

Columbia, Hamilton, Suwannee
Suwannee Valley Transit Authority
Phone: (386) 362-5332

DeSoto
ATC Paratransit
Phone: (863) 382-6004

Duval
Jacksonville Transportation Authority
Phone: (904) 733-0483

Escambia
Pensacola Bay Transportation
Phone: (850) 469-8773 x202

Flagler
Flagler County Public Transportation
Phone: (386) 437-7300 x 318

Franklin
Croom's, Inc.
Phone: (850) 653-2270

Gadsden, Jefferson, Madison, Taylor
Big Bend Transit, Inc.
Phone: (850) 574-6266

(Continued on page 44)

(Continued from page 43)

Glades, Hendry

Good Wheels, Inc.

Phone: (239) 768-2900

Gulf

Gulf County Association of Retarded Citizens, Inc.

Phone: (850) 229-6550

Hardee, Highlands, Okeechobee

ATC Paratransit

Phone: (863) 382-6004

Hernando

MidFlorida Community Services, Inc.

Phone: (352) 799-1510 x 15

Hillsborough

Hillsborough County Board of County Commissioners

Phone: (813) 276-8999

Indian River

Indian River County Council on Aging

Phone: (772) 569-0903

Jackson

JTrans

Phone: (850) 482-7433

Lake

Lake County Program Analysis and Contract Management

Phone: (352) 253-6115

Lee

Good Wheels, Inc.

Phone: (239) 768-2900

Leon

Star Metro

Phone: (850) 891.5196

Levy

Nature Coast Transit

Phone: (352) 486.3485

Liberty

Liberty County Transit

Phone: (850) 643-2524

Manatee

Manatee County Board of County Commissioners

Phone: (941) 747-8621 x 222

Marion

Marion Transit Services

Phone: 352-620-3501 Ext 160

Martin

Council on Aging of Martin County, Inc.

Barbara Timmerman

Phone: (772) 283.1814 x 881

Miami - Dade

Miami-Dade Transit Agency

Phone: (305) 267-6305

Monroe

Guidance Clinic of the Middle Keys

Phone: (305) 434-9000 or (305) 434.9088

Nassau

Care-A-Van Consolidated Transportation Services

Phone: (904) 261-0701

(Continued on page 45)

(Continued from page 44)

Okaloosa

Okaloosa County Board of County Commissioners

Phone: (850) 833-9173,

Orange, Osceola, Seminole

LYNX / ACCESS LYNX

Phone: (407) 841-2279

Palm Beach

Palm Beach Board of County Commissioners

(561) 649-9848 ext. 3030

Pasco

Pasco County Public Transportation

Phone: (727) 834-3200

Pinellas

Pinellas County MPO

Phone: (727) 464-8200

Polk

Polk County Transit Services

Phone: (863) 534-5368

Putnam

ARC Transit, Inc.

Phone: (386) 325-9999

St. Johns

St. Johns County Council on Aging, Inc.

Phone: (904) 461-2012

St. Lucie

St. Lucie County Board of County Commissioners

Phone: (772) 462-1777

Santa Rosa

Pensacola Bay Transportation

Phone: (850) 469-8773 x202

Sarasota

Sarasota County Transportation Authority

Phone: (941) 861-1004

Sumter

Sumter County Board of County Commissioners

Phone: (352) 568-6683

Union

A & A Transport, Inc.

Phone: (386) 496-2056

Volusia

VOTRAN

Phone: (386) 756-7496 x 4112

Wakulla

Wakulla County Senior Citizens' Council

Phone: (850) 926-7145

Introduction to Preparedness Planning for Senior Women

By Marianne Issa, R.N., B.S.N..

Marianne Issa is a RN Consultant for Preparedness, Office of Public Health Nursing, Florida Dept. of Health

Introduction to Preparedness: September 11, 2001, as well as, the historic 2004/2005 hurricane seasons, force us to approach preparedness planning with new-found ambition, vision and purpose. It is not enough or realistic for us to solely rely on government agencies for assistance before, during and/or after events of these magnitudes, as resources quickly become depleted and alternative housing or shelters become overcrowded. Over the past few years, it has become increasingly evident that we must rely on ourselves and our families to develop a preparedness plan which is designed for our individual needs. The preparedness plan should be comprehensive for all events such as hurricanes, tornados, wildfires, flooding, and other natural and man-made events.

Preparedness Planning for Women Over 55: Preparing for disaster is important for all ethnicities, ages, and genders with varying levels of health and disabilities. The focus for this article will be the unique challenges faced by the 2.8 million women in Florida aged 55 years and over when developing a preparedness plan. While some of the issues to be discussed in this paper apply to all populations, this article will identify the concerns a woman needs to consider if she has assumed the role of caregiver for a spouse, parent(s) and/or child with special needs, who depend on her for varying levels and types of support.

When developing a preparedness plan, a systematic approach is advisable. Begin by considering personal needs and what absolute necessities will be required for at least 72 hours without assistance from community or governmental agencies. Personal needs and absolute necessities would include medications, medical supplies, non-perishable foods, water, ice and different means of communication including land lines that do not require electrical support, cellular phones with car charger and battery

(Continued on page 47)

(Continued from page 46)

operated radio and/or television (see www.floridadisaster.org for a listing of preparedness supplies and quantities per person, family disaster guide, and other preparedness related information.)

Individuals, however, should make the effort to store sufficient supplies for up to 5 days without government assistance, if possible. If preparing a plan for more than one person, all personal needs must be considered for each individual. Knowing what will be needed, the quantities, and having as many of the required items on hand at all times requires significant pre-planning.

How will caregiving or medical support services be provided for those who require assistance? The answers to these questions need to be included in the preparedness plan and confirmed by the appropriate provider of care. If generator power is required to support life sustaining equipment, this should be in place and ready for use well in advance of an event. Sufficient fuel should also be stored under safety precaution guidelines. Generators should undergo periodic maintenance to ensure proper operation when needed. Safety shutters may be considered if no other method of window and/or door protection is available. Shutter installation should be completed several days prior to an anticipated event. Important documents should be placed in a safe, dry, accessible location. Copies of these documents should be included in a preparedness plan, as well as all contact and emergency numbers. It is important to update a plan at least annually or more often if necessary.

If a mandatory evacuation is determined by the local emergency management, alternate sheltering options need to be considered as a part of the preparedness plan (see www.floridadisaster.org/County_EM/county_list.htm# for a list of local emergency management offices and www.floridadisaster.org/fl_county_em.asp for links to county emergency management Web sites). As such, a preparedness plan should include transportation needs. If unable to self transport, assistance may be arranged through a local agency or public transportation. Since counties offer different transportation

(Continued on page 48)

(Continued from page 47)

options, pre-planning to determine appropriate availability of transportation will need to be identified. If able to self transport, a full tank of gas should be available several days pre-event if possible.

Last minute or haphazard evacuation preparations place an unnecessary strain on limited local resources and may place the individual or family requiring medical or personal care at risk. If evacuated, one should anticipate that the return home will not be advisable or immediate after an event. As such, an individual should consider temporary relocation when developing a preparedness plan, identify resources that may assist with the relocation process and include this information in the preparedness plan.

General Population Shelters: General Population Shelters (GPSs) are available for individuals who do not require any special services other than a safe shelter, nourishment and utilities. The American Red Cross (ARC) and local emergency management agencies typically operate these shelters and pre-registration is not required. Although GPSs are operated by community agencies, each person or family must bring any items necessary to reasonably meet their personal needs, such as, linen, bedding (including air mattress or cot), clothing, medications, toiletries, books, non-perishable snacks, etc. Space and privacy within GPSs are limited. Also, not all shelters are activated during every event and opening should be confirmed before leaving home.

Special Needs Shelters: Special Needs Shelters (SpNSs) are shelters of last resort for those individuals with chronic illness or disabilities requiring medical assistance or electrical support of equipment to maintain current level of health. Pre-registration and approval is required and should be completed as part of the preparedness plan.

Registration information may be obtained through several resources, such as the local emergency management agency, county health department, primary care provider (PCP), nurse registry, home health agencies, hospice agencies or home

(Continued on page 49)

(Continued from page 48)

medical equipment providers. Most local emergency management agencies assume responsibility of accepting, reviewing and maintaining the registration information of individuals approved for SpNSs, but other agencies may be involved as well.

Completing a SpNS registration form is only the first step. After the registration is completed and submitted to the appropriate agency, the provided information will be reviewed for eligibility and one of several outcomes is reached:

Outcome One - The individual meets the criteria and a shelter is assigned and arrangements are made to provide transportation, if necessary.

Outcome Two - If the individual does not meet the SPNS criteria, he/she will be directed to use the general population shelter.

Outcome Three - If an individual's need exceeds the care that can be provided at the SpNS as determined by the appropriate agency or the individual's PCP, then alternate preparations must be made by the individual and included in the plan.

Last minute pre-event registrations are not routinely accepted for SpNSs and should not be considered as part of an individual's preparedness plan. However, if an unexpected situation occurs, a last minute SpNS registration may be approved and a request for transportation to a shelter may be considered on a case-by-case basis.

Again, keeping in mind, last minute registrations place an unnecessary strain on local resources, as well as placing individuals and resource staff in possible unsafe situations. Developing and maintaining a current preparedness plan reduces the likelihood of inappropriate sheltering and lack of proper care during emergency situations. In most counties, the Department of Health provides the medical personnel to support SpNSs and to assist with clients' medical needs. However, SpNS are not equivalent to acute care facilitates (i.e., hospitals) and individuals should not expect the level of care equivalent to a hospital within

(Continued on page 50)

(Continued from page 49)

a SpNS. Similar to general population shelters, space and privacy is limited within SpNS. Cots are the typical form of bedding provided and are available in most SpNS for clients only. Supplies including medication, medical supplies, linens, special non-perishable dietary needs and a caregiver if applicable, must be provided by the individual.

Pet Considerations: Many GPSs accept certain pets as long as the owner can provide a current vaccination record, an appropriate kennel, food and proper care during the stay in the shelter. Pet friendly SpNS do exist but not in all counties, and pets must be registered pre-event. Pets must meet the same requirements as mentioned above with the exception of owners providing care. For health and safe reasons, shelters that accept pets will house the animal separate from the shelter population. Pet plans need to be included in the preparedness plan to ensure safety for both pets and pet owners. If applicable, a preparedness plan should include the locations of ARC shelters, which are pet friendly. Knowing ahead of time if pets will be allowed in the assigned shelter allows the owner to make other pet care arrangements, thereby assuring timely implementation of a preparedness plan.

Financial/Personal Consideration: As previously mentioned, important documents such as insurance policies, wills, deeds, Do Not Resuscitate orders (DNR), etc. should be placed in a dry, safe environment and removed from the home, if evacuating. If power is interrupted, anticipate automated deposits will be delayed and/or funds may not be available. As such, individuals should plan to have enough cash available for 5 days.

Return to work may be delayed so this financial impact should be considered and properly planned for during the recovery period.

Special Considerations: When direct care, or responsibility of assuring care, has become difficult to manage or continues under current situations, consider sharing or delegating care to others. Alternative sources are family members or friends able to provide care and who may not have been equally impacted by local events or live out of area. Make sure all service providers know what the preparedness plan involves and the current location of those who require continued or resumed care. Pre-planning involves contacting agencies with services that may be utilized to assist with or assume care.

(Continued on page 51)

Suggested Resource:

www.redcross.org – Variety of supportive resources relating to events and other.

www.doh.state.fl.us – Florida Department of Health, preparedness guide and services information

www.salvationarmyusa.org – variety of supportive services

www.dca.state.fl.us – Description of all department programs and initiatives (850) 488-8466, toll free 1-877-352-3222

www.floridahealthstat.com – Lists licensed health care providers, facilitates information on insurance and medications.

www.apd.myflorida.com – Resource for persons with disabilities (850) 488-4257

Florida Department of Elder Affairs
(800) 963-5337 – Helpline for information on elder services and activities and link to local counties

http://elderaffairs.state.fl.us/english/GLR/sops.html - Information on assistance for caregivers and summary of other programs and services

http://elderaffairs.state.fl.us/english/elderhelpline.html - Link to county Area Agencies on Aging services and activities

http://floridacils.org – Florida Association of Centers for Independent Living 850-575-6004 or toll free 1-866-575-6004

www.myflorida.com/accessflorida - ACCESS, Automated Community Connection to Economic Self Sufficiency.
1-800-955-8770

Department of Children and Family Services
(850) 487-1111 - Resource for various services providing family support (877) 891-6445 – emergency financial assistance for housing

www.floridahousing.org – Florida Housing Finance Cooperation, housing program initiatives and services
(850) 488-4197

Resources listed here were sourced from *Alternate Site Discharge Planning Manual.*

References

Florida Department of Health; Alternate Site Discharge Planning, Resource Guide For Special Needs Shelters, August 2006

http://www.floridacharts.com/charts/chart.aspx CHARTS

http://www.doh.state.fl.us/PHNursing/SpNS/SpecialNeedsShelter/SpecialNeedsShelter.html Found on 11/6/06, accessed on 11/6/06

The following should be included in your basic disaster supplies kit:

- **Three-day supply of nonperishable food and manual can opener.**
- **Three-day supply of water (one gallon of water per person, per day).**
- **Portable, battery-powered radio or television and extra batteries.**
- **Flashlight and extra batteries.**
- **First aid kit and manual.**
- **Sanitation and hygiene items (hand sanitizer, moist towelettes, and toilet paper).**
- **Matches in waterproof container.**
- **Whistle.**
- **Extra clothing and blankets.**
- **Kitchen accessories and cooking utensils.**
- **Photocopies of identification and credit cards.**
- **Cash and coins.**
- **Special needs items such as prescription medications, eye glasses, contact lens solution, and hearing aid batteries.**
- **Items for infants, such as formula, diapers, bottles, and pacifiers.**
- **Tools, pet supplies, a map of the local area, and other items to meet your unique family needs.**

From FEMA, *Preparing for Disaster for People with Disabilities and other Special Needs.* Visit http://www.fema.gov/pdf/library/pfd_all.pdf.

Financial Issues: Mid-Life and Beyond

By Elizabeth Goldsmith, Ph.D.,

Elizabeth Goldsmith, Ph.D., is a Professor of Family Financial Analysis Florida State University.

"*To Infinity…and Beyond*," shouts Buzz Lightyear, the brave space ranger from Toy Story. Women don't have to worry about infinity, but they do have to prepare at mid-life for retirement while at the same time enjoying their mid-years to the fullest. And, some say the mid-years are the best. Do you agree or disagree? If you aren't enjoying them, ask yourself why and what you are going to do about it. There is no doubt that part of the challenge is being pushed and pulled between spending (daily life demands) and investing (saving and putting aside for the future). It all comes down to attitudes (your likes and dislikes), values, goal setting, and increasing financial acumen as much as it does to actual dollars.

Why focus on women? I do a lot of public speaking on women and money, and at my last talk on the more general topic of "How America Lives" at a health department in South Florida, a man spoke up and said "I need you to talk to my wife." So, I asked why and he said, "She knows nothing about money." Now, I'm including his comment not to offend or be sexist, but these kind of straight-from-the-hip comments show there is a gender gap when it comes to money (at least in this man's mind and he is not alone). My research backs this up; women absorb financial education like a sponge but sometimes they aren't exposed to as much as men, and more women are brought up to shop more than to invest. Media and industry play into this, but that is a subject for another article. And, certainly there are a lot of women with excellent financial minds and abilities and many women gain financial knowledge as they age often because of necessity.

In addition, women planning now for retirement have lived through dramatic economic, social, and demographic change compared to previous generations. It is estimated that over half of Baby Boomers are approaching retirement without adequate wealth to fund the years ahead. Defined contribution retirement

(Continued on page 54)

(Continued from page 53)

plans have outpaced defined benefit plan growth, placing greater responsibility on the individual to save for retirement and make prudent investment decisions. Large numbers of women are in the workforce (but still a pay gap exists between men and women), divorce rates have risen, and the number of childless families and single parent families have increased. Post-divorce income is often reduced for women and rights to a former spouse's retirement fund are limited. Many women make the mistake during a divorce to think about present needs and neglect future needs. In short, more women are alone out there to fend for themselves or to support children or aging parents without a spouse or partner.

Let's get practical. What should women do to increase savings and investments?

1. Get more education, formally or informally, read, and listen. If you go to programs or seminars, research shows that the factors which will improve the chances that you will like them and learn from them are: facilitator characteristics (Do you like the teacher or speaker? Is there a comfort level); level of complexity (Is it right for you?); learning styles (Do you like to take notes, use a workbook?), and semantics (Does the content have meaning?). Look for a program that appeals to your heart and your head, because a strictly analytical approach may be boring or ineffective.

2. Maximize you contributions to your retirement account, if your employer matches contributions. Money put in by your employer is like free money. If you don't know the match ask your human resources department. If you don't know how much you have already invested, ask them.

3. Use automatic payroll deduction to put money into your retirement plan and other investment vehicles such as U.S. savings bonds, mutual funds, and certificates of deposit. If you never have the money in your hands, you will not miss it.

(Continued on page 55)

(Continued from page 54)

4. When you change jobs rollover your retirement plan to the next employer if possible or re-invest in an Individual Retirement Account (there are several to choose from; Roth IRAs, if you qualify, are excellent).

5. Do not borrow from retirement funds and be cautious before taking out home equity loans.

6. Be active, be productive, and be involved. Ask questions. When a new business starts up, observe how it does; what are people buying?

7. Do not open a gift shop, antique store, boutique, or restaurant without seriously looking at the numbers first. Just because you like being in them doesn't mean a lot of other people will. The book, "*The Millionaire Women Next Door"* shows that many millionaires made their money in gravel and soil, exterminating services, and other ordinary, non-glamorous services and products.

8. Make sure your insurance coverage is appropriate for your life stage (maybe you need less and can put that money to work for you in other ways). Insurance is protection; ask yourself who or what do you need to protect?

We can learn from Buzz Lightyear and his courageous approach. We can think about life beyond today and investing is a big part of that. Save more, you won't regret it.

Seven of ten Baby Boomer women are expected to outlive their husbands. Many of those women will be widows for 15 to 20 years. Women who reach age 65 have an average life expectancy of slightly over 19 years, taking them to age 84. That's roughly four years longer than the average life expectancy of men turning 65.

From the National Endowment for Financial Education 2000. Visit http://www.nefe.org/pages/dynamicswhitepaper.html.

Leisure in the Lives of Mid and Later life Florida Women

By Heather J. Gibson, PhD.

Heather J. Gibson, PhD. is an Associate Professor in the Department of Tourism, Recreation and Sport Management, University of Florida

Common conceptions about leisure include "things that we do in our free-time" or "activities we like to do". Sentiments about leisure can be positive ranging from "it's what makes my life meaningful" and "I wish I had more time for it" to "leisure is idle", "it's what I do when all of the other important things are done", or even "I don't like leisure, it's boring." As a leisure researcher, I commonly encounter this range of conceptions and sentiments. In the process of sharing some of my work with Dr Candy Ashton-Shaeffer on leisure in the lives of mid to later life Floridian women (Gibson, et al., 2002, 2003, 2004a, 2004b, 2006), I will clarify hat leisure is and its value. The field of Leisure Studies espouses the view that while pleasurable activities and time free from other obligations provide access to leisure however, those qualities in and of themselves do not get at the real essence of leisure.

John Kelly (1987) a leisure sociologist, proposes that leisure is defined by two qualities, the meaning (existential quality) of a particular experience, particularly feelings of freedom and satisfaction, and the social context, both in terms of the wider societal influences that shape leisure and the likelihood that for many, leisure experiences are shared with others. As leisure scholars we believe that leisure is one of the three primary domains of life; work and family are the other two. It is best to think of these life domains as interconnected and that each domain may vary in priority over the life span as individuals encounter the different demands of each life stage. Thus, for young adults, work and career development might be more important than family, and for them, much of their leisure may be more connected with fellow employees than family. However, with marriage and young children, leisure becomes more family-focused.

So what happens when women enter mid and later life with the prospects of retirement, grandmotherhood, and the

(Continued on page 57)

(Continued from page 56)

accompanying changes in life's priorities and opportunities? This has been the focus of our work on the role of leisure in the lives of Florida's women aged 55 and over.

We have surveyed, interviewed, and visited rural, urban and suburban locales all over the State of Florida over the past ten years. We were particularly interested in studying this generation of women for whom active participation in the paid workforce outside of the home had become the norm rather than the exception. Thus, potentially these women would experience the transition from paid work to retirement, whereas, up until this point most of the research on retirement was based on men's experiences (e.g., Szinovacz, 1982). We were also interested in how leisure and family shaped the lives of women in mid and later life.

Our first study consisted of a state wide survey of women aged 55 and over. This revealed that for most women what Kelly (1987) calls the core leisure activities, such as socializing with friends and family, reading, church related activities, watching television and eating out were the most commonly cited. Some of these women were also quite active in swimming, golf, and tennis. We first began to formulate and idea that we call the "Florida Factor" in regard to these patterns. We wondered if a combination of climate, availability of facilities, and more importantly, the more general social acceptance of sport participation among older women in Florida might facilitate these leisure patterns compared to women of the same ages living in other parts of the country. Certainly, the climate in Florida appeared to facilitate more active lifestyles in the winter months. Moreover, the women, most of whom are year round residents also noted seasonal variations in their participation patterns with the summer months being quieter due to the migration of the snowbirds and sunbirds.

Dating from the 1950s there is research evidence to suggest that leisure contributes to later life satisfaction (Havighurst, 1957; 1961; Kelly, Steinkamp, & Kelly, 1987; Riddick & Daniels, 1984). Likewise, for the women in our study socializing, church, and out of the home activities in particular seemed to be linked to higher

(Continued on page 58)

(Continued from page 57)

life satisfaction, particularly if the women considered themselves to be in good health. Nonetheless, as explained earlier, leisure is not just about activity participation; it is about the meaning and attitudes towards an activity. Indeed, in this regard we first began to notice some patterns related to retirement and attitudes towards leisure in general. Interestingly, about one third of the women considered themselves retired but they had not actually retired from paid work. Later through some in-person interviews we found that for some women, their retirement status was designated by their husband's retirement, a pattern noted in other literature (e.g., Mason, 1988). We also found that the women who considered themselves retired had a higher regard for the importance of leisure, or what we call a high leisure ethic. Moreover, the older women in the sample, those in their 70s and 80s seemed to have a higher leisure ethic. We questioned whether this was the result of adapting to retirement, or was it a generational difference within the sample as the women ranged in age from 55 to 91? Thus, with these questions in mind, we began the next phase of our research, face-to-face interviews with some of the women who had completed the original questionnaire.

When we asked the women about their leisure we found a range of different meanings (Gibson et al., 2003/2004). For some women, leisure was a shared experience, primarily with their husbands, although for some, church groups or other friends were their leisure partners. These women often spoke about leisure as fun and pleasurable and described shared activities such as camping and dancing. Some of the other women described leisure in much more individualized terms and frequently used "I" rather than "we". Among these women there was a strong sense of entitlement to leisure at this stage in their lives, and the concept of choice and freedom (which are core components of leisure) were very evident. They spoke of leisure as the freedom "to do as they wished", even if this meant "doing nothing". Some spoke about the freedom that this stage in their lives gave them in terms of more free time and the sense that they had waited for this freedom as earlier periods of their life had been busy with children and work. As we delved a little deeper we also began to recognize that some facets of these women's lives facilitated their opportunities for leisure. These included time, health and for some "leisure partners" either

(Continued on page 59)

(Continued from page 58)

friends or their spouse. Equally there were constraints on their leisure including a lack of companions, changes in their or a family member's health, or a lack of money. Interestingly, while some women saw these constraints as interminable, others recognized them but were able to negotiate them somewhat. For example, one woman told us that her bad legs would no longer let her walk on the beach, so she had changed to walking in the pool instead.

As we continued to work, we returned to two themes first identified in our survey data, (a) attitudes and experiences of retirement and (b) their leisure ethic (Gibson et al., 2002). While, many of the women spoke of leisure as freedom and pleasurable, there were others who were much more negative, and words such as "idle" and "boring" were used. When we contextualized these sentiments within their wider lives and their experiences of retirement, we found some interesting patterns.

Women who defined their retirement either in terms of voluntarily leaving the paid workforce or in terms of their husbands' retirement saw this life stage as characterized by freedom, a reward for hard work, and leisure was seen as a reward. When we probed a little deeper we also found that these women had valued leisure throughout their lives. Even though in their earlier years they have may have felt "they didn't have much of it", they still had a high leisure ethic and saw leisure as contributing to their overall health and well-being. Conversely, there were a group of women who either resisted retirement and felt that they were being viewed as "old and unproductive," or another group who had created second careers for themselves usually as volunteers. There were women in these groups who also felt that they could not retire because they still had heavy care responsibilities for their families, both for spouses and their adult children and grandchildren. In the retirement literature, the idea that women never retire is often linked to the fact that while they leave the paid workforce they do not give up their work in the home (e.g., Calasanti, 1996). While this experience is common for many women, there were also women in the high leisure ethic group who were able to deal with this by setting ground rules with their husbands when they retired about sharing the domestic tasks. Nonetheless, as Gilligan's (1982) work shows women have a high ethic of care and it is hard for many to

(Continued on page 60)

(Continued from page 59)

change this to an ethic of self care. Indeed, the women in our study who tended to have the more negative attitudes towards retirement did have a high ethic of care, but they also had a low leisure ethic. They described leisure as boring, and for many, even though they had more freedom and time, they were not sure if they wanted it. They had never consciously valued leisure as an important part of their lives. In fact, they were quite fearful of "having nothing useful to do". So, they tended to shape their lives around service to others, either in the form of volunteering for community organizations or service to their families.

We are definitely not criticizing those who volunteer and provide many hours of service to the community. Volunteering is recognized by many leisure scholars as a form of leisure as it can be a meaningful, pleasurable, and social experience for those involved (Stebbins, 1992). Moreover, volunteering also has wider societal benefits, particularly in contributing to a sense of community and citizenship which is rapidly eroding in many western societies (Putnam, 2000). What is of more concern is the feeling that retirement for some of these women means they feel they are being discarded by society and they are no longer regarded as useful when in fact, these women are full of vitality and have much still to give and so they fill their lives with service and "keep themselves constantly busy". We might also question if this constant busyness more a reflection of a high protestant work ethic that tends to underpin the devaluing of leisure in this country more generally (Sylvester, 1999).

Ekerdt (1986) calls this constant need to be doing something the "busy ethic" whereby those in retirement feel they are being held accountable by the younger generations and cannot be caught not "doing anything". Remember here, the essence of leisure is not necessarily what you fill your time with, but how you feel about it. If individuals feel the pressure to keep busy doing things that they may not necessarily want to do, this is not leisure. Leisure is about choice and experiences that an individual finds meaningful and enjoyable. Part of the value of leisure is not just the pleasure it is the sense of autonomy inherent in the feeling that an individual can choose to do something she finds

(Continued on page 61)

(Continued from page 60)

satisfying. So those women who told us "if they want to sit with their feet up on the couch," this is their choice and they are exercising their autonomy. Classic psychological research shows that individuals who feel they have control over their lives are also more content (Rotter, 1966). As leisure researchers we recognize that this freedom of choice is more than likely a sense of relative freedom in that it is shaped by money, health and other opportunities. However, we also need to understand that most leisure experiences require very few resources and frequently constraints on leisure can be overcome.

For example, one of our research assistants focused on friendships among older women living in rural Florida and found groups of friends where aging-related constraints were not about to stop them from enjoying each other's company (Green, 2002). So in groups where only one female friend still had a driver's license she would take all of the others to their activities in her car. In another group of friends, one woman was largely confined to her house, so all of her friends came to her so that they could maintain their regular face-to-face contact.

Friendship as a form of leisure is often overlooked, yet one of the main characteristics of leisure is the social context. Leisure is commonly shared with others and the friendships in and of themselves may be the most important part of any leisure experience. Certainly, our survey research showed that socializing with friends and family was an important contributor to life satisfaction in mid and later-life Florida women. Likewise, Glass et al., (1999) in a study of mid and later=life individuals in New England found that social activities had a bigger influence on health than physical activities.

From a leisure research perspective, the key explanation may be that individuals need to create opportunities in their lives where the essence is freedom, enjoyment and meaning. For some these may be social experiences, while for others they may be more solitary. At all stages in the lifespan women need to take time for themselves and to value this time and stop feeling guilty about doing so. Instead of being viewed as idle time or feared for being boring, leisure needs to be part of the current discussions on

(Continued on page 62)

(Continued from page 61)

work-life balance. While leisure cannot solve all of our social problems and in studies throughout the world, leisure has been shown to contribute to the quality of life (Walker, 2006). So instead of praising long work hours and congratulating people for not taking their vacation time, we should be encouraging people to take time for themselves and their families throughout life, not just in retirement. International level comparisons show that U.S. residents have some of the longest work hours and lack vacation time, yet we are still not the most productive, nor do we compare well in indicators of health and well-being with our peer nations. Could the explanation for this be that our work-life balance is off kilter and we need to place more emphasis on the role of leisure in our lives? Certainly, the women in our studies who told us they had always valued leisure throughout their lives seemed to be the most content in their retirement years.

Older Women and Exercise: The Facts

- Muscular strength and endurance of older women can increase significantly through participation in a 12-week resistance-training program.
- Some older women who walk with the help of walkers can improve muscular strength necessary to convert from the use of a walker to the use of a cane through regular participation in a resistance exercise program.
- In ten weeks of three-times a week fitness training, older women, 72-98 years can more than double the strength in their leg and hip muscles.
- It is believed that the main cause of loss of strength in older women is lack of activity - most notably progressive resistance overload.
- Exercise has shown to be an effective means of weight-control by increasing energy requirements (at rest and during exercise), decreasing body fat, and maintaining metabolically active tissue in healthy older women.
- Research shows that highly active older women who have participated in a 3-day a week aerobic program for a minimum of 6 months can increase strength (5-65%), decrease body fat (1%), and increase fat free mass (1.5 kg) by undertaking a resistance exercise program, 3 times/week for 6 months with high adherence (83%) and without injury.

Source: www.womens-health-fitness.com

Calasanti, T. (1996). Gender and life satisfaction in retirement: An assessment of the male model. *Journal of Gerontology*, 51, S18-S29.

Ekerdt, D. (1986). The busy ethic: Moral continuity between work and retirement. *The Gerontologist*, 26, 239-244.

Gibson, H., Ashton-Shaeffer, C., Green, J., & Corbin, J. (2002). Leisure and Retirement: Women's stories. *Loisir et Societe/Society and Leisure*, 25, 257-284.

Gibson, H., Ashton-Shaeffer, C., & Sanders, G. (2002). The Role of Leisure in the Lives of Retirement-aged Women Living in Florida. In L. Doty, L. S. Lieberman, Flint, M., & Grant, K. (Eds.). *Successful aging: Women's' health and well-being in the second fifty years* (pp. 174-192). Proceedings of the Fourth Meeting of National Leaders in Women's Health Research, Gainesville, FL, March 2001.

Gibson, H., Ashton-Shaeffer, C., Green, J., & Autry, C., (2003/2004). Leisure in the Lives of Retirement-Aged Women: Conversations about Leisure and Life. *Leisure/Loisir*. 28 (3-4), 203-230.

Gibson, H., Green, J., & Ashton-Shaeffer, C. (2004). "A place to meet up with people you know:" Leisure as the context for friendship among older rural women. Paper presented at the Gerontological Society of America 57th Annual Scientific Meeting, Washington DC, November 19-23, 2004.

Gibson, H., Ashton-Shaeffer, C., Green, J., Nice, B., & Chang, S. (2004). Life and leisure in six small rural towns: insights from later life women. Paper presented at the 8th World Leisure Congress, Brisbane, Australia, September, 12-17, 2004.

Gibson, H., Ashton-Shaeffer, C., Kang, S., & Chang, S. (2006). Women's Roles in Life and Leisure in Rural Florida Revisited.

(Continued on page 64)

(Continued from page 63)

Paper presented at the World Leisure Congress, Hangzhou, China, October 16-20th, 2006.

Gilligan, C. (1982). *In a different voice: Psychological Theory and Women's development*. Cambridge, MA: Harvard University Press.

Glass, T., de Leon, M. C., Marottoli, R., & Berkman, L. (1999). Social, productive and physical activity as predictors of survival among elderly Americans. *British Journal of Medicine*, 319, August, 478-483.

Green, J. (2002). Friendships and the leisure of older women. Unpublished Master's Thesis, University of Florida, Gainesville, FL.

Havighurst, R. (1957). The leisure activities of the middle aged. *American Journal of Sociology*, 63, 152-162.

Havighurst, R. (1961). The nature and values of meaningful free-time activity. In R. Kleemeier, (Ed.) *Aging and Leisure*, New York: Oxford University Press.

Kelly, J. (1987). *Freedom to be: A new sociology of leisure*. New York: MacMillan.

Kelly, J., Steinkamp, M., & Kelly, J. (1987). Later-life satisfaction: Does leisure contribute? *Leisure Sciences*, 9, 189-200.

Mason, J. (1988). No peace for the wicked: older married women and leisure. In E. Wimbush & M. Talbot (Eds.), *Relative freedoms: Women and leisure* (pp.75-85). Milton Keynes: Open University.

Putnam, R. (2001). *Bowling alone: The collapse and revival of American community.* Simon and Schuster.

(Continued on page 65)

(Continued from page 64)

Riddick, C., & Daniel, S. (1984). The relative contribution of leisure activities and other factors to the mental health of older women. *Journal of Leisure Research*, 16, 136-148.

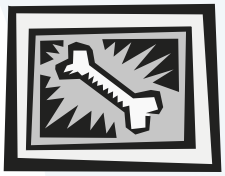
Rotter, (1966). Generalized expectancies for internal versus external control of reinforcement. *Psychological Monographs,* 80(1), 1-28.

Stebbins, R. (1992). Amateurs*, professionals, and serious leisure*. Montreal: McGill Queen's University Press.

Szinovacz, M. (1982). *Women's retirement*. Beverly Hills, CA: Sage.

Sylvester, C. (1999). The western idea of work and leisure: Traditions, transformations and the future. In E. Jackson, & T. Burton, (Eds.). *Leisure Studies: Prospects for the Twenty-first Century* (pp.17-33). State College, PA: Venture Publishing.

Walker, A. (2006). Quality of life in old age in Europe. Key note address World Ageing and Generations Congress, St Gallen, Switzerland, September 27-29th, 2006.



The Basics of Osteoporosis

Provided by Healthy Bones: A National Education Campaign of the National Association of Commissions for Women

Osteoporosis is a medical condition characterized by diminished bone strength and increased risk of fracture. Most people think of their bones as being solid like a rock. Actually, bone is a living tissue, just like other parts of the body—your heart, brain, or skin for example. Bone just happens to be a harder type of tissue. Bone is always changing. Your body keeps your bones strong and healthy by replacing old bone with new bone. After menopause the body removes more bone than it replaces which in many women may lead to osteoporosis. Osteoporotic bones are weaker and are more likely to break. Postmenopausal osteoporosis can be prevented, and with proper therapy it can be treated.

Who is affected?

An estimated 8 million women in the U.S. have osteoporosis. And 40% of women age 50 or older will experience an osteoporosis-related fracture in their lifetime. Osteoporosis also affects men, but to a lesser extent. For those at risk for or who have osteoporosis, prevention and treatment are the best defenses.

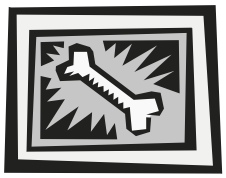
Diagnosis

Because bone loss is gradual and without warning signs, women often do not seek medical treatment until they experience a bone fracture. That's why osteoporosis is often called a "silent disease." To prevent the complications caused by osteoporosis, postmenopausal women should undergo a bone density test to determine the condition of their bones. If you are over age 50 and have other risks for osteoporosis such as the ones listed below, a bone density test could be your first step to understanding your risk for fracture.

Risk Factors

- Answering the following questions may help you to determine if you are at risk for osteoporosis-related fractures.
- Are you postmenopausal?
- Have you had a bone fracture after age 50?
- Did your mother suffer a fracture after age 50?
- Do you weigh less than 125 pounds?

(Continued on page 67)



(Continued from page 66)

- Are you taking oral medicines such as cortisone or prednisone?
- Do you currently smoke?
- Do you need your arms to stand up from a chair?

If you answered yes to any of these questions, you may be at risk for osteoporosis-related fractures. Talk to your doctor about your risk for osteoporosis.

Exercising for Better Bones

Reduced physical activity can lead to bone loss which may be difficult to regain, so prevention is key. Even a few minutes of exercise each day or several times a week can be beneficial to your bones. So don't become discouraged if walking for 30 minutes is too much. Start slowly and build up your time and speed gradually. Track your progress and reward yourself for reaching your exercise milestones. But, remember to consult your doctor before beginning any exercise program.

Tips to remember:

- You should be able to breathe normally and hold a conversation while exercising.
- Exhale while lifting weights and avoid jerky movements
- Maintain good posture while exercising

Although it sounds somewhat intimidating, a bone density test is one of the safest, most accurate ways to measure bone density and provide information about your bone health. Since you can't see or feel bone loss, this test is a way to tell if you have or are at risk for osteoporosis. Knowing your bone mineral density test result (which is called a T-score), your doctor can tell if you have lost bone and if you are at increased risk for fracture.

Understanding your risk for osteoporosis is the first step to preventing fractures. With this knowledge you can develop a strategy with your doctor that may include a diet rich in calcium, dietary supplements, exercise, and in some cases, prescription medicines. Your bones will thank you for taking this small but important first step.

Older Women and HIV/AIDS

By Jane P. Fowler

Jane P. Fowler is the director of the national HIV Wisdom for Older Women program.

Facts

- About 18 percent of AIDS cases in the U.S. female population are said to be in women older than age 50; and, numbers of cases are expected to increase, as women of all ages survive longer due to improved drug therapy and other treatment advances.

- In the last decade, AIDS cases in women over 50 were reported to have tripled, while heterosexual transmission rates in this age group may have increased as much as 106 percent.

- "Older women," according to UNAIDS, "appear to have higher incidence than older men, and during a recent 5-year period, the number of new cases in this group increased by 40 percent. More than half of the infected over 50 are of African-American and Hispanic origin, indicating greater risks among minority groups."

- In the U.S., elder African American women are disproportionately affected; in 2001 they comprised 11 percent of the population of women older than 50, but accounted for more than 50 percent of the AIDS and 65 percent of the HIV cases in this age group.

- While all older individuals with HIV infection or AIDS usually are invisible, isolated and ignored, this is particularly true of women, who are often unable to disclose their HIV status even to family and friends and, certainly, not their community.

- Despite myths and stereotypes, many senior women are sexually active, and, some are drug users; therefore, their behaviors can put them at risk for HIV infection.

(Continued on page 69)

(Continued from page 68)

- Health care and service providers---and older women, themselves---do not realize that they are at the same risk as other age populations; professionals often are reluctant to discuss or question matters of sexuality with their aging patients/clients.

- Most women (and all older persons) are first diagnosed with HIV at a late stage of infection, and often become ill with AIDS-related complications and die sooner than their younger counterparts; these deaths can be attributed to original misdiagnoses and immune systems that naturally weaken with age.

Special Considerations

- HIV/AIDS educational campaigns and programs are not targeted at or to older women (and men); how often does a wrinkled face appear on a prevention poster?

- Rates of HIV infection (not AIDS) in all seniors, including women, are especially difficult to determine because older people are not routinely tested.

- Older people, especially women, with HIV/AIDS face a double stigma: ageism and infection with a sexually transmitted disease; in addition, they are sensitive to a cultural attitude that assumes: "Elderly people have lived their lives -- so what if they die from AIDS?"

- Seniors of both sexes are unlikely to consistently use condoms during sex because of a generational mindset and unfamiliarity with HIV/STD prevention methods.

- For older women, there are special considerations: after menopause, condom use for birth control becomes unimportant, and normal aging changes such as a decrease in vaginal lubrication and thinning vaginal walls can put them at higher risk during unprotected sexual intercourse.

(Continued on page 70)

(Continued from page 69)

- As HIV symptoms are often similar to those associated with aging (fatigue, weight loss, dementia, skin rashes, swollen lymph nodes), misdiagnosis is frequent in older women/people who are, in fact, infected.

- Women and older males may confront social and professional bias regarding the allocation of limited health care services and resources available to the AIDS community (i.e., "why waste money on the elderly?")

- Because the aging process itself lowers energy levels and results in restrictions in social routines which can cause emotional/psychological problems, the older woman/adult additionally infected with HIV may feel another "loss" and endure more severe depression.

- Senior women often are less likely to find support and comfort among family and friends, and because they are traditionally not comfortable in support groups, and they may be less inclined to join them, citing lack of shared experiences concerning different issues.

- Due to the general lack of awareness of HIV/AIDS in older adults -- in particular, women -- this segment of the population, for the most part, has been omitted from research, clinical drug trials, educational prevention programs and intervention efforts.

Necessary Actions

- Specific programs must be implemented for older adults, especially women, who need to be informed about the transmission and prevention of HIV.

- Outreach should include workshops and trainings devoted to basic HIV/AIDS information, "safe" sexual and drug-using practices, testing, negotiation skills -- all in relationship to aging.

(Continued on page 71)

(Continued from page 70)

- More research is needed to study seniors' sexual and drug-using behaviors and to determine HIV disease progression and treatments in the over-50 population.

- Health care and service providers on all levels should be educated on HIV risk behaviors and symptoms of HIV infection; they need to conduct thorough sex and drug-use risk assessments with their older clients/patients.

- Programs aimed at reaching health care and service providers should cover misdiagnoses, testing technologies, treatments, support groups, case management and the importance of being actively involved in the health and well-being of their older clients/patients.

- Successful media and social marketing campaigns can raise awareness of HIV/AIDS in older people and reinforce the need for educational programs, while promoting respect and validation for the elderly as a group.

Jane P. Fowler compiled much of this tip sheet, based primarily on personal perspectives and experiences of consumers and professionals, while she was co-chairperson of the National Association on HIV Over Fifty. Now director of the national HIV Wisdom for Older Women program, she can be reached at: jane@hivwisdom.org. The web site is: www.hivwisdom.org.

Special Concerns for Elderly Immigrants

By Aude Sicard

Aude Sicard is a community relations specialist for Jackson Memorial Hospital's Cuban/Haitian Refugee Program.

Prologue by Marie Flore Lindor-Latortue B.A., M.H.S.A.

Over the past ten years that I have spent as a social worker specializing in health care, I have a particular concern for immigrant populations that tend not to seek appropriate health care. I have interviewed more than 30 elderly Haitian women and found that "I do not need to access health care if I am not sick" is a strongly held belief in the population. Elderly Haitian women, who tend to rely on traditional remedies instead of visiting a physician and who have only limited health insurance, are facing epidemics of high blood pressure and diabetes.

In addition, because immigration matters often affect this population, even though public funding is available, they are often reluctant to access these benefits. Lastly, the group affirmed that language barrier limits their ability to seek medical attention. There is a continuous need for services for this population.

I am grateful to Aude Sicard for authoring this article and bringing this attention to this important issue.

Caring for Our Elderly Immigrants

Caring for elderly parents is quite a challenge for the immigrant family. As they strive to continue living independently with integrity and dignity, the elderly face changes that can be legal, cultural, socio-economical, physical, and/or emotional.

Immigrating into a foreign country can be a stressful life event for the elderly. It generally brings about new financial, medical and psychosocial issues. Newly arrived elderly immigrants are entirely dependent on their families because of their ineligibility for government healthcare funds and supplementary social benefits. They don't have sufficient savings or insurance coverage from their previous employment from their countries of origin. Limited exposure beyond their ethnically-concentrated communities and strong cultural beliefs constitute barriers to successful acculturation. They consequently assume diverse roles

(Continued on page 73)

(Continued from page 72)

within the family, i.e. grandparent, counselor, maid, baby-sitter, housekeeper, doctor, nurse, and or teacher, and thus with their in-kind contribution provide largely for their upkeep.

Despite their important role, elderly immigrants are ineligible for federal health and welfare benefits despite their lawful presence in the U.S. Some of the factors that influenced immigrants' coverage and access to health care come from policy changes restricting Medicaid coverage and the resulting confusion surrounding eligibility for Medicaid. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) fundamentally changed cash assistance, and the treatment of legal immigrants with regard to Medicaid. Previously, all legal permanent residents and other legal immigrants had the same access to public benefits, including Medicaid, as did U.S. citizens (Friedland, Robert, 1997). Their eligibility for publicly funded health care varies depending on their income and their particular immigrant status (whether "documented," those in the country legally, or "undocumented," those in the country illegally). The impact of U.S. immigration policies on data collection, particularly in the post-September 11th environment, has rendered access to benefits more difficult. However, immigrants are protective of their anonymity and, as a consequence of their awareness of heightened security measures, they become more distrustful of a system they don't comprehend.

Immigrant elders with limited English proficiency are generally unable to enjoy the freedom of action they were accustomed to in their homeland. They depend on their children to translate their needs. They often feel limited and diminished in a way. This fact, coupled with the clash of cultures, is often perceived as a danger to traditional family values and mores. The complexities and costs of contemporary life in America are compounded by barriers and humiliations encountered daily by elderly immigrants. The stress of day-to-day living has negative health consequences for their health status, including mental health, especially among newer arrivals. Cultural barriers to health care and limited English proficiency are exacerbated by the lack of cultural competency of health care providers.

(Continued on page 74)

(Continued from page 73)

The elderly immigrant is at high risk for depression because he/she is more likely than younger people to have experienced illness, death of loved ones, impaired function and loss of independence. The cumulative effect of negative life experiences may be overwhelming to an older person. Depression is a medical illness characterized by persistent sadness, discouragement, and loss of self-worth. These feelings are accompanied by reduced energy and concentration, sleep problems (insomnia), decreased appetite and weight loss. In the elderly, it also frequently presents with excessive concerns about bodily aches and pains (Ponce, Ninez. 2006).

The challenges for healthcare providers are how to render services that are culturally-acceptable to elderly immigrants and how to finance the healthcare of the uninsured elderly immigrants who are not eligible for Medicare or Medicaid. Lack of insurance, language barriers, immigration status, and cultural differences are four of the main reasons preventing immigrants from seeking care. They would often rather use traditional remedies than try to navigate a health care system that doesn't speak their language.

A study conducted by the Keiser Foundation found that immigrants use 55 percent less health care than non-immigrants, and that both insured and non-insured immigrants use less services than the native born. Immigrants actually subsidize care for the rest of the population, according to the study, because they pay Medicare payroll taxes and health insurance premiums, but do not reap all the benefits of these services.

Florida's per capita spending on Medicaid ranks as one of the lowest in the country (46th nationally) despite having the fourth largest Medicaid enrollment, about 2.2 million. The state ranks near the bottom (worst) on a number of measures of health status, including the number of premature deaths per capita, prevalence of cancer, number of AIDS cases, and rate of violent crime. Despite its large elderly population, Florida has relatively low expenditures on long-term care. Long-term care is 28 percent of the state's Medicaid budget, compared with the

(Continued on page 75)

(Continued from page 74)

national average of 34 percent. Florida has not been as aggressive as some other states in maximizing federal funds. The state has not "abused" provider taxes and DSH spending as much as other states have done, according to many sources.

Recommendations

1. Expand outreach by community-based entities funded to disseminate information, and provide case management in order to decrease disparities in accessing health care by the immigrant community.
2. Promote prevention of diseases via workshops particularly for organizations addressing diabetes, hypertension and HIV/AIDS, three chronic health conditions that were cited as leading health problems within the immigrant/refugee community (UCLA).
3. Promote services for prevention, such as: cancer screening, preventive cardiology and immunizations. Preventive services could delay or prevent major illnesses that could deplete the limited financial resources of elderly immigrants and their families.
4. Increase and mandate continuing staff training on issues of cultural competence for health clinics and hospitals, regarding health-related values, beliefs and practices of our diverse population.

References

The Keiser Commission on Medicaid and the Uninsured – Key Facts. 2003. Immigrants-Health-Care-Coverage-and-Access-fact-sheet.

Friedland, Robert B., and Pankaj, Veena. 1997. National Academy on Aging. Welfare Reform and Elderly Legal Immigrants. www.georgetown.edu/research/ihcrp/agingsociety/pdfs/welfare.pdf.

Ninez Ponce, M.P.P., Ph.D., Leighton Ku, Ph.D., William Cunningham, M.D., M.P.H. *Language Barriers and Seniors: Implications for Medicare Policies* Presented by: Ninez Ponce, M.P.P., Ph.D., Assistant Professor, Health Services, UCLA School of Public Health.

Gorospe, Emmanuel C., M.D. 2006. Emerging Challenge for the U.S. Healthcare System. *Journal of Health Care Administration.*

Visitation and Custody Rights of Grandparents

By Anastasia Garcia, Esq.

Anastasia Garcia, Esq. is an attorney practicing in the area of Matrimonial Law.

There may come a time when grandparents have to face the reality of having to care for their grandchildren. If life deals them the hand of tragedy and their grandchildren loose both of their parents, there is the adoption process for them to contend with. However, this article deals with the circumstance where one or both of the parents are alive but not fit to care for the children, or a situation where one or both parents are denying the grandparents access to the children.

First, we are going to explore the issue of grandparent visitation, then we are going to explore the issue of custody to grandparents. As to visitation, under the Florida statutes, specifically Statute 752.01, grandparents have the option to ask for visitation if it is in the best interest of the minor child and or children if the following circumstances have occurred: a) one or both parents of the child are deceased, b) if the parents are divorced, c) if a parent has deserted a child or d) if a minor child is living with both parents and either or both parents are denying access or using their parental authority to prohibit the grandparents from having a relationship with the minor child. However, Florida Courts, including the Florida Supreme Court, have deemed this statute unconstitutional for several reasons. The Courts have determined that the statute violates the privacy rights of parents in an intact family. Furthermore, the Courts have concluded that the State has no interest in awarding this visitation unless the State is already involved in a case and the child is threatened with some kind of harm. However, where the matter is a choice made by a parent, the Courts have determined that there should be no intrusion by the government in the personal choices parents make regarding their children's relationship with grandparents.

However, pursuant to Florida Statutes 39.4105, a grandparent may have a right to visitation with a child if the child has been adjudicated a dependent child and taken from physical custody of his or her parent or legal guardian.

(Continued on page 77)

(Continued from page 76)

Pursuant to Florida Statutes found in Chapter 751, a grandparent or other extended family, may attempt to take custody of a child under several circumstances. One circumstance is if they have the notarized consent of the child's legal parents. In a situation, though, where there is no consent by the parents and there is a request by a third party, i.e. a grandparent, for custody, the custody should be denied to the parent only when an award of custody to the parent proves to be detrimental to the welfare of a child. To determine detriment to a child or unfitness of a parent under these circumstances, the statue refers to circumstances that are likely to result in mental, physical or emotional harm to a child. Under these circumstances, the Court could award Custody to a third party family member, i.e. a grandparent, on a temporary basis. Once the non-custodial parent proves that he or she is fit and that the child or children will not suffer harm or detriment while in their custody, then custody to the parent would be re-established even if a grandparent is able to demonstrate a superior ability to provide for the child financially, spiritually, etc.

Please note the difference between the visitation analysis and the custody analysis. In the visitation analysis, the conclusion is that it is almost impossible, at this time, for grandparents to obtain visitation rights to a child if there is an objection by either parent. In the unfortunate situation where parents are deemed not fit by a Court, a grandparent has the same ability as other extended family to seek custody. However, a custody award in that situation may be very temporary in nature and once a parent is able to establish the ability to care for a child, a Court will restore custody to them. The underlying analysis here is the constitutional right of each family to conduct its affairs without intrusion from the government while balancing the right of children to live happily in safe environments.

The one common theme in all of these situations is the Court will always look to the best interest of a child, despite the wishes of an adult.

A Summary of Recent Findings Regarding Older Women and the Use of Technology

By Sara J. Czaja Ph.D.

Sara J. Czaja, Ph.D. is a Professor in the Department of Psychiatry and Behavioral Sciences, Center on Aging University of Miami School of Medicine, Miami, Florida

Currently, all forms of technology, including computers, communication, safety, and health monitoring devices are being used to perform routine tasks and activities. Use of technology has become an integral component of work, education, communication, and entertainment. Technology is also being increasingly used within the health care arena for service delivery, in-home monitoring, interactive communication (e.g., between patient and physician), transfer of health information, and peer support. In 2003, about 66% of the U.S. population used a computer in some part of their daily life and about 55% accessed the Internet. Use of automatic teller machines, interactive telephone-based menu systems, cellular telephones, and video players is also quite common. Furthermore, telephones, television, home security systems and other communication devices are becoming more integrated with computer network resources providing faster and more powerful interactive services. To function independently and successfully interact with the environment, people of all ages need to interact with some form of technology.

Although older adults, in general, in the U.S. are increasingly using technology, an age-related digital divide still exists. More than 32 million of older people (55+ years) have a computer at home as compared to 62 million of people between 35-54 years. Similarly, although use of the Internet among older people is increasing, it is still lower than that of younger age groups. In 2005 about 26% of people age 65+ were Internet users as compared to 67% of people age 50-64 and 80% of those 30-49 years old. Recent data from our research indicate that older adults are less likely than younger adults to use other forms of technology such as automatic teller machines or VCRs.

Further examination of the “digital divide” also suggests some gender differences in the use of technology. For example, although in the general population there are no longer differences between the numbers of men and women who go on-line (67% men and 68% women) from home or at work, more

(Continued on page 79)

(Continued from page 78)

men aged 65+ (34%) use the Internet as compared to women in that age group (Pew Internet and American Life Project, 2005). Data from our recent study (Czaja, Charness, Fisk, Hertzog, Nair and Sharit, 2006) also suggest differences in use of technology according to gender among older adults. We examined differences in use of and attitudes towards technology among a sample of 1204 community dwelling adults ranging in age from 18-91 years. The older females in our sample reported using fewer technologies than did the older males. We also found that in general older people reported less use of technology than younger people. In addition, younger and middle-aged women (40 – 59 years) were more likely to have experience with computers and the World Wide Web (WWW) than older women (60+ years). Consistent with recent findings from the Pew Internet and American Life Project (2005) we also found no difference between males and females in use of the Internet. However, women in our sample reported less breadth of computer and WWW experience than males.

In today's world, not being able to use technology is disadvantageous with respect to independent living and successful negotiation of the built environment. Furthermore, the full benefits of technology may not be realized by people who do not interact with these systems. If well designed, technology holds great potential for improving the quality of life especially for older people who are ill or isolated. For example, technology and telemedicine/e-health applications clearly hold promise in terms of increasing the physical and emotional well-being of older people. Use of technology can also enable older people to remain connected to family and friends, especially those who are distant. Technology also can help older people remain employed and maintain or upgrade their skills or ease the transition to retirement. However, unless we have an understanding of why some adults have difficulty adapting to new technologies, successful use of technology will continue to be a challenge for many people.

In this regard our research has shown that attitudes towards technology are an important predictor of technology adoption. We also found that the women in our sample reported that they would have more problems learning and be able to successfully use computers than men. The older women also reported more computer anxiety. Findings from the recent Pew report (Pew

(Continued on page 80)

Internet and American Life Project, 2005) also indicate that in general men are more likely than women to try new technologies and have more confidence in interacting with different types of technology. As a consequence men are more likely than women to be able to troubleshoot and fix technologies such as computers. These findings are important given the pervasive use of technology and computers throughout society and the fact that as women age, they are more likely to live alone. We need to develop strategies to ensure that women, especially older women, have equal access to technology, available technical support and confidence in their ability to successfully interact and use technical systems. Although the gender gap is closing with respect to use of technologies such as the Internet and computers, a gender divide still exists for some subpopulations of women.

References

Czaja SJ, Charness N, Fisk AD, Hertzog C, Nair SN, Rogers W, Sharit J (2006). Factors Predicting the Use of Technology: Findings from the Center for Research and Education on Aging and Technology Enhancement (CREATE). *Psychology and Aging*, 21, 333-352.

Pew Internet & American Life Project (2005) How Men and Women Use the Internet. Available on-line at: http://www.pewinternet.org/pdfs/PIP_Digital_Divisions_December 28_2005.pdf

Facts: Elderly Participation in Labor Force

- Of the 59 million wage and salaried women working in the United States as of June 2000, less than half — just 47 percent — participate in a pension plan.
- Women's employment patterns are different than those of men. They are more likely to work in part-time jobs that don't qualify for pension coverage, or to work fewer years in pension-covered employment because of interruptions in their careers to take care of family members.
- On average, a female retiring at age 55 can expect to live another 27 years, four years longer than a male retiring at the same age, and females need needs to save for these extra years.
- Studies indicate that women tend to invest more conservatively than men, receiving lower rates of return from their investment over time, thus reducing the amount of savings they have at retirement.
- There were 10.3 million employed women aged 55 and over in the U.S. in 2004.
- These women were most frequently employed in management, professional and related occupations (3.9 million) and sales and office occupations (3.8 million).
- The remainder were employed in service occupations (1.8 million); production, transportation, and material moving occupations (674,000); and natural resources, construction, and maintenance occupations (78,000)..

Source: U.S. Department of Labor, Bureau of Labor Statistics, Employment and Earnings, January 2005

Additional Resources

Finance

Alliance for Investor Education (AIE). www.investoreducation.org.

AIE is dedicated to facilitating greater understanding of investments and the financial markets among current and prospective investors. AIE pursues initiatives for education and joins with others to motivate Americans to obtain objective information and increase their knowledge and understanding of investing.

American Financial Services Association Education Foundation (AFSAEF).
http://www.afsaef.org

AFSAEF is a non-profit organization to heighten consumers' awareness of personal financial responsibility.

919 18th Street NW, Suite 300

Washington, DC, 20006

(202) 466-8611

American Savings Education Council (ASEC).
www.asec.org.

ASEC's mission is to make saving and retirement planning a priority for all Americans.

Suite 6002121 K Street NW
Washington, DC 20037

(202) 659-0670

National Endowment for Financial Education (NEFE).
http://www.nefe.org/

The National Endowment for Financial Education is a non-profit foundation dedicated to helping all Americans acquire the information and gain the skills necessary to take control of their personal finances

5299 DTC Boulevard, Suite 1300
Greenwood Village, CO 80111

(303) 741-6333

Women's Institute for Financial Education (WIFE).
http://www.wife.org

WIFE is the oldest non-profit organization dedicated to providing financial education to women in their quest for financial independence.

PO Box 910014
San Diego, CA 92191

(760) 736-1660

(Continued on page 83)

(Continued from page 82)

Insurance

Florida Insurance Education Foundation (FIEF). http://www.insuranceed.org/
FIEF is a non-profit organization dedicated to educating and empowering consumers with the knowledge needed to make informed insurance decisions.
2888 Remington Green Circle, Suite A
Tallahassee, FL 32308

National Women's Health Information Center (NWHIC). www.womenshealth.gov
NWHIC gives current information resources on women's health today. It offers free women's health information on more than 800 topics through their call center and web site.
(800) 944-9662

Women's Health

Administration on Aging (AOA)
http://www.aoa.gov
AoA is one of the nation's largest providers of home and community-based care for older persons and their caregivers. AoA's mission is to develop a comprehensive, coordinated and cost-effective system of long-term care that helps elderly individuals to maintain their dignity in their homes and communities.
Administration on Aging
Washington, DC 20201
(202) 619-0724

National Partnership for Women and Families. http://www.nationalpartnership.org
A non-profit, non-partisan organization that uses public education and advocacy to promote fairness in the workplace and quality health care.
1875 Connecticut Ave NW, Suite 710
Washington, DC 20009
(202) 986-2600

Office of Women's Health (OWH)
http://www.4woman.gov/
OWH coordinates the efforts of all the HHS agencies and office involved in women's health. OWH works to improve the health and well-being of women and girls in the United States.
8270 Willow Oaks Corp Drive
Fairfax, VA 22031
(800) 994-9662

(Continued on page 84)

Women Miscellaneous

American Association of Retired Persons (AARP)
www.aarp.org.
AARP is a private, nonprofit membership organization dedicated to enhancing the experience for mature Americans through advocacy, information, and services.
601 E Street NW
Washington, DC 20049
(888) OUR-AARP

Older Women's League (OWL). http://www.owl-national.org/
The only national grassroots membership organization to focus solely on issues unique to women as they age, OWL strives to improve the status and quality of life for midlife and older women.
3300 N Fairfax Drive Suite 218
Arlington, VA 22201
(800) 825-3695

Social Security Administration. www.ssa.gov

The National Center on Women and Aging.
http://iasp.brandeis.edu/womenandaging/finances/
The mission of the National Program on Women and Aging is to focus national attention on the special concerns of women as they age, to develop solutions and strategies for dealing with these concerns, and to reach out to women and organizations across the country, promoting the changes necessary to improve older women's lives.

Florida Commission on the Status of Women 2006

Commission History Highlights

1961 — **President John F. Kennedy created the Presidential Commission on the Status of Women (PCSW).**

1964 — **Florida Governor Farris Bryant created the Governor's Commission on the Status of Women (COSW) to study laws and regulations pertaining to women in Florida and make recommendations to the legislature based on their findings.**

1966 — **The Commission presented its first report to Governor Farris Bryant.**

1967 — **Florida Governor Claude Kirk announced the appointment of 14 new members to the COSW, bringing the total number of commissioners to 24.**

1971 — **Governor Reubin Askew reestablished the Governor's Commission on the Status of Women by executive order.**

1974 — **Governor Reubin Askew appointed an executive director to help coordinate the Commission's activities.**

1977

The Commission's budget is cut and its fate between 1977 and 1978 are not known.

1979

Governor Bob Graham reactivated the Governor's Commission on the Status of Women (still referred to as the COSW) by means of Executive Order 79-60.

1982

The first Florida Women's Hall of Fame ceremony and reception was held by the Commission at the Governor's Mansion in Tallahassee in May of 1982.

1991

Governor Lawton Chiles lobbied the Florida Legislature to statutorily create the Florida Commission on the Status of Women after he took office in 1991. The leading sponsor in the House of Representatives for CS/CS/HB 109 was Representative Elaine Gordon, while Senator Carrie Meek sponsored the companion bill, SB 1324. The Commission's legislative authority now exists in Section 14.24, Florida Statutes. Since 1991, the Florida Commission on the Status of Women has been fully supported by the Governor, the Cabinet and the Florida Legislature.

2006-2007 Commissioners

NANCY C. ACEVEDO

Commissioner Acevedo of Winter Springs was appointed to the Commission in 2002 and reappointed in 2004 by Speaker of the House Tom Feeney. Commissioner Acevedo is currently an Intelligence Analyst with the Seminole County Sheriff's Office/ Intelligence Center/Homeland Security. She is a graduate of the University of Puerto Rico and the Inter-American University, and holds a Ph.D. in Education. As part of her professional accomplishments Acevedo served as San Juan Compliance Director, and as advisor and representative of the U.S. Government to the Government of Colombia. Commissioner Acevedo has served as lecturer with the National Canners Association and has collaborated in the preparation of the Food and Drug Guidelines. She has been a speaker for the Institute of International Research in Washington, D.C. regarding new drug regulations and requirements. She is also an active member in many other civic and professional organizations. Acevedo is a recipient of numerous awards for her exemplary work, community service and dedication to public service.

She is a graduate of the SCSO Community Law Enforcement Academy, member of the Advisory Board for the Use of Excessive Force since 2000, an active member of the Florida Crime Intelligence Analyst Association (FCIAA), the International Association of Crime Analysts (IACA) and the International Association of Law Enforcement Intelligence Analysts (IALEIA). Commissioner Acevedo currently serve as instructor for "Your Child & the Internet" course offered by the Seminole County Sheriff Office. She also serves as Diplomat to the Florida International Business Council, and as a gubernatorial appointee to the East Central Florida Regional Planning Council. Recently she received a Presidential appointment to the U.S. Small Business Administration National Advisory Board.

CLAUDIA KIRK BARTO

Claudia Kirk Barto is the Executive Director of the Palm Beach Office of the Cystic Fibrosis Foundation. Her primary responsibility is to help fund cystic fibrosis research through events such as the Jeb Bush Florida Classic, the Sixty-Five Roses Ball (which is in its fortieth year), the Mike Schmidt Fishing Tournament, the Fore CF Golf Tournament, the Procida Tile Baseball Classic and the Great Strides Walks.

She previously served as Deputy Executive Director for The Leukemia & Lymphoma Society were she began her crusade to inspire her generation to give back. Prior to that she spent six years with the United Way of Palm Beach County learning the intricacies of area nonprofits and the many needs that go unmet in her community. Claudia grew up in Palm Beach were philanthropy is a way of life.

She received her degree in communications from Florida State University. In April 2000, she was appointed to the Florida Commission on the Status of Women by Comptroller Bob Milligan and recently reappointed by CFO Tom Gallagher. Claudia and her husband Stephen W. Barto, Jr. live in West Palm Beach with their two sons, five-year-old Wen and two-year-old Kirk. They are expecting a daughter in the spring of 2007.

BLANCA BICHARA

Commissioner Blanca Bichara of Miami was appointed to the Commission in January 2000 by Governor Jeb Bush and subsequently re-appointed in February 2004 by Governor Jeb Bush. Commissioner Bichara currently co-owns and manages Flamingo Graphics, a minority printing company specializing in the printing of lottery products for the on-line games for the United States and the International Legalized Lottery Industry.

Commissioner Bichara also has served and continues to serve in many non-profit boards. She serves as the Business liaison on the School Advisory Board of Kinloch Park Middle School in Dade County is past member of the Dade County School Advisory Board at the district level. She served as past Vice President of kids voting in Miami and was the treasurer of the League of Women Voters in Dade County. She is currently the President of the board of Chrysalis Center which provides mental health services in the South Florida area.

THELMA V. CRUMP

Commissioner Thelma V. Crump was appointed in October 2005 to the Florida Commission on the Status of Women (FCSW) by Governor Jeb Bush. She received a Bachelor of Science degree in journalism with a concentration in public relations and political science from the School of Journalism, Media and Graphic Arts, as well as a Master's degree in Business Administration in Marketing and Management from the School of Business and Industry at Florida Agricultural and Mechanical University. She has completed coursework toward a Ph.D. in communication from the College of Communication at Florida State University.

Commissioner Crump is a Regulatory Supervisor Consultant for the Florida Public Service Commission (PSC). She is a nationally-known authority on utility consumer education and has worked with the state and national media on consumer education for the PSC, the Federal Communications Commission, the Federal Trade Commission and the National Association of Regulatory Utility Commission. She has promoted current telecommunication issues, such as Lifeline Assistance and Link-Up Florida, and has written a monthly newspaper column for the chairman and former chairmen of the PSC. She is a managing partner with Crump Management, Inc., a company specializing in the development of real estate properties.

Commissioner Crump has served on various boards, including the Boys and Girls Club of the Big Bend, where she was vice president for three years. She is the President of the Florida Association of Black Telecommunications Professionals (FABTP). FABTP is a formed affiliate of the National Association of Black Telecommunications Professionals (NABTP), a non-profit 501(c)(3) organization founded in 1990 with a national and international membership of telecommunications professionals, small business owners, and students. She also serves on the board of directors for NABTP. She is the Chairman of the Oakridge Elementary School Partnership/Mentoring Program, a program that encourages businesses in the Tallahassee community to assist Oakridge Elementary School with mentors, special events, and fundraisers.

Thelma is a journalist, playwright, author and speaker. She also teaches women how to market themselves, using her recent book, "A Women's Guide and Lessons on How to Market Yourself in Today's Fast Track World," a guide to the health and success of women. A native and fifth generation Floridian, Commissioner Crump is in charge of the Public Relations Ministry at her church, New Mount Zion African Methodist Episcopal Church, and resides in Tallahassee.

ANASTASIA GARCIA, Esq.

Commissioner Garcia of Coral Gables was appointed to the Commission in 2004 by Commissioner of Agriculture Charles Bronson. Commissioner Garcia is an attorney practicing in the area of Matrimonial Law. Mrs. Garcia is also a Florida Supreme Court Certified Family Mediator. Commissioner Garcia earned her J.D. in 1992 from the George Washington University National Law Center. Commissioner Garcia has served on various boards and is involved with her community. Commissioner Garcia is the owner of the Law Offices of Anastasia M. Garcia, she is a partner in Lakes Title Services LLC and she is a shareholder and corporate counsel for Dade Steel Sales Corporation.

SUSANNE HEBERT

Commissioner Hebert of Clearwater received her first appointment in November of 2003 to the Commission by Senate President Jim King. She serves as a corporate executive with Macys Visual Merchandising in Tampa. A graduate of the University of Florida in Ornamental Horticulture, Susanne previously served as both an interior horticultural designer and exterior landscape planner for Burdines. She is a past president of the Tampa Bay Chapter of the Florida Nurserymen and Grower's Association. Susanne has been instrumental, through Macys, for charitable contributions to organizations which include, The Boley Centers, The Kids Wish Network, It's All About Kids, Inc., The Lowry Park Zoo and The Tampa Bay Performing Arts Center. Outside of her professional duties, Susanne serves as board member of the Feather Sound Municipal Taxing District, a member of the Advisory Committee for the Tampa Bay Youth Orchestra and rehearsal manager for the orchestra's Senior Orchestra, where she enjoys helping talented young musicians realize their dreams.

ALLISON DOLINER HOCKMAN, Esq.

Commissioner Hockman of Coral Gables received her first appointment in December 1998 to the Commission by the late Governor Lawton Chiles and subsequently received her second appointment in February 2000 by Commissioner of Agriculture Bob Crawford. In 2004, she was reappointed by Commissioner of Agriculture Charles Bronson. Commissioner Hockman is a Family Law attorney specializing in Collaborative Family Law, Family Law Appeals and Family Law Mediation. She is past president of the Florida Association of Women Lawyers, Dade County Chapter; past president of the Coral Gables Bar Association; and has been named Who's Who of Executive Women and Outstanding Young Women of America. She formerly served as a research assistant for the late Honorable Norman Hendry and the Honorable Thomas Barkdull on the Third District Court of Appeal. Commissioner Hockman currently serves on the Board of Directors for CHARLEE Homes for Children, a Dade County program providing therapeutic, residential and supportive services to abused, abandoned, and neglected children within a safe environment in a community based continuum of care, GABLESTAGE, a non profit community theatre and sits on the Family Law Rules Committee of the Florida Bar.

CHERYL HOLLEY

Commissioner Holley of Tampa was appointed to the FCSW in 2004. She has been a successful entrepreneur since the young age of 19. She has worked for the Republican Party of Florida as well as running several National and State political races from the Presidency, Governor and local House Seats. She also started her own company, Personally Yours, which continues today. Commissioner Holley serves on the boards of the Sylvia Thomas Center for Adoptive and Foster Parents 2004, Hillsborough County Republican Executive Committee, as well as the Outback Bowl Hostess Committee. Commissioner Holley is also active in her community through many volunteer involvements. She has received many awards for her outstanding work in the community with several of the organizations in which her peers nominated her for. One of her proudest is “Women of Achievement” at age 21 her peers where 20 years her senior.

MONA JAIN , M.D., Ph.D.

Commissioner Jain of Bradenton received her first appointment in 1991 and the second appointment in 1993 to the Commission by the Late Governor Lawton Chiles and subsequently her third appointment in 2002 and fourth appointment in 2006 by Senate Presidents John McKay and Tom Lee.

Commissioner Jain has had a lifelong focus on education and health and is a former Fulbright Scholar and National Science Foundation Scholar. Since 1961, she has been an educator and administrator in American, British and Indian education systems. Dr. Jain, now retired as Director of Children and Family Services for Manatee County Head Start, has worked for educational opportunities for all students, especially continuing education for non-traditional mature students.

Commissioner Jain is actively involved in numerous Local, State, National and International Community, Civic and Professional Organizations/Associations. Throughout her career she has been recognized for outstanding professional and community involvements including: Community Service Award from the American Medical Women's Association; the 2001 Distinguished Alumnus Award from the University of South Florida; recognition from the United Negro College Fund for her distinguished career in education; received a Proclamation from the Sarasota County Commission; and Leadership and Professional Awards from the American Association of University Women and Delta Kappa Gamma International.

Dr. Jain has also been honored by placement in American and International "Who's Who". Recognition of her commitment and dedication is not limited to the United States, during her visit to India, her country of birth, she was granted a private audience with the International Humanitarian Mother Teresa.

Sarasota and Manatee Counties have been home to Dr. Jain and her family for the last forty plus years. Her husband Kailash is a businessman and her daughter Anila Jain M.D., MBA is a Medical Consultant and Child Advocate in Manatee County.

MARIE FLORE LINDOR-LATORTUE

Commissioner Marie Flore Lindor-Latortue of Miami was appointed to the Commission in November 2004 by Governor Jeb Bush. She was born and raised in Port-au-Prince, Haiti. In 1992, she graduated from the Interamerican University of Puerto Rico with a double major: B.A. in Education and B.A. in Psychology. In 1995, she obtained her master degree in Health Services Administration at Barry University, Miami, Florida. She is currently a Ph.D. candidate in Leadership and Higher Education Administration. She has served voluntarily in several non-profit organizations particularly “The Make a Wish Foundation of Florida” and WDMA Jazz Station and community radio. She has been named Jackson Memorial Hospital Employee of the Month in September 2001. She has many years of experience in social services and health education program development. She and her husband Luc-Philipe Roland are the parents of two sons Luc-Phillipe and Raphael Yassin Latortue.

CARRIE ESTEVEZ LEE

Commissioner Lee of Gainesville was appointed to the Commission in January 2002 to the FCSW by Governor Jeb Bush and served as the 2005 - 2006 Commission Chair. Commissioner Lee was born in Havana, Cuba and grew up in Miami. She graduated from the University of Florida with a Bachelor of Arts in Secondary English and a Masters in Education in Reading and Middle School Education. She has taught in both public and parochial schools. Commissioner Lee has worked along with her husband in the Real Estate field for over 25 years and is also a Real Estate Broker. Commissioner Lee has been involved in many community organizations and has been active in her community. Commissioner Lee is a 2005 Honorary member of Florida Blue Key. Commissioner Lee currently is a Board Member of the University of Florida Museum of Science and Natural History, she serves as Board Chair of Gainesville Catholic Charities as well as being a member of the St. Augustine Diocesan Catholic Charities Board.

JANET MABRY

Commissioner Mabry of Gulf Breeze was appointed to the FCSW by Senate President Jim King in December of 2003 and reappointed in March of 2006 by Chief Financial Officer Tom Gallagher. She is currently the President and owner of Mabry and Associates, a lobbying and government consulting firm since 1982. She received her B.A. in Political Science from Florida State University and went on to receive a dual Master's degree in Sociology and Political Science from Northern Arizona University. She has worked as a Legislative Assistant to House minority leader Ron Richmond and served as the Director at the St. Petersburg Adult Day Care Center and the Clearwater/St. Petersburg Girls Club Inc. Commissioner Mabry is very active as a volunteer in her community schools and charitable organizations. She is also the mother of two children, ages 16 and 18.

LAURA MCLEOD

Commissioner McLeod of Tallahassee was appointed in February 2002 to the FCSW by Commissioner of Agriculture Charles Bronson. Commissioner McLeod, began her professional career in the field of health prevention, education and treatment. This encompassed her career for over a decade, as well as opening her first business in management consulting and personnel placement in health care. Commissioner McLeod then entered association management for a statewide, not-for-profit association where she used her public relations, organizational and leadership skills to implement a statewide drug prevention and education program for which she won a national education award. Commissioner McLeod currently is President of McLeod & Associates, a governmental consulting firm in Tallahassee.

ANITA MITCHELL

Commissioner Mitchell of West Palm Beach was appointed in January 2000 to the Commission by Commissioner of Education Tom Gallagher, and reappointed in January 2004 by Chief Financial Officer Tom Gallagher. Commissioner Mitchell is president of The Mitchell Group, a governmental relations consulting firm. She has worked as a corporate communications specialist, a political activist/lobbyist, a media consultant, a radio talk show host, a program facilitator/fund-raiser, a communications/public relations expert, and in sales and marketing. She presently serves on the Board of Directors of the World Trade Center, Palm Beaches, the Constitutional Accountability Commission and as Chairman of the Mission Sandbox Foundation. Commissioner Mitchell has been listed in *Who's Who in Communications* and *Who's Who in Politics South/ Southwest*, and is a graduate of Leadership Palm Beach County.

KATHLEEN PASSIDOMO, Esq.

Commissioner Passidomo of Naples was appointed in January 2001 to the FCSW by the Attorney General and reappointed by then Attorney General Crist, in 2004. She currently serves as the 2006 - 2007 Commission Chair. She graduated *cum laude* from Trinity College in Washington, D.C. in May of 1975 and received her law degree from Stetson University College of Law in December of 1978. She is a partner in the firm Kelly, Passidomo & Alba LLP, a Florida Bar Board Certified Real Estate Lawyer and received the 1990 Attorney of the Year Award from the Florida Law Related Education Association of the Florida Bar. She is President-Elect of the Board of Directors of the Collier County Bar Association , the Chairman of the Collier County Bar Association Foundation and is a past President of the Collier County Women's Bar Association. She is a graduate of Leadership Florida Class XI and Leadership Collier Class of 1991 and currently serves on the Board of Directors of the Leadership Collier Foundation. She is a member of the Florida Federal Judicial Nomination Commission and a member of the Board of Trustees of International College where she also serves on the Executive Committee and as liaison to the International College Foundation Board.

She is a past President of the Board of Directors of the Southwest Florida Land Preservation Trust and of The United Way of Collier County. She was the founding Chairman of the Collier County Juvenile Justice Council and a founding member of the Board of Supervisors of the Ave Maria Stewardship Community District. In 1991 she received the Girl's Incorporated of Naples-Collier County "She Knows Where She's Going" Award and in 1996 she was awarded the Leadership Collier Distinguished Alumni Award. In 2000 she and her husband were co-recipients of the Naples Daily News Citizen of the Year award.

JUANITA M. SCOTT

Commissioner Scott of Pensacola originally appointed in July 2002 to the Commission by Attorney General Bob Butterworth. Commissioner Scott currently serves as Coordinator for Professional Development at Pensacola Junior College. In that capacity, she establishes and coordinates all aspects of professional development and training needs throughout the college. Her professional backgrounds includes over fifteen years experience in the areas of Human Resources, Administration and Training. Commissioner Scott has served as Director of Human Resources and Vice President of Administration for a minority/women-owned business that provides rail car manufacturing and training services to the transportation industry nationwide. Commission Scott is an advocate for civic responsibility and frequently speaks to youth groups to encourage and promote youth involvement in community activism. She holds a Masters Degree in Public Administration in Administrative Leadership and a Bachelors Degree in Managing Human Resources.

DEBBIE SEMBLER

Commissioner Debbie Nye Sembler of St. Petersburg is a native Floridian and a graduate of the University of Florida with a Bachelor of Science degree in Public Relations and Marketing. She began her professional career in New York City for the Americana Hotels and also worked for Dorf/MJH, N.W. Ayer and Hill and Knowlton Public Relations Agencies. She opened the Wyndham Hotel Sea World in Orlando as the Public Relations Director and was the first Marketing Director for Old Hyde Park Village Shopping Center in Tampa. Commissioner Sembler was appointed by Governor Jeb Bush in January 2003 to the University of South Florida Board of Trustees and was reappointed to serve a 5-year term in January 2006. She currently serves on the Executive Committee of the Tampa Bay Holocaust Museum. She has been a member of many charitable and religious organizations over the past 18 years and has supported local and national Republican candidates with fundraising. Commissioner Sembler was the recipient of the Gulf Coast Family Services Honorary Award in 1994 and the "To Life" Award from the Tampa Bay Holocaust Museum in January of 2004 for her devotion to these two organizations. Sembler is a full-time mother of three children ages 11 to 18.

ANNE VOSS

Commissioner Voss of Tampa was appointed in January 2006 to the FCSW by Senate President Tom Lee. She was born in Houston, Texas and graduated from Occidental College in Los Angeles with a BA in Political Science and was chosen to attend American University for an honor's study program. She is the Vice President of Strategic Solutions of Tampa, a political consulting firm and Senior Vice President of the Women's Political Network. Prior to her husband's retirement from the U.S. Army, Commissioner Voss was Coordinator for the US Army Child Development Services at Picatinny Arsenal, N. J. and an Assistant Station Manager for the American Red Cross in Pirmasens, Germany.

Commissioner Voss was a Red Cross Volunteer for 16 years; president of the Armed Forces Industrial College Wives Club, Tampa Newcomers and Tampa Republican Women Federated. She is currently President of the Florida Federation of Republican Women and serves on the Vestry of St. John's Episcopal Church. Commissioner Voss's awards include: Department of Army, Commander's Award for Civilian Service; Department of Army, Achievement Medal for Civilian Service; Department of Army, Commendation and Red Cross Certificate of Recognition for 16 years of volunteer service.

NORMA WHITE, L.H.D.

Commissioner White of Jacksonville was appointed in January 2000 to the Commission by Commissioner of Insurance Bill Nelson and re-appointed in January 2004 by Senator James "Jim" King. Commissioner White attended Julliard School of Music, earned a master's degree from Columbia University, and is the recipient of an honorary doctorate from Florida A and M University. She worked in the Duval County School District for 37 years, serving as band director, assistant principal, magnet coordinator and music supervisor. She also served as the program facilitator for Florida Community College. Commissioner White was the first female member of the famed FAMU "Marching 100"--as well as the first female to direct that band, the first African-American to win the EVE Award in Fine Arts, the first Florida resident to become International President of Alpha Kappa Alpha Sorority, Incorporated and was the first Vice Chairman of the Florida A and M University Board of Trustees.

DEE WILLIAMS

Commissioner Williams of Sun City Center received her first appointment in December 1997 to the Commission by President of the Senate Toni Jennings and subsequently received her second appointment in January 2002 by Speaker of the House Tom Feeney. Commissioner Williams retired from Lucent Technologies (formerly AT&T) in February 1986. Her career was spent in the secretarial field from the steno pool to administrative staff. During her working years, she continued her education by obtaining a license in cosmetology and as a real estate broker. Commissioner Williams is serving her 16th year as president of the Sun City Center Republican Club, the largest in the United States. In addition, she is a precinct chair, a clerk for the Hillsborough County Election Board, elected to the Architectural Committee of her Homeowner's Association, and serves on the Citizen's Advisory Board of Hillsborough County Tax Collector Doug Belden.

Former Commission Members

Karen C. Amlong, Esquire
Marie Florence S. Bell
The Honorable Rosemary Barkett
Roxcy O'Neal Bolton
Conchy Bretos
Yvonne Burkholz-Megar
Barbara Carey del Castillo, Esquire
Patricia Clements, PhD
Jackie Colon
Rose Marie Cossick
Carolyn Cramer
Jennifer Knapp Crock
Elsie Crowell
Karen Cunningham, Ph.D.
Helen Gordon Davis
Marilyn J. Dewey
Barbara Effman
Peggy Gagnon
Susan Gilbert
Susan Glickman
Kathryn L. "Kate" Gooderham
Debbie Green
Susan Guber
Donna Hansen
Hon. Edward Healey
The Honorable Sally Heyman
Lena Juarez
Robert Levy
Navita Cummings James, Ph.D.
Peggy Morgan
Jeanne O'Kon, Ph.D.
J. Kayty Pappas
Nancy Patterson
Martha "Marty" Pinkston, Ed.D.
Mona Reis
Judith Byrne Riley
Caroline Routson
Marsha Griffin Rydberg
Joyce A. Szilvasy
D. Anne Terrell, Esq.
Lisa A. Tropepe
Laura Ward
Debbie Warren
Doris Weatherford
Judy K. Wilson, Ph.D.
Susan Wilson
Karen Woodall
Barbara Zdravecky

Commission Staff

Kelly Sciba, APR, Executive Assistant II

Michele S. Manning, CPM, Administrative Assistant III

Angella Jones, Staff Assistant

Ebony Harris, Administrative Secretary

Lindsey Interlandi, Intern

Office of the Attorney General
The Capitol, PL-01
Tallahassee, FL 32399-1050
Phone: (850) 414-3300
Fax: (850) 921-4131
Web: www.fcsw.net

Improving the lives of Florida women.

Florida Commission on the Status of Women

Office of the Attorney General
The Capitol, PL-01
Tallahassee, FL32399-1050
Phone: (850) 414-3300
Fax: (850) 921-4131
Web: www.fcsw.net

Please visit our website at:

www.fcsw.net